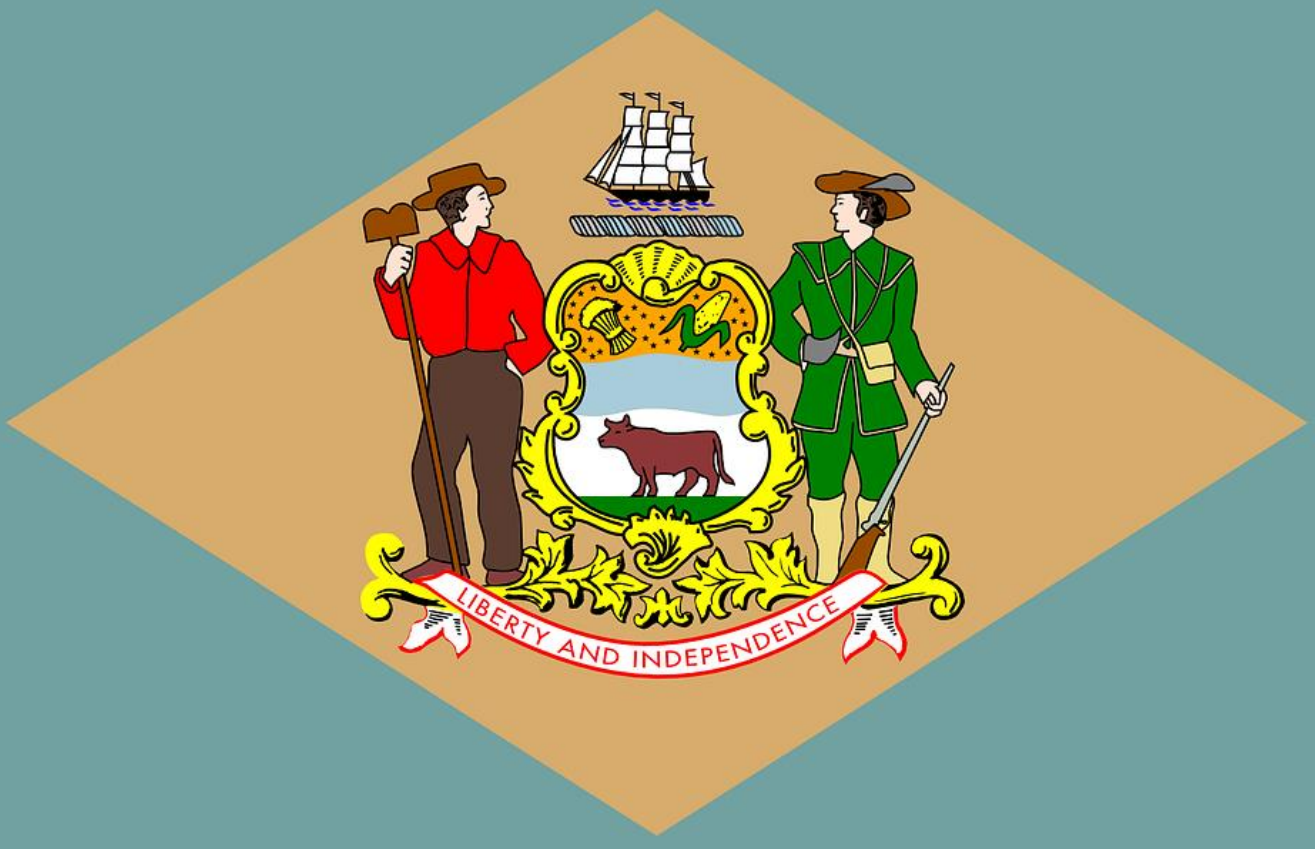
FLEX CEUs

Ethics and Jurisprudence for the Delaware Physical Therapist



OUTLINE

Introduction

This course fulfills the 2-hour continuing competency requirements for ethics, laws, and regulations for physical therapists practicing in the state of Delaware. The Code of Ethics for the Physical Therapist (Code of Ethics) delineates the ethical obligations of all physical therapists as determined by the House of Delegates of the American Physical Therapy Association (APTA). Regulations pursuant to the state of Delaware will also be reviewed.

Instructor Biography

Michele S. Jang, PT is a course author for Flex Therapist CEUs; providing online continuing education units for physical therapists. She graduated with a degree in physical therapy from California State University, Long Beach. She is an experienced educator and currently manages a private physical therapy practice.

Importance of Ethics

Ethics is defined as "that branch of philosophy dealing with values relating to human conduct, with respect to the rightness and wrongness of certain actions and to the goodness and badness of the motives and ends of such action" (Ethics, 2014). Ethics define what governs our value system and steers our moral compass in any given society or culture. Since the dawn of civilization, societies have had to come to an agreement on what standards they would hold their citizens accountable to; whether that is sanctioned by an aristocracy, religious instruction, or system of government. We can find the beginnings of ethics in the study of the earliest nomadic people and cooperative groups who sought to not only live for today's survival, but also held a vision to building a future, using standards that were agreed upon. The concept of marking time, calendars, and agriculture depended on the cooperation of people working in harmony with one another and following the same guidelines. The Code of the Hammurabi was the earliest Sumerian code of ethics and laws to be written down for the sake of establishing a standard of morals and consequences. This is where the popular "eye for an eye" concept came from (Hammurabi, 2014). In medicine, there is another defining code of ethics, coined by Hippocrates as the Hippocratic Oath. This is where ethics in medicine begins and is the cornerstone to a physical therapy practice. Though times have changed, the importance of "do no harm" is emphasized.

The Oath
By Hippocrates
Written 400 B.C.E
Translated by Francis Adams

> *I SWEAR by Apollo the physician, and Aesculapius, and Health, and All-heal, and all the gods and goddesses, that, according to my ability and judgment, I will keep this Oath and this stipulation- to reckon him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art to*

my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others. I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practice my Art. I will not cut persons laboring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further from the seduction of females or males, of freemen and slaves. Whatever, in connection with my professional practice or not, in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath un-violated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times! But should I trespass and violate this Oath, may the reverse be my lot!

Ethical Dilemmas

Ethical dilemmas are issues and situations that cause friction against the primary code of ethics physical therapists are required to follow. While most physical therapists would consider themselves highly ethical and may have a hard time imagining themselves acting immorally, an ethical dilemma may emerge from something as innocent as conflicting state and county guidelines or unknowingly using outdated standards or therapeutic equipment. Physical therapy works specifically in the care and well being of humans. As such, maintaining and keeping healthy and professional boundaries and clear communication are integral to the healthcare field. “Do No Harm” is not a term to throw around lightly, but to hold us firm in our convictions to provide the best possible care, while weighing out carefully all the possible side effects or consequences of our actions, however far reaching. Let’s take a look at a scenario which brings up an ethical dilemma and ask the ethical question of, "What is the right thing to do?"

Scenario: It is the end of a long day of treating clients and you have just completed your note on your last patient, Mrs. Jones. Mrs. Jones has difficulty walking and is at high risk for falls. She has limited use of her arm as well as some short-term memory loss. She relies on friends and family to provide transportation. Her daughter has been running errands and will be picking Mrs. Jones up but you notice that the daughter has not come yet. You have front row concert seats and are meeting a friend in 15 minutes. No one else is in the office and as it stands, you need to lock up. You search for the daughter’s phone number but can’t find it, and Mrs. Jones is unable to recall the number herself. What do you do? Do you: A) sit with Mrs. Jones in the office and wait until the daughter arrives, or B) have Mrs. Jones wait outside the office in the parking lot?

"What is the right thing to do?" While it is human nature for us to want to satisfy our own desires, it is our ethical responsibility to put the needs of the clients first. As much as you may have wanted to attend the concert and as much as the seats may have cost, there is no comparison in price that matches another person's life, well-being, and safety.

Ethical Approaches

There are different schools of thought which utilize ethics to make decisions. We will explore five of these.

Utilitarianism:

"Actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness" – John Stuart Mill

Utilitarianism is the ethical approach that promotes the maximum of pleasure and happiness with the minimum of pain and suffering. This sounds pretty reasonable and most people would tend to agree that given a choice between pleasure and pain, most people are going to go with pleasure. Utilitarianism takes this approach a step further in not only seeking benefits of pleasure for oneself, but making decisions that will give the most people benefits, while inflicting suffering as little as absolutely possible (Driver, 2014).

Personalized:

This relatively recent take on ethical responsibility has been brought to light due to medical advances and the ability to personalize a client's profile in order to concentrate their treatment or tailor their prescription. Modern science has even mapped the human genome through Whole Genome Sequencing. The original intention is to reduce the amount of mortality and morbidity due to faulty diagnosis or prescription from an adverse drug response. But how much information is too much information? Where does the "right to know" boundary lie? What if we knew an unborn fetus has a grave disorder? What if a new drug was known to treat this disorder but in doing so put the pregnant mother at risk? (Vogenberg, 2018)

Deontologic:

According to the Encyclopedia Britannica, the philosophy of Deontology is derived from the Greek deon, "duty," and logos, "science," focusing on logic and ethics Deontological thought comes from the place that there is definitely a "right" and a "wrong" and that humans should strive to always do the right thing, regardless of the cost ("Deontological ethics," 2014).

Ethical Intuitionism:

Ethical intuitionism relies heavily on our intuitive sense or 'common sense' to guide our moral compass. It supposes that there are certain inherent truths that we

can discern without having facts or a formal education on the subject. We don't need a religious teaching or edict from the Queen to tell us that taking care of our young is a good thing or that kicking animals is a bad thing. Sadly, this doesn't mean that everyone is on the same page with these inherent truths, which is where the law of Karma comes in (Stratton-Lake, 2014).

Natural Law Theory:

Natural Law is one of those rare ethics philosophies that both theists and atheists can actually agree on. This law speaks to our common sense approach to basic survival, basic goodness, and basic decency as human beings. It states, "The atheist uses reason to discover the laws governing natural events and applies them to thinking about human action. Actions in accord with such natural law are morally correct. Those that go against such natural laws are morally wrong. For the theists there is a deity that created all of nature and created the laws as well and so obedience to those laws and the supplement to those laws provided by the deity is the morally correct thing to do" (Murray, 2014).

Ethics Versus Morals

While these terms are often used interchangeably, there is a difference between ethics and morals. Morals generally refer to what an individual considers "right" and "wrong" or wrong, whereas ethics are rules that are generally agreed upon by a group of people, such as a workplace, or society at large. ("Ethics vs", 2018) Shared morals may help guide ethical policies, and in turn ethics may help guide morals. However, this distinction is important to make as situations may occur in which a physical therapist's personal morals do not perfectly align with a code of ethics.

Morality is defined as: "conformity to the rules of right conduct; moral or virtuous conduct" ("Morality," 2014). Morals can be virtuous, but they stem from a cultural, religious, or belief system context, that can change and evolve.

As part of determining a code of ethics that protects and benefits all people, we take bits and pieces of what has worked for thousands of years, what is deemed "true" and "virtuous" and what is in the best interest of our community. Let's take a look at some more of these contributing thoughts that make up the whole.

Altruism: Altruism is the practice of acting towards the benefit of another without any regard to benefit for yourself.

Dignity: All people have the right to their own dignity or "worthiness." They have the right to be treated with respect regardless of background, income level, ability, gender, age, or any other factor that uses a hierarchical pecking order. When all else fails, stick with the golden rule, "Treat others as you would want to be treated."

Equality: Equality is a leveling of the playing field. In cases of economic parity and great need for healthcare, equality and justice both serve the community by

saying that everyone deserves equal access to healthcare.

Freedom: Freedom in the framework of ethics says that a person has the freedom of their own autonomy, up to, but not including the freedom to affect another person negatively. A scenario which describes this term is the following: A person has a right to choose to smoke tobacco, but they do not have the freedom to make that health choice for other people via second hand smoke. Therefore we have laws which limit the areas in which to smoke.

Prudence: Caution and discretion in practical manners.

We now have a basic knowledge of some of the foundations of ethical reasoning and how morals can be brought into play. However, what are values and how do they fit in? Values are a way to quantify the worthiness of the principles and morals a group holds dear. "Family Values" encompasses many characteristics that would be thought as the most beneficial way to raise and care for a family. In the same way, ethical values are the pathway that the healthcare field utilizes as their foundation for the success of their patients, colleagues, employees, and research participants.

Values are of great benefit to:

- clients who know their rights and choices will be respected and that they will be treated with dignity as a partner in their path to well being
- employees who know what is expected of them and have the comfort and empowerment of recourse and redress if an issue or concern comes up
- colleagues who will be treated with professional respect for their knowledge and expertise that they bring
- research participants who are empowered by their contribution and autonomy to choose to participate
- the PT, who knows their tradition is from a long line of tried and proven methods that benefit and serve their community with dignity

While we looked at all of the values, the virtues, and the morals of operating within an ethical model, the bottom line is: following the Code of Ethics keeps your patients safe and your business secure. Operating within ethical standards not only ensures that you are serving your patients to the best of your ability, it protects your license and therefore, your livelihood. While you may encounter local, cultural, and practical variations, the standards within the Code of Ethics are recognized throughout the world, and becoming familiar with them will provide knowledge you will use for the rest of your practice.

Bioethical Concerns

Bioethical concerns relate to how we approach newer technologies ethically. Examples

include: Artificial insemination, cloning, stem cell research, and prolonging care for those in long-term comas. These are not "naturally" occurring for humans, but instead is the result of human engineering. There is great debate among cultures and religious groups who have moral objections to invasive procedures.

HIPAA

HIPAA is the federal Health Insurance Portability and Accountability Act of 1996. The primary goal of the law is to make it easier for people to keep health insurance, protect the confidentiality and security of healthcare information, and help the healthcare industry control administrative costs (HIPAA, 2017).

Licensure and Regulation

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

State Licensure and Regulation

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

Purpose and Requirements for State Licensure

State licensure is inherently restrictive for the licensee and exclusive to the particular profession. Only those who "meet and maintain prescribed standards" established by the State's regulatory board will, for the protection and benefit of the public, be allowed to profess their qualifications and provide their services to the public. The public is dependent upon the State to evaluate and affirm the qualifications for licensure of physical therapists. One of the main tools used by a State's regulatory entity to determine if a physical therapist has met that threshold is the physical therapist's passage of the National Physical Therapy Exam (NPTE) of the Federation of State Boards of Physical Therapy (FSBPT). The NPTE is the only examination for licensure of physical therapists—all 50 states and the District of Columbia use it. The NPTE is "competency specific" and covers the entire scope of

entry-level practice, including theory, examination and evaluation, diagnosis, prognosis, treatment intervention, prevention, and consultation that are consistent with the exam blueprint. A formal, systematic process referred to as an "analysis of practice" determines the contents of a licensure examination. This process begins with the identification of work requirements for entry-level practitioners and ends with the development of a formal set of test specifications that delineates the knowledge and skills related to safe and effective entry-level practice.

Because physical therapy practice evolves, it is imperative that the licensure examinations be updated on an ongoing basis. Thus, a practice analysis must be conducted periodically to ensure that changes in entry-level requirements are incorporated into the licensure examinations. Revisiting the practice analysis regularly ensures that fewer test questions are included on skill areas of decreasing importance and more test questions address skill areas of increasing importance. The time frame for updating a practice analysis varies by profession; for the physical therapy profession this analysis is conducted at least every 5 years.

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

State Regulatory Boards

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

The Model Practice Act for Physical Therapy

Over decades, the various physical therapy practice acts have contained functional and useful regulatory language but also some problematic language. Most jurisdictional practice acts had their origins in the 1950s and early 1960s, and amendments turned some

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

Terms and Titles of the Physical Therapy Profession

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

Direct Access to Physical Therapist Services

The vast majority of U.S. jurisdictions have some form of patient access to evaluation and treatment by licensed physical therapists. Access to physical therapist services is critical to ensuring optimum patient functional status and independence. Throughout the experience of obtaining direct access at the state level, physical therapists have been questioned about their ability to identify a patient's signs and symptoms correctly, especially those that may represent cancer or other life-threatening conditions, if the patient has not first been screened by a physician. The misguided presumption is that physical therapists are not sufficiently educated or clinically trained to correctly diagnose an underlying pathological condition. This argument falsely concludes that direct access to physical therapists is

therefore a threat to the safety of the public. However, a closer look at the facts and evidence proves otherwise.

Physical therapists diagnose impairments, functional limitations, and disabilities related to medical conditions, movement dysfunction, and other health-related disorders. Physical therapists do not provide a medical diagnosis. However, they are well-prepared to identify when a patient's signs and symptoms potentially lie outside the scope of the physical therapist's diagnosis and require a referral to a physician for further diagnostic work-up and identification of underlying pathology. The examination process, routinely employed by physical therapists, ensures that direct access to physical therapists also allows referral to physicians when indicated. With more than 30 years of experience with direct access in the states that permit it, physical therapists have not been noted to misinterpret a patient's signs and symptoms as non-pathological leading to serious injury or death. Physical therapist malpractice rates do not differ between states with patient direct access and those with a physician referral requirement. Furthermore, when the number of complaints filed against physical therapists with state licensure boards were examined prior to and after elimination of the physician referral requirement, no increase of complaints centered on patient harm was found. In a study from 2017 entitled "The Influence of Patient Choice of First Provider on Costs and Outcomes: Analysis From a Physical Therapy Patient Registry," outcomes from direct access care and physician referral were compared. No difference in care or outcomes were found, and additionally the direct access group was noted to spend $1,543 less on average on total treatment costs, indicating that direct access is equally as safe and potentially more cost-efficient. (Denninger, 2017). Most referrals from physicians are written as "evaluate and treat." Medical "diagnoses" may be non-specific terms such as "low back pain." Even if a specific medical diagnosis is provided along with an "evaluate and treat" referral, it is incumbent upon the physical therapist to identify the rehabilitation diagnosis. Physical therapists independently design the plan of care and the schedule of implementation. It is the physical therapist who has ultimate responsibility for what interventions will be provided, how many times a week or month the patient will be seen, and the overall duration of the episode of care. Direct access also supports a collaborative model of practice between physicians and physical therapists and can create opportunities that enhance patient management, safety, and outcomes. Collaboration is, in many respects, the flip side of the direct access "coin." Historically, physical therapists emerged as a profession within the medical model, not as an alternative to medical care. Traditionally, physical therapists receive a substantial proportion of their clinical education and training in academic medical centers and hospitals, where team collaboration is paramount. Both physical therapists and physicians have a mutual respect for, and deep understanding of, their complementary roles in patient care. Direct access does not alter that relationship; it merely allows the collaboration to be initiated by the physical therapist at a point in the physical therapy episode of care that is most beneficial to the patient and most cost effective for the health care system.

Delaware Regulations

DEPARTMENT OF STATE

DIVISION OF PROFESSIONAL REGULATION
EXAMINING BOARD OF PHYSICAL THERAPISTS AND ATHLETIC TRAINERS
Statutory Authority: 24 Delaware Code, Section 2604(a)(1) (24 Del.C. §2604(a)(1))
24 DE Admin. Code 2600
FINAL
ORDER
2600 Examining Board of Physical Therapists and Athletic Trainers

After due notice in the Register of Regulations and two Delaware newspapers, a public hearing was held on October 28, 2014 at a scheduled meeting of the Delaware Examining Board of Physical Therapists and Athletic Trainers ("the Board") to receive comments regarding the Board's proposed revisions to its rules and regulations.
The Board's proposed amendments serve to clarify rules pertaining to home health aides, supervision, and the practice of athletic training. Proof of current CPR certification is added to licensure requirements. Rules relating to licensure reactivation and reinstatement are revised for consistency. Rule 12.24 is added to specifically prohibit licensee involvement in kickbacks. Finally, a new Rule 15.0 is added to set forth advanced training requirements for the emergency administration of asthma and anaphylaxes medications and for physical therapy and athletic training care provided outside the clinical setting to athletic injuries.
A public hearing was held on October 28, 2014, with deliberations conducted on November 18, 2014. The proposed changes to the rules and regulations were published in the Register of Regulations, Volume 18, Issue 4, on October 1, 2014. Notice of the October 28, 2014 hearing was published in the News Journal (Exhibit 1) and the Delaware State News. Exhibit 2. Pursuant to 29 Del.C. §10118(a), the date to receive final written comments was November 12, 2014, 15 days following the public hearing. The Board deliberated on the proposed revisions at a scheduled meeting on November 18, 2014.
Summary of the Evidence and Information Submitted The following exhibits were made a part of the record:

Board Exhibit 1: News Journal Affidavit of Publication.
Board Exhibit 2: Delaware State News Affidavit of Publication.
Board Exhibit 3: Written comment from Marybeth Glasheen-Wray concerning proposed Rule 6.4.
Board Exhibit 4: Written comment from Board Chairperson Julie Knowles concerning proposed Rule 6.4.

Findings of Fact and Conclusions

The public was given notice and an opportunity to provide the Board with comments in writing and by testimony on the proposed amendments to the Board's rules and regulations. Pursuant to 24 Del.C. §2506(a)(1), the Board has the statutory authority to promulgate rules and regulations. Further, the Administrative Procedure Act, 29 Del.C. §10118(c), provides that the Board can make non-substantive changes to the proposed rules and regulations, without further rule-making, if such changes are not substantive.
The Board finds that the rules and regulations, as published, include a number of drafting errors in that certain language was inadvertently included and other language was excluded. The Board finds these changes to be nonsubstantive. Specifically, the Board strikes the last

sentence of proposed Rule 5.3.2 and the term "athletic training," pertaining to ethics education, is added to Rules 8.3 and 9.3. Rule 13.2.5.5 is revised in terms of organization of the language. These minor revisions are non-substantive but are needed in the interests of clarity and consistency.

With respect to Exhibits 3 and 4, written comment from Marybeth Glasheen-Wray and Julie Knowles concerning proposed Rule 6.4, the Board finds that the proposed Rule 6.4 accurately captures the permissible scope of practice for physical therapists and should be accepted as proposed.

In short, the Board finds that the adoption of the proposed rules and regulations, as amended, serves to provide greater public protection and advance professional practice standards and are in the best interest of the public.

Decision and Effective Date

The Board hereby adopts the proposed amendments to the rules and regulations, with the non-substantive revisions noted in bold print, to be effective 10 days following final publication of this Order in the Register of Regulations. Text and Citation

The text of the revised rules and regulations is set forth in Exhibit A, attached hereto.

IT IS SO ORDERED this 18th day of November, 2014 by the Delaware Examining Board of Physical Therapists and Athletic Trainers.

Julie Knowles, Professional Member, Chairperson
Samuel Sullivan, Professional Member, Secretary
Amy Blansfield, Professional Member
Angela Smith, Professional Member
Tyler Luff, Public Member
Jeffrey Schneider, Professional Member, Vice-Chairperson
Wayne Woodzell, Professional Member
Damien McGovern, Professional Member
Waheedah Shabazz, Public Member

2600 Examining Board of Physical Therapists and Athletic Trainers

1.0 Definitions

1.1 Consultation (24 Del.C. §2612)

1.1.1 Consultation in direct access. A licensed health practitioner who has been granted prescriptive authority must be consulted if a patient is still receiving physical therapy after 30 calendar days have lapsed from the date of the initial assessment. This consultation must be documented and could take place at any time during the initial thirty day period. The consultation can be made by telephone, fax, in writing, or in person. There is nothing in these Rules and Regulations or in the Physical Therapy Law that limits the number of consultations the Physical Therapist can make on the patient's behalf. The consult should be with the patient's personal licensed health practitioner. If the patient does not have a personal licensed health practitioner, the Physical Therapist is to offer the patient at least three licensed health practitioners from which to choose. The referral to a licensed health practitioner after the initial thirty day period must not be in conflict with 24 Del.C. §2616(a)(8) which deals with referral for profit. If no licensed health practitioner consult has been made in this initial thirty day period, treatment must be terminated and no treatment may be resumed without a licensed health practitioner consult.

1.1.2 Consultation with written prescription from a licensed health practitioner. A prescription accompanying a patient must not be

substantially modified without documented consultation with the referring practitioner. The consultation can be made by telephone, fax, in writing, or in person.

1.2 Direct Supervision

1.2.1 Direct supervision in connection with a Physical Therapist, Physical Therapist Assistant, or Athletic Trainer practicing under a temporary license means:

1.2.1.1 a licensed Physical Therapist or Athletic Trainer supervisor shall be on the premises when the individual with a temporary license is practicing and

1.2.1.2 evaluations and progress notes written by the individual with a temporary license shall be cosigned by the licensed Physical Therapist supervisor.

1.2.2 Direct supervision in relation to a Physical Therapist Assistant with less than one (1) year experience means a Physical Therapist shall be on the premises at all times and see each patient.

1.2.3 Direct supervision in relation to a Physical Therapist Assistant with one (1) year or more experience means that the supervising Physical Therapist must see the patient at least once every sixth treatment day, and the Physical Therapist Assistant must receive on-site, face to face supervision at least once every twelfth treatment day. The initial evaluation counts as a "treatment day." When not providing direct supervision on the premises, the supervising Physical Therapist must have at least one (1) year clinical experience. The Physical Therapist and must be available and accessible by telecommunications to the Physical Therapist Assistant during all working hours of the Physical Therapist Assistant.

1.2.4 Direct supervision in relation to an Athletic Trainer treating an injury not defined as an 'athletic injury,' which must be a musculoskeletal disorder if seen for physical therapy, when the Athletic Trainer has one (1) year or more experience, means that the supervising Physical Therapist must see the patient at least once every fifth sixth treatment day, and the Athletic Trainer must receive on-site, face to face supervision at least once every tenth twelfth treatment day. The initial evaluation counts as a "treatment day." When not providing direct supervision on the premises, the supervising Physical Therapist must have at least one (1) year clinical experience. The Physical Therapist and must be available and accessible by telecommunications to the Athletic Trainer during all working hours of the Athletic Trainer.

1.2.5 Direct supervision in connection with an Athletic Trainer treating an injury not defined as an 'athletic injury,' which must be a musculoskeletal disorder if seen for physical therapy, when the Athletic Trainer has less than one (1) year of continuous experience means a Physical Therapist shall be on the premises at all times and see each patient.

1.2.6 Direct supervision in connection with an Athletic Trainer with a temporary license treating an 'athletic injury' is that the licensed Athletic Trainer supervisor shall be on the premises when the individual with a

temporary license is practicing and all evaluations and progress notes shall be co-signed by the Athletic Trainer supervisor.

1.2.7 Direct supervision in relation to an Athletic Trainer with one (1) year or more experience, who is treating a non-athletic injury, means that an Athletic Trainer must receive on-site, face to face supervision at least once every fifth treatment day or once every three weeks, whichever occurs first. The Supervising Physical Therapist must have at least one (1) year experience. The Supervising Physical Therapist must be available and accessible by telecommunications to the Athletic Trainer during all working hours.

1.2.8 At any given time, a Physical Therapist shall not supervise more than: 2 Physical Therapist Assistants; or 2 Athletic Trainers; or 1 Physical Therapist Assistant and 1 Athletic Trainer. While a Physical Therapist may supervise up to two Physical Therapist Assistants, only one of those Physical Therapist Assistants may be off-site.

1.2.9 Direct supervision in connection with support personnel means a licensed Physical Therapist, Physical Therapist Assistant or Athletic Trainer shall be personally present and immediately available within the treatment area to give aid, direction, and instruction when procedures are performed.

1.3 Support personnel (24 Del.C. §2615) means a person(s) who performs certain routine, designated physical therapy tasks, or athletic training tasks, under the direct supervision of a licensed Physical Therapist or Physical Therapist Assistant or Athletic Trainer. There shall be documented evidence of sufficient in-service training to assure safe performance of the duties assigned to the support personnel.

2.0 Board

2.1 Specific duties of the officers:

2.1.1 The Chairperson:

2.1.1.1 Shall call meetings of the Board at least twice a year. 2.1.1.2 Shall represent the Board in all official functions and act as Board spokesperson.

2.1.2 The Vice-Chairperson:

2.1.2.1 Shall substitute for the Chairperson during the officer's absence.

2.1.3 The Secretary:

2.1.3.1 Shall preside when the Chairperson and Vice-Chairperson are absent.

3.0 Responsibility of Physical Therapist

The Physical Therapist is responsible for the actions of the Physical Therapist Assistant or the Athletic Trainer when under his/her supervision. All supervision must be documented.

4.0 Physical Therapist Assistants (24 Del.C. §2602(7))

The Physical Therapist Assistant may treat patients only under the direction of a Physical Therapist as defined in Rules 1.2.2 and 1.2.3. The Physical Therapist Assistant may perform physical therapy procedures and related tasks that have been selected and delegated by the supervising Physical Therapist. The Physical

Therapist Assistant may administer treatment with therapeutic exercise, massage, mechanical devices, and therapeutic agents that use the properties of air, water, electricity, sound or light. The Physical Therapist Assistant may make minor modifications to treatment plans within the predetermined plan of care, assist the Physical Therapist with evaluations, and document treatment progress. The ability of the Physical Therapist Assistant to perform the selected and delegated tasks shall be assessed by the supervising Physical Therapist. The Physical Therapist Assistant shall not perform interpretation of referrals, physical therapy evaluation and reevaluation, major modification of the treatment plan, final discharge of the patient, or therapeutic techniques beyond the skill and knowledge of the Physical Therapist Assistant without proper supervision.

5.0 Athletic Trainers (24 Del.C. §§2602(2) and (3))

5.1 Athletic injuries:

5.1.1 Athletic trainers may treat athletic injuries. Athletic injuries shall be considered musculoskeletal injuries to athletes that occur while currently participating in, or currently training for, scholastic, professional, or sanctioned amateur athletics, where such injury limits the athlete's ability to participate or train for their sport. Athletic Trainers may also treat musculoskeletal injuries received by athletes that occur while currently participating in recreational activities, where such recreational activities are recognized by the Amateur Athletic Union. All Athletic injuries must be documented by the Athletic Trainer as interfering with participation in or training for such athletic activities. Nothing prohibits the Athletic Trainer from treating minor sprains, strains, and contusions to athletes currently participating in professional, scholastic, recreational, or sanctioned amateur athletic activities.

5.2 Non-athletic injuries:

5.2.1 Athletic Trainers may treat musculoskeletal injuries as part of a physical therapy plan of care only under the direction and supervision of a Physical Therapist as defined in Rules 1.2.5 and 1.2.7. The Athletic Trainer may perform physical therapy and athletic training procedures and related tasks that have been selected and delegated by the supervising Physical Therapist. The Athletic Trainer may administer treatment with therapeutic exercises and modalities such as heat, cold, light air water, sound, electricity, massage and non-thrust mobilization. The Athletic Trainer may document treatment progress. The ability of the Athletic Trainer to perform selected and delegated tasks shall be assessed by the supervising Physical Therapist. The Athletic Trainer shall not perform interpretation of referrals, physical therapy evaluation and reevaluation, modification of the treatment plan, final discharge of the patient, or therapeutic techniques beyond the skill and knowledge of the athletic trainer without proper supervision. The supervising Physical Therapist must be contacted for approval to make any modification of the treatment plan within the physical therapy plan of care.

5.3 Exceptions:

5.3.1 Nothing in this regulation shall limit an Athletic Trainer's ability to provide preventative care procedures of conditioning, taping, protective

bandaging, padding and icing. Nothing in this regulation shall limit an Athletic Trainer's ability to provide emergency treatment to injuries, or to provide immediate care to athletes who are currently participating in scholastic, professional, or sanctioned amateur athletics, within the scope of their training, so long as the immediate care does not last longer than 5 days without a consultation with a physician.

5.3.2 Nothing in this regulation shall limit an Athletic Trainer's ability to provide care that the general population is permitted to perform as long as the Athletic Trainer does not represent himself or herself as an Athletic Trainer during the performance of such care, and if working in a physician's office or as a physician extender, only provides assistance to the physician during regular physician office visits where the patient is provided direct on-site care by the physician and the visit is not for rehabilitation purposes. [For the purpose of this regulation, a physician extender is a health care provider who is not a physician but who performs medical activities typically performed by a physician.] 8 DE Reg. 1591 (5/1/05)

6.0 Support Personnel (24 Del.C. §2615)

6.1 Treatments which may be performed by support personnel under direct supervision are:

6.1.1 ambulation
6.1.2 functional activities
6.1.3 transfers
6.1.4 routine follow-up of specific exercises
6.1.5 hot or cold packs 6.1.6 whirlpool/Hubbard tank
6.1.7 contrast bath
6.1.8 infrared
6.1.9 paraffin bath
6.1.10 ultra sound

6.2 Exceptions - A support person may perform:

6.2.1 patient related activities that do not involve treatment, including transporting patients, undressing and dressing patients, and applying assistive and supportive devices without direct supervision, and

6.2.2 set up and preparation of patients requiring treatment using modalities.

6.3 Prohibited Activities - support personnel may not perform:

6.3.1 evaluation, or

6.3.2 treatments other than those listed in Rule 6.1.

6.4 Home health aides: A Physical Therapist may develop a physical therapy home health plan of care and a home health aide plan of care relating to physical therapy; however, the home health care aide or certified nurse's aide must be under the supervision of the nurse employed by the home health agency.

7.0 Licensure Procedures; Renewal of Licenses (24 Del.C. §2606)

7.1 Applications, the Rules and Regulations, and the Practice Act (24 Del.C. Ch. 26) are available on the Division of Professional Regulation's website.

7.2 Applicants for Physical Therapist or Physical Therapist Assistant licensure shall not be admitted to the examination without the submission of the following documents:

7.2.1 Professional Qualifications - proof of graduation (official transcript) from an educational program for the Physical Therapist or Physical Therapist Assistant which is accredited by the appropriate accrediting agency as set forth in the Practice Act.

7.2.2 Proof of current CPR certification by the American Red Cross, American Heart Association, National Safety Council or other agency approved by the Board and posted on the Division of Professional Regulation's website.

7.2.3 Proof of completion of a criminal background check, pursuant to application instructions.

7.2.~~2~~4 A fee in check or money order payable to the State of Delaware.

7.2.~~3~~5 A completed application form.

7.3 The Board may shall use the Physical Therapist and Physical Therapist Assistant examination endorsed by the Federation of State Boards of Physical Therapy.

7.4 All applicants for licensure as a Physical Therapist or Physical Therapist Assistant must successfully pass the examination described in Rule 7.3 in order to become eligible for licensure. The Board will adopt the criterionreferenced passing point recommended by the Federation of State Boards of Physical Therapy.

7.5 Applicants for licensure as an Athletic Trainer must submit to the Board the following:

7.5.1 Professional Qualifications - proof of graduation (official transcript) from an educational program described in 24 Del.C. §2606(a)(1), whether an accredited program or National Athletic Trainers Association Board of Certification (NATABOC) internship.

7.5.2 Official letter of Athletic Trainer certification from NATABOC.

7.5.3 Proof of current CPR certification by the American Red Cross, American Heart Association, National Safety Council or other agency approved by the Board and posted on the Division of Professional Regulation's website.

7.5.4 Proof of completion of a criminal background check, pursuant to application instructions.

7.5.~~3~~5 A check or money order made payable to the State of Delaware.

7.5.~~4~~6 The completed application form.

7.6 Licenses shall expire biennially on every odd numbered year. License renewal shall be accomplished online at www.dpr.delaware.gov and shall include:

7.6.1 the applicable fee, and

7.6.2 attestation of completion of continuing education courses required by Rule 13.0.

8.0 Admission to Practice, Licensure by Reciprocity (24 Del.C. §2610)

Definition - The granting of a license to an applicant who meets all the requirements set forth in this Rule and 24 Del.C. §2610.

8.1 The reciprocity applicant shall submit the documentation listed in Rules 7.2 or 7.5.

8.2 An applicant shall be deemed to have satisfied this Rule upon evidence satisfactory to the Board that he/she has complied with the standards set forth below:

8.2.1 The Physical Therapist or Physical Therapist Assistant applicant has passed the examination in the state, territory, or the District of Columbia in which he/she was originally licensed/registered. The passing score shall be 1.5 standard deviation below the national norm for those Physical Therapists and Physical Therapist Assistants having taken the examination prior to 1990.

8.2.2 All Physical Therapist/Physical Therapy Assistant reciprocity applicants shall supply his/her examination scores to the Board. The applicant may obtain his/her scores from the regulatory body of the state, territory, or the District of Columbia in which he/she was originally licensed/registered or from the FSBPT Score Transfer Service. From Physical Therapist applicants who were licensed/registered by a state, territory, or the District of Columbia only prior to 1963, the Board shall accept the following:

8.2.2.1 Professional Examination Service-American Physical Therapy Association (PES-APTA) examination scores with a passing grade of 1.5 standard deviation below the national norm on all sections, or

8.2.2.2 other examining mechanisms which in the judgment of the Board were substantially equal to the mechanisms of the State of Delaware at the time of examination.

8.2.3 For the Athletic Trainer candidate, the passing score shall be that which was established at time of examination. All sections of the examination shall be passed. The reciprocity applicant shall have their National Athletic Trainer Association Board of Certification (NATABOC) [verification of certification] forwarded directly to the Board office.

8.3 All reciprocity applicants shall show proof of completion of a minimum two hours ethics class related to the practice of physical therapy [and/or athletic training] and proof of current CPR certification by the American Red Cross, American Heart Association, National Safety Council or other agency approved by the Board and posted on the Division of Professional Regulation's website.

8.4 All reciprocity applicants shall show proof of completion of a criminal background check, pursuant to application instructions.

9.0 Foreign Trained Applicant for Licensure (24 Del.C. §2606(b))

9.1 Applicants for licensure who are graduates of a Physical Therapist, Physical Therapist Assistant school or Athletic Trainer program located in a foreign country shall complete all of the following requirements before being admitted to the examination:

9.1.1 The applicant shall submit proof satisfactory to the Board of graduation from an education program appropriate to their profession in a foreign country. Each foreign applicant must demonstrate that they have met the minimum education requirements as presented by the Federation of State Boards in the Course Work Evaluation Tool for Persons Who

Received Their Physical Therapy Education Outside the United States. The applicant shall arrange and pay for a credential evaluation of such foreign school's program to be completed by an agency approved by the Board.

9.1.2 The applicant shall complete the requirements of Rules 7.2 or 7.5.

9.1.3 The applicant shall pass the examination described in Rules 7.3 and 7.4.

9.2 The applicant shall show proof of completion of a criminal background check, pursuant to application instructions.

9.3 The applicant shall show proof of completion of a minimum two hours ethics class related to the practice of physical therapy [and/or athletic training] and proof of current CPR certification by the American Red Cross, American Heart Association, National Safety Council or other agency approved by the Board and posted on the Division of Professional Regulation's website.

10.0 Temporary Licensure (24 Del.C. §2611)

10.1 The Board may issue a temporary license to all applicants who have submitted to the Board the documents listed in Rule 7.2 and Rule 7.5, respectively, and who have been determined to be eligible to take the examination. The Board shall accept a letter signed by the Physical Therapist or Physical Therapist Assistant applicant's school official stating that the applicant has completed all requirements for graduation; provided, however, that the applicant shall submit to the Board an official transcript as soon as it becomes available. The Board will determine the Physical Therapist or Physical Therapist Assistant applicant's eligibility to take the examination. In the case of Athletic Trainer applicants for temporary license, a letter from NATA stating the applicant's eligibility to take the NATA examination will be required. Physical Therapist and Physical Therapist Assistant applicants may practice only under the direct supervision of a licensed Physical Therapist. Athletic Trainer applicants may practice only under the direct supervision of a licensed Athletic Trainer or Physical Therapist as that supervision is defined in Rule 1.2.1. A temporary license shall expire upon notice to the applicant of his/her failure to pass the license examination and may not be renewed. In all other cases, a temporary license may be renewed only once.

10.2 Applicants requesting reciprocity as a Physical Therapist, Physical Therapist Assistant, and Athletic Trainer. The Board may issue a temporary license to an applicant upon the applicant's submission of letters of good standing from all jurisdictions in which the applicant is or has ever been licensed. The temporary licensee may practice only under the direct supervision of an applicable licensed professional.

10.3 Applicants engaged in a special project, teaching assignment, or medical emergency as described in 24 Del.C. §2611(b) must submit letters of good standing from all jurisdictions in which the applicant is or has ever been licensed.

11.0 Reactivation and Reinstatement (24 Del.C. §2607)

11.1 Any person who has been registered in the State and is not actively engaged in the practice of physical therapy or athletic training in the State may, upon request, be placed on the inactive register for the remainder of the biennial licensure period. Subsequent requests for extensions of inactive status should be submitted

biennially. The Board may reactivate an inactive license if the Physical Therapist, Physical Therapist Assistant or Athletic Trainer:

11.1.1 Files a written request for reactivation;

11.1.2 has been actively engaged in the practice for the past five years. If the licensee has not met this condition, the following requirements shall be completed:

11.1.2.1 The Physical Therapist or Physical Therapist Assistant working in a clinical setting shall work under the direct supervision of a Physical Therapist in Delaware for a minimum of six months. Prior to commencement of this period of supervision, the supervisor shall submit the applicable form to the Board.

11.1.2.2 The Athletic Trainer shall work under the direct supervision of an Athletic Trainer in Delaware for a minimum of six months. Prior to commencement of this period of supervision, the supervisor shall submit the applicable form to the Board.

11.1.2.3 At the end of the period, the supervising Physical Therapist/Athletic Trainer shall certify to the applicant's clinical competence on forms supplied by the Board;

11.1.3 Submits proof of completion of 1.5 CEU's during the previous 12 months.

11.2 Provided reinstatement is requested within 5 years of the expiration date, the Board may reinstate the license of a Physical Therapist, Physical Therapist Assistant, or Athletic Trainer who allowed their license to lapse without requesting placement on the inactive register if the Physical Therapist, Physical Therapist Assistant, or Athletic Trainer:

11.2.1 completes a form supplied by the Board

11.2.2 provides proof of completion of 3.0 CEU's during the previous 24 months

11.3 If the Delaware license has been expired over five years, the Physical Therapist/Physical Therapist Assistant/ Athletic Trainer must file a new application and provide proof of completion of 3.0 CEU's. In addition:

11.3.1 The Physical Therapist or Physical Therapist Assistant working in a clinical setting shall work under the direct supervision of a Physical Therapist in Delaware for a minimum of six months. Prior to commencement of this period of supervision, the supervisor shall submit the applicable form to the Board.

11.3.2 The Athletic Trainer shall work under the direct supervision of an Athletic Trainer in Delaware for a minimum of six months. Prior to commencement of this period of supervision, the supervisor shall submit the applicable form to the Board.

11.3.3 At the end of the period, the supervising Physical Therapist/Athletic Trainer shall certify to the applicant's clinical competence on forms supplied by the Board;

11.3.4 Rule 11.3 does not apply to an individual licensed in another state.

12.0 Unprofessional Conduct (24 Del.C. §2616(7))

Unprofessional conduct shall mean the departure from or the failure to conform to the minimal standards of acceptable and prevailing physical therapy practice or athletic training practice, in which actual injury to a patient need not be established. 24 Del.C. §2616(7).

12.1 Assuming duties within the practice of physical therapy or athletic training without adequate preparation or supervision or when competency has not been established or maintained.

12.2 The Physical Therapist or Athletic Trainer who knowingly allows a Physical Therapist Assistant or Athletic Trainer to perform prohibited activities is guilty of unprofessional conduct.

12.3 The Physical Therapist, Physical Therapist Assistant, or Athletic Trainer who knowingly performs prohibited activities is guilty of unprofessional conduct.

12.4 The Physical Therapist, Athletic Trainer, or Physical Therapist Assistant who knowingly allows support personnel to perform prohibited activities is guilty of unprofessional conduct.

12.5 Performing new physical therapy or athletic training techniques or procedures without proper education and practice or without proper supervision.

12.6 Failing to take appropriate action or to follow policies and procedures in the practice situation designed to safeguard the patient.

12.7 Inaccurately recording, falsifying, or altering a patient or facility record.

12.8 Committing any act of verbal, physical, mental or sexual abuse of patients.

12.9 Assigning untrained persons to perform functions which are detrimental to patient safety, for which they are not adequately trained or supervised, or which are not authorized under these Rules and Regulations.

12.10 Failing to supervise individuals to whom physical therapy or athletic training tasks have been delegated.

12.11 Failing to safeguard the patient's dignity and right to privacy in providing services regardless of race, color, creed and status.

12.12 Violating the confidentiality of information concerning the patient.

12.13 Failing to take appropriate action in safeguarding the patient from incompetent health care practice.

12.14 Practicing physical therapy as a Physical Therapist or Physical Therapist Assistant or athletic training as an Athletic Trainer when unfit to perform procedures or unable to make decisions because of physical, psychological, or mental impairment.

12.15 Practicing as a Physical Therapist, Physical Therapist Assistant or Athletic Trainer when physical or mental ability to practice is impaired by alcohol or drugs.

12.16 Diverting drugs, supplies or property of a patient or a facility.

12.17 Allowing another person to use his/her license.

12.18 Resorting to fraud, misrepresentation, or deceit in taking the licensing examination or obtaining a license as a Physical Therapist, Physical Therapist Assistant or Athletic Trainer.

12.19 Impersonating any applicant or acting as proxy for the applicant in a Physical Therapist, Physical Therapist Assistant, or Athletic Trainer licensing examination.

12.20 A Physical Therapist, who initiated a physical therapy plan of care without a referral, continuing to treat a patient for longer than thirty days without a licensed

health practitioner consult. An Athletic Trainer continuing to treat a patient, who initiated treatment for a minor strain, sprain, or contusion for longer than thirty days without a licensed health practitioner consult; preventative taping, padding, bandaging, icing and conditioning excluded.

12.21 Substantially modifying a treatment prescription without consulting the referring licensed health practitioner.

12.22 Failing to comply with the mandatory continuing education requirements of 24 Del.C. §2607(a) and Rule 13.0.

12.23 Any licensee who has knowledge that another licensee has violated the Code of Professional Conduct set forth in Rule 12.0, or any other Board law, Rule or Regulation, shall present that information by complaint to the Division of Professional Regulation for investigation.

12.24 Involvement in a contract involving less than fair market value for services, such as the contracting of athletic training services for less than fair market value, where such services include the direct or indirect kickback of referrals or other financial gain.

13.0 Mandatory Continuing Education Units (CEU's) (24 Del.C. §2607(a))

13.1 Three CEU's are required for every biennial license renewal for Physical Therapists, Physical Therapist Assistants, and Athletic Trainers. The required CEU's shall be completed no later than January 31 of every odd-numbered year and every 2 years after such date. Effective as of the license renewal period beginning February 1, 2013, the required hours shall include 0.2 units of Ethics and completion of a CPR course, which will count for 0.1 unit proof of current CPR certification by the American Red Cross, American Heart Association, National Safety Council or other agency approved by the Board and posted on the Division of Professional Regulation's website. Proof of current CPR certification will count for 0.1 CEU.

13.1.1 One CEU will be given for every 10 hours of an approved continuing education course. (1 contact hour = .1 CEU).

13.1.2 CEU's shall not be carried over from one biennial period to the next.

13.1.3 CEU requirements shall be prorated for new licensees. If the license is granted during the six month period shown below, the following will be required for renewal:

13.1.3.1 If an applicant is granted a license during the first six months of a license period, between the dates of February 1 of an odd-numbered year and July 31 of that year, the new licensee must complete 2.5 CEUs.

13.1.3.2 If an applicant is granted a license during the second six months of a license period, between the dates of August 1 of an odd-numbered year and January 31 of an even-numbered year, the licensee must complete 2.0 CEUs.

13.1.3.3 If an applicant is granted a license during the third period of six months during a license period, between the dates of February 1 of an even-numbered year and July 31 of an even-numbered year, the licensee must complete 1.5 CEUs.

13.1.3.4 If an applicant is granted a license during the last period of six months during a license period, between the dates of August 1 of an even-numbered year and January 31 of an odd-numbered year, the licensee must complete .5 CEUs.

13.2 Each course must include topics relevant to the field of health care as it pertains to Physical Therapy or Athletic Training. Approval of CEU's shall be within the discretion of the Board.

13.2.1 Continuing education units that have been previously approved during the current licensing period by another agency such as a national governing body, for example, APTA and BOC, or a fellow state licensing board shall be acceptable to the Examining Board for the State of Delaware as appropriate CEU's.

13.2.2 Any sponsors or licensees wishing to receive prior written approval of CEU courses from the Board must complete a CEU Application Form. CEU applications shall be reviewed and approved or denied by a designated Board member, and the designated Board member's decision shall be ratified by the Board. Board approval shall expire 3 years after the approval date. If the course is amended at any time during the 3 years, the sponsor or licensee shall submit a new Application Form.

13.2.3 Hardship. An applicant for license renewal may be granted an extension of time in which to complete CEU hours or a total or partial waiver of CEU requirements upon a showing of hardship. Hardship may include, but is not limited to, disability, illness, extended absence from the country and exceptional family responsibilities. No extension of time or waiver shall be granted unless the licensee submits a written request to the Board prior to the expiration of the license.

13.2.4 CEU's may be earned through Board approved courses in colleges and universities, extension courses, independent study courses, workshops, seminars, conferences, lectures, videotapes, professional presentations and publications, and in-services oriented toward the enhancement of their respective professional practice. CEU programs shall be conducted under responsible sponsorship, capable direction and qualified instruction. The program may include staff development activities of agencies and crossdisciplinary offerings.

13.2.5 The following are examples of acceptable continuing education which the Board may approve. The Board will determine the appropriate number of contact hours for these categories of continuing education, subject to any limitation shown below.

13.2.5.1 professional meetings including national, state, chapter, and state board meetings

13.2.5.2 seminars/workshops

13.2.5.3 staff/faculty in-services

13.2.5.4 first time presentation of professionally oriented course/lecture (0.3 CEU/hour per presentation)

13.2.5.5 approved self studies including: online courses that demonstrate time requirements and are related to physical therapy

or athletic training [if there is a sponsoring agency and the sponsoring agency provides a certificate of completion.] videotapes, if: there is a sponsoring agency there is a facilitator or program official present the program official is not the only attendee correspondence course, if a sponsoring agency provides a certificate of completion

13.2.6 The following are also examples of acceptable continuing education in the amount of CEU's shown.

13.2.6.1 university/college courses: 1.0 0.34 CEU for each 3 1 credit profession-related course per semester 0.8 0.27 CEU for each 3 1 credit profession-related course per trimester 0.7 0.24 CEU for each 3 1 credit profession-related course per quarter

13.2.6.2 passing of licensing examination (1.5 CEU's)

13.2.6.3 original publication in peer reviewed publication (0.3 CEU)

13.2.6.4 original publication in non-peer reviewed publication (0.1 CEU)

13.2.6.5 holding of an office (0.3 CEU), to include: executive officer's position for the national or state professional associations (President, VicePresident, Secretary, Treasurer) member, Examining Board of Physical Therapists

13.2.6.6 acting as the direct clinical instructor providing supervision to a Physical Therapist, Physical Therapist Assistant or Athletic Trainer student officially enrolled in an accredited institution during an internship (40 contact hours = 0.1 CEU)

13.2.6.7 acting as the direct clinical instructor providing supervision to an Athletic Training student officially enrolled in an accredited Athletic Training Education Program (40 contact hours = 0.1 CEU).

13.3 Proof of continuing education is satisfied with an attestation by the licensee that he or she has satisfied the requirements of Rule 13.0.

13.3.1 Attestation shall be completed electronically.

13.3.2 Licensees selected for random audit will be required to supplement the attestation with attendance verification pursuant to Rule 13.4.

13.4 Random audits will be performed by the Board to ensure compliance with the CEU requirements.

13.4.1 The Board will notify licensees within sixty (60) days after January 31 that they have been selected for audit.

13.4.2 Licensees selected for random audit shall be required to submit verification within twenty (20) days of receipt of notification of selection for audit.

13.4.3 Verification shall include, but is not limited to, the following information:

13.4.3.1 Proof of attendance. While course brochures may be used to verify contact hours, they are not considered to be acceptable proof for use of verification of course attendance;

13.4.3.2 Date of CEU course;

13.4.3.3 Instructor of CEU course;

13.4.3.4 Sponsor of CEU course;
13.4.3.5 Title of CEU course; and
13.4.3.6 Number of hours of CEU course.

13.4.4 The Board shall review all documentation submitted by licensees pursuant to the CE audit. If the Board determines that the licensee has met the CE requirements, his or her license shall remain in effect. If the Board determines that the licensee has not met the CE requirements, the licensee shall be notified and a hearing may be held pursuant to the Administrative Procedures Act. The hearing will be conducted to determine if there are any extenuating circumstances justifying the noncompliance with the CE requirements. Unjustified noncompliance with the CE requirements set forth in these Rules and Regulations shall constitute a violation of 24 Del.C. §2616(a)(7) and Rule 12.4.22 and the licensee may be subject to one or more of the disciplinary sanctions set forth in 24 Del.C. §2616.

14.0 Telehealth

Telehealth encompasses a wide variety of healthcare and health promotion activities relating to the fields of physical therapy and athletic training, over large and small distances.

15.0 Advanced Training Requirements

Certain techniques used in physical therapy and athletic training require advanced training to assure the licensee meets accepted standards of care.

15.1 Emergency administration of asthma and anaphylaxes medications: The licensee must be certified in first aid by the American Red Cross, American Heart Association, National Safety Council or other agency approved by the Board and posted on the Division of Professional Regulation's website. Proof of such certification shall be provided by the licensee to the Board or a member of the public on demand.

15.2 Emergency administration of glucagon: The licensee must complete the online course covering the emergency administration of glucagon provided by the American Diabetes Association, or other agency approved by the Board and posted on the Division of Professional Regulation's website. Proof of such course completion shall be provided by the licensee to the Board or a member of the public on demand.

15.3 Physical therapy and athletic training care provided outside the clinical setting to athletic injuries: The licensee must be certified as a Sports Physical Therapy Specialist by the APTA or certified as an Athletic Trainer by the NATA and must have current CPR certification. Proof of such certification(s) shall be provided by the licensee to the Board or a member of the public on demand.

~~14~~16.0 Voluntary Treatment Option for Chemically Dependent or Impaired Professionals

~~14~~16.1 If the report is received by the chairperson of the regulatory Board, that chairperson shall immediately notify the Director of Professional Regulation or his/her designate of the report. If the Director of Professional Regulation receives the report, he/she shall immediately notify the chairperson of the regulatory Board, or that chairperson's designate or designates.

~~14~~16.2 The chairperson of the regulatory Board or that chairperson's designate or designates shall, within 7 days of receipt of the report, contact the individual in question and inform him/her in writing of the report, provide the individual written information describing the Voluntary Treatment Option, and give him/her the opportunity to enter the Voluntary Treatment Option.

~~14~~16.3 In order for the individual to participate in the Voluntary Treatment Option, he/she shall agree to submit to a voluntary drug and alcohol screening and evaluation at a specified laboratory or health care facility. This initial evaluation and screen shall take place within 30 days following notification to the professional by the participating Board chairperson or that chairperson's designate(s).

~~14~~16.4 A regulated professional with chemical dependency or impairment due to addiction to drugs or alcohol may enter into the Voluntary Treatment Option and continue to practice, subject to any limitations on practice the participating Board chairperson or that chairperson's designate or designates or the Director of the Division of Professional Regulation or his/her designate may, in consultation with the treating professional, deem necessary, only if such action will not endanger the public health, welfare or safety, and the regulated professional enters into an agreement with the Director of Professional Regulation or his/her designate and the chairperson of the participating Board or that chairperson's designate for a treatment plan and progresses satisfactorily in such treatment program and complies with all terms of that agreement. Treatment programs may be operated by professional Committees and Associations or other similar professional groups with the approval of the Director of Professional Regulation and the chairperson of the participating Board.

~~14~~16.5 Failure to cooperate fully with the participating Board chairperson or that chairperson's designate or designates or the Director of the Division of Professional Regulation or his/her designate in regard to the Voluntary Treatment Option or to comply with their requests for evaluations and screens may disqualify the regulated professional from the provisions of the Voluntary Treatment Option, and the participating Board chairperson or that chairperson's designate or designates shall cause to be activated an immediate investigation and institution of disciplinary proceedings, if appropriate, as outlined in Rule 14.8.

~~14~~16.6 The Voluntary Treatment Option may require a regulated professional to enter into an agreement which includes, but is not limited to, the following provisions:

> ~~14~~16.6.1 Entry of the regulated professional into a treatment program approved by the participating Board. Board approval shall not require that the regulated professional be identified to the Board. Treatment and evaluation functions must be performed by separate agencies to assure an unbiased assessment of the regulated professional's progress.
>
> ~~14~~16.6.2 Consent to the treating professional of the approved treatment program to report on the progress of the regulated professional to the chairperson of the participating Board or to that chairperson's designate or designates or to the Director of the Division of Professional Regulation or his/her designate at such intervals as required by the chairperson of the participating Board or that chairperson's designate or designates or the

Director of the Division of Professional Regulation or his/her designate, and such person making such report will not be liable when such reports are made in good faith and without malice.

~~14~~16.6.3 Consent of the regulated professional, in accordance with applicable law, to the release of any treatment information from anyone within the approved treatment program.

~~14~~16.6.4 Agreement by the regulated professional to be personally responsible for all costs and charges associated with the Voluntary Treatment Option and treatment program(s). In addition, the Division of Professional Regulation may assess a fee to be paid by the regulated professional to cover administrative costs associated with the Voluntary Treatment Option. The amount of the fee imposed under this subparagraph shall approximate and reasonably reflect the costs necessary to defray the expenses of the participating Board, as well as the proportional expenses incurred by the Division of Professional Regulation in its services on behalf of the Board in addition to the administrative costs associated with the Voluntary Treatment Option.

~~14~~16.6.5 Agreement by the regulated professional that failure to satisfactorily progress in such treatment program shall be reported to the participating Board's chairperson or his/her designate or designates or to the Director of the Division of Professional Regulation or his/ her designate by the treating professional who shall be immune from any liability for such reporting made in good faith and without malice.

~~14~~16.6.6 Compliance by the regulated professional with any terms or restrictions placed on professional practice as outlined in the agreement under the Voluntary Treatment Option.

~~14~~16.7 The regulated professional's records of participation in the Voluntary Treatment Option will not reflect disciplinary action and shall not be considered public records open to public inspection. However, the participating Board may consider such records in setting a disciplinary sanction in any future matter in which the regulated professional's chemical dependency or impairment is an issue.

~~14~~16.8 The participating Board's chairperson, his/her designate or designates or the Director of the Division of Professional Regulation or his/her designate may, in consultation with the treating professional at any time during the Voluntary Treatment Option, restrict the practice of a chemically dependent or impaired professional if such action is deemed necessary to protect the public health, welfare or safety.

~~14~~16.9 If practice is restricted, the regulated professional may apply for unrestricted licensure upon completion of the program.

~~14~~16.10 Failure to enter into such agreement or to comply with the terms and make satisfactory progress in the treatment program shall disqualify the regulated professional from the provisions of the Voluntary Treatment Option, and the participating Board shall be notified and cause to be activated an immediate investigation and disciplinary proceedings as appropriate.

~~14~~16.11 Any person who reports pursuant to this Rule in good faith and without malice shall be immune from any civil, criminal or disciplinary liability arising

from such reports, and shall have his/her confidentiality protected if the matter is handled in a nondisciplinary matter.

~~14~~16.12 Any regulated professional who complies with all of the terms and completes the Voluntary Treatment Option shall have his/her confidentiality protected unless otherwise specified in a participating Board's Rules and Regulations. In such an instance, the written agreement with the regulated professional shall include the potential for disclosure and specify those to whom such information may be disclosed.

~~15~~17.0 Crimes substantially related to the practice of physical therapy and athletic training:

~~15~~17.1 Conviction of any of the following crimes, or of the attempt to commit or of a conspiracy to commit or conceal or of solicitation to commit any of the following crimes, is deemed to be substantially related to the practice of physical therapy and athletic training in the State of Delaware without regard to the place of conviction:

~~15~~17.1.1 Offensive touching. 11 Del.C. §601.
~~15~~17.1.2 Aggravated menacing. 11 Del.C. §602 (b).
~~15~~17.1.3 Abuse of a pregnant female in the second degree. 11 Del.C. §605.
~~15~~17.1.4 Abuse of a pregnant female in the first degree. 11 Del.C. §606.
~~15~~17.1.5 Assault in the second degree. 11 Del.C. §612.
~~15~~17.1.6 Assault in the first degree. 11 Del.C. §613.
~~15~~17.1.7 Assault by abuse or neglect. 11 Del.C. §615.
~~15~~17.1.8 Unlawfully administering drugs. 11 Del.C. §625.
~~15~~17.1.9 Unlawfully administering controlled substance or counterfeit substance or narcotic drugs. 11 Del.C. §626.
~~15~~17.1.10 Criminally negligent homicide. 11 Del.C. §631.
~~15~~17.1.11 Manslaughter. 11 Del.C. §632.
~~15~~17.1.12 Murder by abuse or neglect in the second degree. 11 Del.C. §633.
~~15~~17.1.13 Murder by abuse or neglect in the first degree. 11 Del.C. §634.
~~15~~17.1.14 Murder in the second degree; class A felony. 11 Del.C. §635.
~~15~~17.1.15 Murder in the first degree. 11 Del.C. §636.
~~15~~17.1.16 Promoting suicide. 11 Del.C. §645.
~~15~~17.1.17 Abortion. 11 Del.C. §651.
1517.1.18 Issuing abortional articles. 11 Del.C. §653.
~~15~~17.1.19 Incest. 11 Del.C. §766.
~~15~~17.1.20 Unlawful sexual contact in the third degree. 11 Del.C. §767.
~~15~~17.1.21 Unlawful sexual contact in the second degree. 11 Del.C. §768.
~~15~~17.1.22 Unlawful sexual contact in the first degree. 11 Del.C. §769.
~~15~~17.1.23 Rape in the fourth degree. 11 Del.C. §770.
~~15~~17.1.24 Rape in the third degree. 11 Del.C. §771.
~~15~~17.1.25 Rape in the second degree. 11 Del.C. §772.
~~15~~17.1.26 Rape in the first degree. 11 Del.C. §773.
~~15~~17.1.27 Sexual extortion. 11 Del.C. §774.
~~15~~17.1.28 Bestiality. 11 Del.C. §775.
~~15~~17.1.29 Continuous sexual abuse of a child. 11 Del.C. §776.
~~15~~17.1.30 Dangerous crime against a child. 11 Del.C. §777.

~~15~~17.1.31 Female genital mutilation. 11 Del.C. §780.
~~15~~17.1.32 Unlawful imprisonment in the first degree. 11 Del.C. §782.
~~15~~17.1.33 Kidnapping in the second degree. 11 Del.C. §783.
~~15~~17.1.34 Kidnapping in the first degree. 11 Del.C. §783A.
~~15~~17.1.35 Arson in the first degree. 11 Del.C. §803.
~~15~~17.1.36 Burglary in the third degree. 11 Del.C. §824.
~~15~~17.1.37 Burglary in the second degree. 11 Del.C. §825.
~~15~~17.1.38 Burglary in the first degree. 11 Del.C. §826.
~~15~~17.1.39 Robbery in the second degree. 11 Del.C. §831.
~~15~~17.1.40 Robbery in the first degree. 11 Del.C. §832.
~~15~~17.1.41 Carjacking in the second degree. 11 Del.C. §835.
~~15~~17.1.42 Carjacking in the first degree. 11 Del.C. §836.
~~15~~17.1.43 Theft; felony. 11 Del.C. §841.
~~15~~17.1.44 Extortion. 11 Del.C. §846.
~~15~~17.1.45 Identity theft. 11 Del.C. §854.
~~15~~17.1.46 Forgery. 11 Del.C. §861.
~~15~~17.1.47 Falsifying business records. 11 Del.C. §871.
~~15~~17.1.48 Tampering with public records in the second degree. 11 Del.C. §873.
~~15~~17.1.49 Tampering with public records in the first degree. 11 Del.C. §876.
~~15~~17.1.50 Offering a false instrument for filing. 11 Del.C. §877.
~~15~~17.1.51 Issuing a false certificate. 11 Del.C. §878.
~~15~~17.1.52 Reencoder and scanning devices. 11 Del.C. §903A.
~~15~~17.1.53 Criminal impersonation of a police officer. 11 Del.C. §907B.
~~15~~17.1.54 Insurance fraud. 11 Del.C. §913.
~~15~~17.1.55 Health care fraud. 11 Del.C. §913A.
~~15~~17.1.56 Dealing in children. 11 Del.C. §1100.
~~15~~17.1.57 Sexual exploitation of a child. 11 Del.C. §1108.
~~15~~17.1.58 Unlawfully dealing in child pornography. 11 Del.C. §1109.
~~15~~17.1.59 Possession of child pornography. 11 Del.C. §1111.
~~15~~17.1.60 Sexual solicitation of a child. 11 Del.C. §1112A.
~~15~~17.1.61 Bribery. 11 Del.C. §1201.
~~15~~17.1.62 Receiving a bribe; felony. 11 Del.C. §1203.
~~15~~17.1.63 Perjury in the second degree. 11 Del.C. §1222.
~~15~~17.1.64 Perjury in the first degree. 11 Del.C. §1223.
~~15~~17.1.65 Escape after conviction. 11 Del.C. §1253.
~~15~~17.1.66 Assault in a detention facility. 11 Del.C. §1254.
~~15~~17.1.67 Promoting prison contraband; felony. 11 Del.C. §1256.
~~15~~17.1.68 Bribing a witness. 11 Del.C. §1261.
~~15~~17.1.69 Bribe receiving by a witness. 11 Del.C. §1262.
~~15~~17.1.70 Tampering with a witness. 11 Del.C. §1263.
~~15~~17.1.71 Interfering with child witness; class F. 11 Del.C. §1263A.
~~15~~17.1.72 Bribing a juror. 11 Del.C. §1264.
~~15~~17.1.73 Bribe receiving by a juror. 11 Del.C. §1265.
~~15~~17.1.74 Tampering with physical evidence. 11 Del.C. §1269.

~~15~~17.1.75 Riot. 11 Del.C. §1302. 1517.1.76 Hate crimes; felony. 11 Del.C. §1304.
~~15~~17.1.77 Aggravated harassment. 11 Del.C. §1312.
~~15~~17.1.78 Stalking; felony. 11 Del.C. §1312A.
~~15~~17.1.79 Abusing a corpse. 11 Del.C. §1332.
~~15~~17.1.80 Violation of privacy; felony. 11 Del.C. §1335.
~~15~~17.1.81 Bombs, incendiary devices, Molotov cocktails and explosive devices. 11 Del.C. §1338.
~~15~~17.1.82 Adulteration. 11 Del.C. §1339.
~~15~~17.1.83 Promoting prostitution in the second degree. 11 Del.C. §1352.
~~15~~17.1.84 Promoting prostitution in the first degree. 11 Del.C. §1353.
~~15~~17.1.85 Obscenity. 11 Del.C. §1361.
~~15~~17.1.86 Carrying a concealed deadly weapon; Class E (if previous conviction within 5 years). 11 Del.C. §1442.
~~15~~17.1.87 Possessing a destructive weapon. 11 Del.C. §1444.
~~15~~17.1.88 Unlawfully dealing with a dangerous weapon; felony. 11 Del.C. §1445.
~~15~~17.1.89 Possession of a deadly weapon during commission of a felony. 11 Del.C. §1447.
~~15~~17.1.90 Possession of a firearm during commission of a felony. 11 Del.C. §1447A.
~~15~~17.1.91 Possession and purchase of deadly weapons by persons prohibited. 11 Del.C. §1448.
~~15~~17.1.92 Engaging in a firearms transaction on behalf of another. 11 Del.C. §1455.
~~15~~17.1.93 Organized Crime and Racketeering. 11 Del.C. §1504.
~~15~~17.1.94 Victim or Witness Intimidation. 11 Del.C. §§3532 & 3533.
~~15~~17.1.95 Abuse, neglect, mistreatment or financial exploitation of residents or patients; felony or under subsection (c). 16 Del.C. §1136(a), (b) and (c).
~~15~~17.1.96 Prohibited acts A under the Uniform Controlled Substances Act. 16 Del.C. §4751(a), (b) and (c).
~~15~~17.1.97 Prohibited acts B under the Uniform Controlled Substances Act. 16 Del.C. §4752(a) and (b).
~~15~~17.1.98 Trafficking in marijuana, cocaine, illegal drugs, methamphetamines, Lysergic Acid Diethylamide (L.S.D.), designer drugs, or 3,4-methylenedioxymethamphetamine (MDMA). 16 Del.C. §4753A (a)(1)-(9).
~~15~~17.1.99 Prohibited acts E under the Uniform Controlled Substances Act. 16 Del.C. §4755.(a)(1) and (2).
~~15~~17.1.100 Prohibited acts under the Uniform Controlled Substances Act. 16 Del.C. §4756(a)(1)-(5) and (b).
~~15~~17.1.101 Distribution to persons under 21 years of age. 16 Del.C. §4761.
~~15~~17.1.102 Purchase of drugs from minors. 16 Del.C. §4761A.

~~15~~17.1.103 Operation of a vessel or boat while under the influence of intoxicating liquor and/or drugs; felony. 23 Del.C. §2302(a) and §2305 (3) and (4).
~~15~~17.1.104 Failure to collect or pay over tax. 30 Del.C. §572.
~~15~~17.1.105 Third or more conviction for driving a vehicle while under the influence or with a prohibited alcohol or drug content; felony. 21 Del.C. §4177(a); 21 Del.C. §4177(d)(3)-(7).
~~13~~17.1.106 Duty of driver involved in accident resulting in injury or death to any person; felony. 21 Del.C. §4202.
~~15~~17.1.107 Prohibition of Intimidation under the Fair Housing Act; felony. 6 Del.C. §2581.
~~15~~17.1.108 Interception of Communications Generally; Divulging Contents of Communications; felony. 11 Del.C. §2402.
~~15~~17.1.109 Breaking and Entering, Etc. to Place or Remove Equipment. 11 Del.C. §2410.
~~15~~17.1.110 Aggravated Act of Intimidation. 11 Del.C. §3533.
~~15~~17.1.111 Attempt to Intimidate. 11 Del.C. §3534.
~~15~~17.1.112 Providing false information when seeking employment in a public school. 11 Del.C. §8572.
~~15~~17.1.113 Abuse, neglect, exploitation or mistreatment of infirm adult; felony. 31 Del.C. §3913(a), (b) and (c).

~~15~~17.2 Crimes substantially related to the practice of physical therapy and athletic training shall be deemed to include any crimes under any federal law, state law, or valid town, city or county ordinance, that are substantially similar to the crimes identified in this Rule.

4 DE Reg. 1114 (1/1/01)
5 DE Reg. 2101 (5/1/02)
6 DE Reg. 189 (8/1/02)
8 DE Reg. 1452 (04/01/05)
8 DE Reg. 1591 (5/1/05)
10 DE Reg. 741 (10/01/06)
15 DE Reg. 1054 (01/01/12)
18 DE Reg. 469 (12/01/14) (Final)

("DE", 2014)

APTA Code of Ethics

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Preamble

The Code of Ethics for the Physical Therapist (Code of Ethics) delineates the ethical

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

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

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

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

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

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

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

This Code of Ethics is built upon the five roles of the physical therapist (management of patients/clients, consultation, education, research, and administration), the core values of the profession, and the multiple realms of ethical action (individual, organizational, and societal). Physical therapist practice is guided by a set of seven core values: accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility. Throughout the document the primary core values that support specific principles are indicated in parentheses. Unless a specific role is indicated in the principle, the duties and obligations being delineated pertain to the five roles of the physical therapist. Fundamental to the Code of Ethics is the special obligation of physical therapists to empower, educate, and enable those with impairments, activity limitations, participation restrictions, and disabilities to facilitate greater independence, health, wellness, and enhanced quality of life.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Principle #4: Physical therapists shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, research participants, other healthcare providers, employers, payers, and the public. (Core Value: Integrity)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6B. Physical therapists shall take responsibility for their professional development based on critical self-assessment and reflection on changes in physical therapist

practice, education, healthcare delivery, and technology.

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

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

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

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

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

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

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

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

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

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

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

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

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

8D. Physical therapists shall educate members of the public about the benefits of

physical therapy and the unique role of the physical therapist.

("Code ", 2013)

APTA Guide for Professional Conduct

Purpose

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

Interpreting Ethical Principles

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

Preamble to the Code The Preamble states as follows:

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

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

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

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

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

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

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

This Code of Ethics is built upon the five roles of the physical therapist (management of patients/clients, consultation, education, research, and administration), the core values of the profession, and the multiple realms of ethical action (individual, organizational, and societal). Physical therapist practice is guided by a set of seven core values: accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility. Throughout the document the primary core values that support specific principles are indicated in parentheses. Unless a specific role is indicated in the principle, the duties and obligations being delineated pertain to the five roles of the physical therapist.

Fundamental to the Code of Ethics is the special obligation of physical therapists to empower, educate, and enable those with impairments and activity limitations.

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

Topics

Respect

Principle 1A states as follows:

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

status, sexual orientation, health condition, or disability.

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

Altruism

Principle 2A states as follows:

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

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

Patient Autonomy

Principle 2C states as follows:

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

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

Professional Judgment

Principles 3, 3A, and 3B state as follows:

3. Physical therapists shall be accountable for making sound professional

judgments. (Core Values: Excellence, Integrity)

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

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

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

With regard to the patient/client management role, once a physical therapist accepts an individual for physical therapy services he/she shall be responsible for: the examination, evaluation, and diagnosis of that individual; the prognosis and intervention; re-examination and modification of the plan of care; and the maintenance of adequate records, including progress reports. A physical therapist shall establish the plan of care and shall provide and/or supervise and direct the appropriate interventions. Regardless of practice setting, a physical therapist has primary responsibility for the physical therapy care of a patient and shall make independent judgments regarding that care consistent with accepted professional standards. If the diagnostic process reveals findings that are outside the scope of the physical therapist's knowledge, experience, or expertise, or that indicate the need for care outside the scope of physical therapy, the physical therapist shall so inform the patient/client and shall refer the patient/client to an appropriate practitioner.

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

Supervision

Principle 3E states as follows:

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

Interpretation: Principle 3E describes an additional circumstance in which sound professional judgment is required; namely, through the appropriate direction of and

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

Integrity in Relationships

Principle 4 states as follows:

> **4.** Physical therapists shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public. (Core Value: Integrity)
>
> **Interpretation:** Principle 4 addresses the need for integrity in relationships. This is not limited to relationships with patients/clients, but includes everyone physical therapists come into contact with professionally. For example, demonstrating integrity could encompass working collaboratively with the health care team and taking responsibility for one's role as a member of that team.

Reporting

Principle 4C states as follows:

> **4C.** Physical therapists shall discourage misconduct by healthcare professionals and report illegal or unethical acts to the relevant authority, when appropriate.
>
> **Interpretation:** When considering the application of "when appropriate" under Principle 4C, keep in mind that not all allegedly illegal or unethical acts should be reported immediately to an agency/authority. The determination of when to do so depends upon each situation's unique set of facts, applicable laws, regulations, and policies. Depending upon those facts, it might be appropriate to communicate with the individuals involved. Consider whether the action has been corrected, and in that case, not reporting may be the most appropriate action. Note, however, that when an agency/authority does examine a potential ethical issue, fact finding will be its first step. The determination of ethicality requires an understanding of all of the relevant facts, but may still be subject to interpretation. The EJC Opinion titled Topic: Preserving Confidences; Physical Therapist's Reporting Obligation With Respect to Unethical, Incompetent, or Illegal Acts provides further information on the complexities of reporting.

Exploitation

Principle 4E states as follows:

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

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

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

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

A physical therapist stands in a relationship of trust to each patient and has an ethical obligation to act in the patient's best interest and to avoid any exploitation or abuse of the patient. Thus, if a physical therapist has natural feelings of attraction toward a patient, he/she must sublimate those feelings in order to avoid sexual exploitation of the patient. One's ethical decision-making process should focus on whether the patient/client, supervisee, or student is being exploited. In this context, questions have been asked about whether one can have a sexual relationship once the patient/client relationship ends. To this question, the EJC has opined as follows:

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

Colleague Impairment

Principle 5D and 5E state as follows:

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

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

Interpretation: The central tenet of Principles 5D and 5E is that inaction is not an option for a physical therapist when faced with the circumstances described. Principle 5D states that a physical therapist shall encourage colleagues to seek assistance or counsel while Principle 5E addresses reporting information to the appropriate authority. Principles 5D and 5E both require a factual determination on your part. This may be challenging in the sense that you might not know or it might be difficult for you to determine whether someone in fact has a physical, psychological, or substance-related impairment. In addition, it might be difficult to

determine whether such impairment may be adversely affecting his or her professional responsibilities. Moreover, once you do make these determinations, the obligation under 5D centers not on reporting, but on encouraging the colleague to seek assistance. However, the obligation under 5E does focus on reporting. But note that 5E discusses reporting when a colleague is unable to perform, whereas 5D discusses encouraging colleagues to seek assistance when the impairment may adversely affect his or her professional responsibilities. So, 5D discusses something that may be affecting performance, whereas 5E addresses a situation in which someone is clearly unable to perform. The 2 situations are distinct. In addition, it is important to note that 5E does not mandate to whom you report; it gives you discretion to determine the appropriate authority.

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

Professional Competence

Principle 6A states as follows:

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

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

Professional Growth

Principle 6D states as follows:

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

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

Charges and Coding

Principle 7E states as follows:

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

Interpretation: Principle 7E provides that the physical therapist must make sure that the process of documentation and coding accurately captures the charges for services performed. In this context, where charges cannot be determined because of payment methodology, physical therapists may review the House of Delegates policy titled Professional Fees for Physical Therapy Services. Additional resources on documentation and coding include the House of Delegates policy titled Documentation Authority for Physical Therapy Services and the Documentation and Coding and Billing information on the APTA Web site.

Pro Bono Services

Principle 8A states as follows:

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

Interpretation: The key word in Principle 8A is "or." If a physical therapist is unable to provide pro bono services he or she can fulfill ethical obligations by supporting organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured. In addition, physical therapists may review the House of Delegates guidelines titled Guidelines: Pro Bono Physical Therapy Services. Additional resources on pro bono physical therapy services are available on the APTA Web site.

Principle 8A also addresses supporting organizations to meet health needs. In terms of supporting organizations, the principle does not specify the type of support that is required. Physical therapists may express support through volunteerism, financial contributions, advocacy, education, or simply promoting their work in conversations with colleagues. (APTA, 2013)

Case Examples

- During a continuing education course, a fellow physical therapy participant tells a story about trying an untested ointment modality on a patient with some success. Upon returning to work, you find that you have a similar patient. What do you do?
    - Though the modality tried by the fellow colleague appeared to have positive results, you should choose to use equipment, techniques, and data that have been evidence-based and recognized within the field of physical therapy.

- A PT is planning on taking a vacation with plans for the PTA to cover her patients while she is gone. While reviewing her files, she notices that a patient will be due for a re-evaluation during the time she is scheduled off. What should be done?

- The PT will need to complete the re-evaluation before her vacation as this is a task that the PTA is unable to do. Best practice will be getting the re-evaluation done before it is overdue.

- A famous hockey player has just been admitted to your practice. Everyone in the office is buzzing with excitement. “What room is he in?” “What are his injuries?” “I wonder if he will be able to finish this season?” Should you engage in the discussion?
    - Engaging in discussions that disclose a person's identity, as well as condition, are clear contradictions to the principle of 2E, which states physical therapists shall protect confidential patient/client information and may disclose confidential information to appropriate authorities only when allowed as required by law. Any behavior similar to this example should be avoided.

- You've recently registered a new patient who no longer drives. In order to come to his visits, he must arrange rides through a service that offers rides for disabled clients. What APTA core value does this uphold?
    - Coordinating appointment dates and times with the ride service and completing the paperwork they require is an example demonstrating the APTA’s core value of social responsibility by advocating for patients' rights to access necessary transportation services.

- A new patient comes in for an evaluation. The patient is in severe pain. Should the physical therapist start treating the pain or complete the evaluation first?
    - Physical therapy treatment may not be provided prior to the completion of an evaluation of the patient's condition by a PT. Despite how much pain the patient is in, the physical therapist must attempt to complete as much of the evaluation as possible to understand the condition they are dealing with.
- You have received your license as a PT in Delaware in 2016. When will you need to renew your license?
    - You will first need to renew your license in 2017. Licenses must be renewed every other year and only on odd numbered years. Your CEU requirement will be prorated to only portion of the previous two years that you were licensed.

- A child has been receiving physical therapy for 5 years for a brain trauma injury. The parents want the child to continue physical therapy services although clearly the progress notes and records do not reflect significant improvement the past 6 months. Should the PT continue treating the patient?
    - Recording or documenting improvements such so that continued care will be authorized and reimbursed is in contradiction to principle 3A and 3B, demonstrates poor professional judgment, and has subsequent legal ramifications.

- At your new job at SNF, part of your duties include supervision of a newly

graduated PTA. How often must you see patients receiving services from the PTA?

- Since the PTA has not held their license for more than a year you must physically see the patient every day they receive services and must remain on site during services. When supervising a PTA licensed for over a year you are only required to see the patient every sixth day services are received. There are other requirements in this case to remember, such as how often to see the PTA face-to-face.

- One of your patients frequents a chiropractor for a condition unrelated to the carpal tunnel syndrome you are treating. This clinic utilizes a modality that you are not familiar with. How should you address this with your patient?
    - Rather than expressing your doubts regarding this modality; honor the patient's autonomy (principle 2C) and right to make treatment decisions on their own behalf and respect the chiropractor's treatment as valid and complementary.

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