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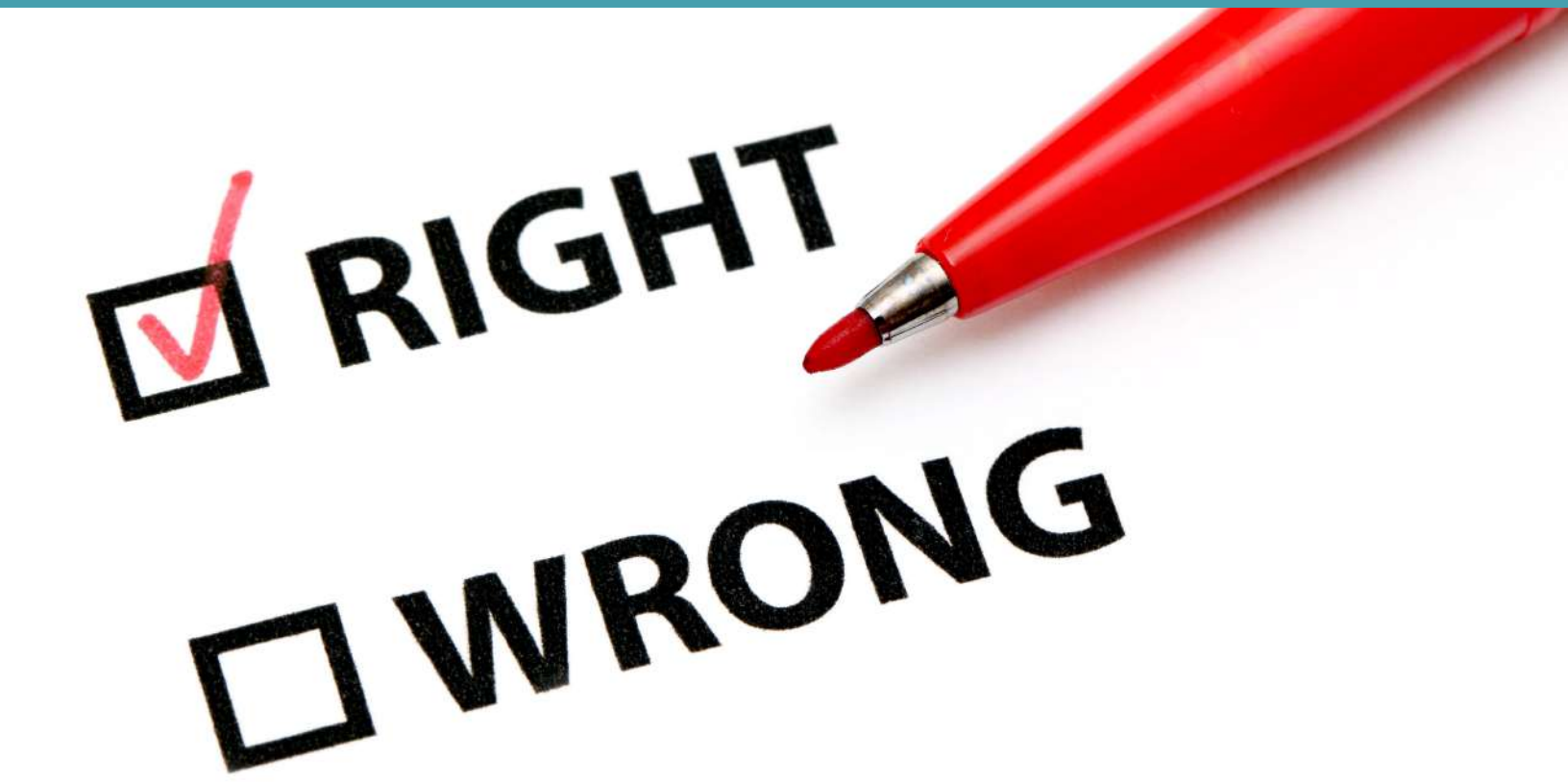
Professional and Ethical Issues in Occupational Therapy



Introduction

While occupational therapists do work that improves their patients' well-being and quality of life, there are a variety of circumstances that can jeopardize these outcomes. For this reason, ethics is an essential part of a therapist's job. There are many factors that an occupational therapist must carefully consider to practice ethically in patient care settings, academia, and research-based work. Ethics is not only embedded in the American Occupational Therapy Association's practice framework and foundational documentation, but it is also a therapist's responsibility as part of occupational therapy licensure in the state where they practice.

While there are basic ethics concepts that a therapist should be familiar with, this topic is not always straightforward, especially when it is applied to occupational therapy practice. Ethics has a place in every setting where an occupational therapist is employed, which is why therapists should be comfortable dealing with ethical dilemmas, gray areas, and other scenarios that might arise during the course of their career.

Section 1: Ethical Principles, Frameworks, and Core Values in Occupational Therapy

1,2,3,4,5

In a general sense, ethics is a branch of philosophy that helps us determine what is right and wrong in given situations. The concept of ethics allows us to engage in ethical reasoning, which should ideally take place when someone must morally reflect on a specific action or behavior they have engaged in.

As a result, all healthcare professions set forth standards for providers to guide them toward ethical behaviors. Within the field of occupational therapy, professionals should be familiar with foundational information set forth by the American Occupational Therapy Association. AOTA's Code of Ethics outlines the core values of occupational therapy, which are comparable to an organization's mission statement. The core values of the profession are basic terms that can be applied to a therapist's work:

- **Altruism:** A selfless concern for the well-being of others, which a therapist can put into practice by remaining responsive and sensitive to their patients
- **Equality:** The right that each person has to the same opportunities, which occupational therapists can embody by limiting their biases, fairly treating all patients, and understanding that each person has a different lifestyle and background
- **Freedom:** Allowing someone the ability to make their own choices, remain independent, and take initiative if and when they choose; a therapist can place value on a person's freedom by encouraging them to pursue meaningful goals and develop their own hobbies, interests, and roles
- **Justice:** Providing objectively needed services to all those who need them regardless of their race, religion, sexual orientation, gender identity, age, socioeconomic status, or other demographic, which therapists do by following the rules and regulations associated with their state and national licensing bodies and offering comprehensive, inclusive care
- **Dignity:** Preservation of a person's worth and value, which therapists can do by being humble about their own status and remaining culturally competent and sensitive to others
- **Truth:** Being honest, accurate, and forthcoming about everything treatment-related, which therapists can do by being professionally competent and truthful in therapy communications with patients, organizations, families, payors, and all other relevant parties
- **Prudence:** Using sound reasoning to govern one's actions, which therapists can do by remaining tactful, judicious, and discretionary while using logic to manage one's own affairs and those of their patients

These core values are used as a general guide for therapists who assume a variety of roles since they can help inform any interactions therapists might engage in.

The Code of Ethics also discusses specific principles that help establish standards of conduct for therapists to follow. These principles are more commonly known by therapists than the core values since they can be used to inform practice and guide therapeutic decision making. However, therapists must acknowledge that certain ethical dilemmas can still arise while following these principles, so they must use their best judgment to reason through such scenarios. These principles include:

- Beneficence: Engaging in actions that are for the good of others
    - Defending the rights of others
    - Removing barriers and obstacles to prevent harm
    - Demonstrate continual concern for the well-being and health of patients
- Autonomy: Each person has a right to make their own choices
    - Treating patients according to their preferences and needs
    - Giving patients the ability to make decisions about their care and anything else that affects them
    - Putting healthcare proxies, surrogates, and/or power of attorneys into place for patients who lack decision-making capabilities
- Justice: The receipt of inclusive, objective care that is equitable
    - Making care-related decisions that are free of biases
    - Providing services that follow all local and national legislature and organizational policies regarding occupational therapy's scope of practice
    - Allowing all patients fair opportunities to receive the same treatment
- Veracity: Accurately representing the profession of occupational therapy
    - Giving patients accurate, accessible information about services
    - Providing additional intervention to reinforce patient comprehension and encourage skill transfer
- Fidelity: Respectful interactions with patients, families, colleagues, payors, etc.
    - Achieving a fair balance between all aspects of a therapist's job
    - Maintaining an equitable relationship with their organization and the patients they treat
- Nonmaleficence: Avoiding any actions that cause harm to others

- Taking steps to avoid intentional or unintentional harm to patients
- Weighing the risks or discomfort related to services against the benefits and positive outcomes to determine if care is in the patient's best interest

AOTA emphasizes the importance of going beyond simply memorizing these principles and rather using them as a way to stimulate ongoing reflection and mindfulness regarding a therapist's professional actions. The standards of conduct are another set of guidelines included in the most recent version of AOTA's Code of Ethics. These standards relate directly to the aforementioned principles, which describe a range of duties under each category.

Standard of Conduct #1: Professional Integrity, Responsibility, Accountability

The first of these standards is professional integrity, responsibility, and accountability. These tenets are upheld through a therapist's compliance with all policies set forth by AOTA, the National Board for Certification in Occupational Therapy (NBCOT), and state licensure boards. Therapists must:

- Remain forthcoming about any conflicting business relationships and avoid entering any partnerships that are considered a conflict of interest
- Avoid leveraging one's role as an occupational therapy professional to create a perceived or real conflict of interest among any individuals
- Comply with scope of practice guidelines when working independently and within an interdisciplinary team
- Professionally represent any organization they are affiliated with
- Truthfully promote and portray the profession in all community settings
- Accurately relay legal or policy-related information to all their partners, if and when applicable
- Refrain from any illegal activities that directly or indirectly impact patients or colleagues

- Report any known illegal, unethical, or unsafe activities to the appropriate governing bodies
- Obtain and report any information gained through research according to accepted research protocols in an ethical manner
- Avoid bartering for services or exploiting any patients, resources, or one's title as occupational therapy personnel for their own professional, personal, or financial gain

Standard of Conduct #2: Therapeutic Relationships

The next standard is therapeutic relationships, which states that all patient-provider interactions should promote well-being and be free of biases, prejudices, and discrimination based on any aspect of someone's persona. Therapists can abide by this standard of conduct by:

- Honoring all patient wishes whenever possible
- Not causing harm to any patients, students, research participants, or others involved in occupational therapy services
- Avoiding the use of threats or manipulation to improve therapy compliance
- Declining monetary or non-monetary gifts if they are given in exchange for services or cross the lines of professional boundaries
- Refraining from any sexual or romantic activities with patients or their direct family during the course of a professional relationship
- Doing their part to effectively transition patients to someone else's care if their employment agreement ceases
- Creating a collaborative partnership with patients to make decision-making more effective and person-centered
- Requesting exemptions from service provision for religious or cultural reasons, when appropriate and according to institutional procedures
- Prevent and address any interpersonal workplace conflicts that arise or organizational limitations that serve as a barrier to patient care

- Sidestepping any type of activity that negatively impacts patient well-being

Standard of Conduct #3: Documentation, Reimbursement, Financial Concerns

The next standard is documentation, reimbursement, and other financial concerns. While these matters tend to be a rather tedious part of a therapist's job, they are necessary to give organizations the funding needed to treat patients. There are less specific duties associated with documentation and financial matters, but it is equally as important as the others. Therapists can ensure compliance with this standard by:

- Completing documentation fully, accurately, and in a timely manner to ensure for appropriate reimbursement
- Invoicing and collecting payment legally and accurately
- Documenting all continuing education and professional development activities per local legislature to fulfill licensure requirements
- Pushing back on any inappropriate policies or directives (impractical productivity standards, falsification of documentation, plagiarism, fraud, etc.) that interfere with a therapist's ability to provide quality care

Standard of Conduct #4: Service Delivery

The service delivery standard of conduct goes far beyond that of the therapeutic relationship, which only focuses on the interactions between therapists and patients. The service delivery standard warrants therapists to consider all the factors involved in providing quality therapy, including cultural sensitivity, occupation- and evidence-based interventions, and person-centered goals. Therapists looking to comply with service delivery standards should focus on:

- Responding to occupational therapy referrals promptly and professionally
- Selecting appropriate and comprehensive evaluation methods to assist in treatment planning that properly addresses patient needs
- Utilizing up-to-date, evidence-based interventions and assessments that the therapist is competent in and are within the occupational therapy scope of practice

- Receiving informed consent before completing an evaluation
- Offering resources that help patients overcome barriers to goal achievement or occupational participation
- Educating patients on the risks, advantages, and expected outcomes of all treatments
- Clearly outlining the frequency and duration of services so patients know what the expectations are
- When mandated to, providing services within the occupational therapy scope of practice during public health emergencies
- Reporting or working to change unjust policies that limit patient access
- Making referrals to providers who can meet new or ongoing patient needs
- Recording and respecting a patient's right to decline or discontinue services at any point in the plan of care
- Collaborating with the patient to decide when termination is most beneficial for them

Standard of Conduct #5: Professional Competence, Education, Supervision, Training

This standard ensures that all therapists maintain the appropriate training and continuing education necessary for initial or continued licensure and certification in the field. This is not only paramount for the sake of meeting local and national requirements, but also for being a competent professional who is capable of giving patients quality treatment. In order to maintain this standard of conduct, therapist must focus on:

- Obtaining and maintaining the appropriate credentials for their clinical, academic, research, or other work roles
- Accurately relaying information regarding their credentials, education, and work experience to others

- Using sound clinical judgment and research to weigh the potential risks versus benefits of emerging treatments or practice areas that do not have established protocols
- Engaging in ongoing professional development related to one's specialty
- Resolving any concerns related to incompetence or unethical practice in oneself or colleagues
- Delegating to colleagues who have demonstrated competence in their assigned duties
- Providing and receiving appropriate supervision according to national certification policies
- Being truthful and precise when reporting information on job performance for employees, students, and supervisees
- Not breaching laws related to copyright or educational material access
- In academic and fieldwork settings, giving students accurate information about educational requirements they are expected to fulfill

Standard of Conduct #6: Communication

Just as a therapist's documentation must be accurate and thorough to convey the work they do, they also must communicate clearly to appropriately represent the profession. Therapists must adhere to the following standards for all oral, written, and electronic communications:

- Keeping patient information confidential according to HIPAA, FERPA, and any other relevant regulations
- Safeguarding information about students, colleagues, employees, and partners
- Professionally and tactfully using social media without violating patient confidentiality
- Modifying treatment for patients with limited health literacy, cognitive deficits, or cultural barriers

- Crediting sources where appropriate in any written oral, or electronic communication
- Refraining from misleading, fraudulent, harassing, discriminatory, or insensitive communication or marketing
- Making patients fully aware of any side effects, adverse outcomes, and other treatment-related concerns that can jeopardize their safety
- Collaborating with other professionals and disciplines whenever possible to provide the most comprehensive care

Standard of Conduct #7: Professional Civility

The last standard states that therapists must act professionally in all interactions with patients, colleagues, business partners, and more. This is especially crucial since there will be times when therapists are asked to do certain job duties that do not align with their personal values or are placed in similarly difficult situations. In order for therapists to assume professional civility, they must focus on:

- Engaging in inclusive and diverse actions, conversations, and decision-making
- Treating all individuals equitably
- Respecting the views and opinions that others hold regardless of conflicting viewpoints
- Behaving with cultural humility and sensitivity that does not alienate those who do not fit into certain groups
- Ensuring that all personal and professional interactions with colleagues are respectful and free of character defamation toward any party
- Refraining from any and all actions that are centered in harassment, bullying, or violence

Occupational Therapy Practice Framework

The AOTA Code of Ethics is not the only official document that emphasizes the importance of therapists providing services in an equitable and just manner. The most recent version of the Occupational Therapy Practice Framework states therapy

professionals should provide individualized, person-centered treatment to all regardless of any personal factors. Personal factors are any traits specific to a person's life and background that do not relate to their health status. Therapists should always take someone's personal factors into consideration by including them in their occupational profile and making modifications to account for them as needed throughout treatment. Some personal factors include:

- Sexual orientation
- Gender identity
- Socioeconomic status
- Upbringing, life experiences
- Race, ethnicity
- Social background
- Age
- Lifestyle
- Past and present habits
- Sociocultural identification
- Coping style
- Temperament
- Personality type
- Professional identity
- Education

Section 1 Personal Reflection

Which of the six principles of occupational therapy relate to the first standard of conduct (Professional Integrity, Responsibility, and Accountability) and why?

Section 1 Key Words

Bias - A personal preference or favoritism that leans toward one group, person, or choice in favor of another; this term is usually used to describe a preference that is unfair or inequitable

Cultural competence - Understanding and acceptance of individuals who hold a different set of beliefs or are from a different culture than you

Cultural humility - A dynamic, ongoing process of curiosity and self-reflection that involves identifying one's own cultural biases and critiquing one's tendencies to change how you act toward those of a different culture than you; the desired product of cultural humility is cultural competence

Cultural sensitivity - A neutral awareness of the spectrum of similarities and differences between those of various cultures; this awareness exists without any positive or negative meaning being ascribed to each

Dual relationships - Patient-provider relationships where more than one role exists; for example, a therapist who is treating a patient that is also a family member, friend, student, colleague, etc. is engaging in a dual relationship; dual relationships are also known as multiple relationships

Family Educational Rights and Privacy Act (FERPA) - Federal legislation that allows families to access, change parts of, and dictate disclosures for their child's education records; this is known as the HIPAA of the school system

Health Insurance Portability and Accountability Act (HIPAA) - Federal legislation that protects confidential patient information and requires patient consent prior to information disclosures

National Board for Certification in Occupational Therapy (NBCOT) - The national accrediting body that oversees and manages the board certifications of practicing occupational therapy professionals in the United States

Organizational limitations - Any aspects of an organization or other work setting that limit an employee's motivation or ability to effectively complete their job duties; in relation to therapists, these limitations usually include decreased autonomy, understaffing, unrealistic productivity standards, patient care restrictions related to health insurance policies, and administrative constraints

Professional civility - The act of behaving professionally and productively to all duties within the workplace, even in the event that certain work duties do not align with one's values

Professional development activities - Any range of classes, seminars, workshops, and other trainings therapists take to gain specialized knowledge and maintain their licensing requirements

Professional integrity - Behaving in an ethical, honest, and equitable manner within the workplace

Section 2: Professional Standards and Issues

6,7,8,9,10,11,12,13,14,15,16,17,18,19,20,21,22

There are a range of issues that impact the field of occupational therapy and the providers who practice in this profession. This is because many policies and regulations apply to the work that licensed therapists and therapy assistants do. Licensing standards are some of the first issues therapists become familiar with, since they must meet these requirements when they finish their academic training before they become employed as a therapist. All licensed therapy professionals must fulfill certain standards in order to practice in their chosen profession.

There are many agencies that set forth and govern these standards in occupational therapy. One such organization is the National Board for Certification in Occupational Therapy (NBCOT). NBCOT is responsible for creating and providing certification exams for initial applicants who have completed accredited occupational therapy programs and are looking to obtain their certification in order to practice. This national agency also manages renewals and associated standards for therapy professionals who are currently practicing.

Prospective therapists looking to receive an initial NBCOT certification must meet the following requirements:

- Be in the final stages of completing an occupational therapy or occupational therapy assistant degree from an ACOTE-accredited program
- Submit an official final transcript or a degree verification form, if the final transcript are not available

- Complete an online application and pay the application fee

Once someone completes these steps and their application is approved, they will be eligible to sit for the national board certification exam, which they can take at a range of testing sites near them. The applicants have 4 hours to complete the entire exam and they must score at least a 450 in order to pass.

Once applicants pass the exam, they are known as certificants. Registered occupational therapists can use the 'OTR' credential after their name and registered occupational therapy assistants can use the 'COTA' credential after their name. Each certification is valid for 3 years, at which point certificants must complete the renewal process. Certificants must meet the following requirements to renew their occupational therapy certification:

- Complete 36 units of continuing education consisting of:
    - Competency assessment units, which are online quizzes, case simulations, and assessments that NBCOT provides for a range of practice areas; these are worth between .25 and 2 units each
    - Professional service, which is a professional development activity that can include providing Level I or II fieldwork supervision; volunteering for a public service organization that adds to the development of one's OT career; peer reviewing a research article or textbook; or mentoring an OT or non-OT colleague
    - Workshops, independent learning, and courses with assessments, including workplace trainings; conferences; seminars; reading peer-reviewed journal articles or textbooks and writing a report on the practice-related points; taking a course; joining a professional study group; or receiving mentoring from a therapy colleague
    - Disseminating knowledge, including presenting or co-presenting a course or poster presentation at a seminar or conference; assuming a secondary work role as an adjunct faculty; providing in-services for OTAs or other professionals in a place of work; presenting or co-presenting for any community organization on a practice-related topic; being the primary or co-author of a non-peer-reviewed professional article, content in a lay man's publication such as a general newspaper,

or a textbook chapter; or serve as the primary or co-primary investigator for research studies

Once someone passes the NBCOT examination and receives their board certification, they can then apply for licensure within the state(s) they wish to work. While this licensure is required before a therapist begins to work, they technically can begin searching for employment before their licensure is approved. In order to start the licensure process, therapists must contact their State Regulatory Board (SRB). While NBCOT governs professional occupational therapy credentials on a national level, SRBs have their own state-specific requirements and licensing for occupational therapy providers. So NBCOT exclusively heads up certifications for all occupational therapists and occupational therapy assistants in the United States while state regulatory boards have various smaller departments responsible for individual professions. Just as each state's requirements for an occupational therapy license differ slightly, there is also some variation with the types of professions that are required to be licensed. Therapists should be aware of what professions their SRB requires licensure for. Most SRBs require providers in the following health and wellness-related professions to be licensed:

- Acupuncture
- Applied behavior analysis (ABA)
- Athletic training
- Audiology
- Chiropractic
- Creative arts therapy
- Diabetes education
- Dietetics
    - Dietician
    - Dietetic technician
    - Nutritionist
- Marriage and family therapy

- Massage therapy
- Medicine
    - Physicians
    - Physician assistants
- Mental health counseling
- Midwifery
- Naturopathy
- Nursing
    - Clinical nurse specialists
    - Licensed practical nurses
    - Nurse practitioners
    - Registered nurses
- Occupational therapy
    - Occupational therapists
    - Occupational therapy assistants
- Ophthalmology
- Optometry
- Physical therapy
    - Physical therapists
    - Physical therapy assistants
- Podiatry
- Polysomnographic Technology
- Psychoanalysis
- Psychology

- Rehabilitation counseling
- Respiratory therapy
    - Respiratory therapists
    - Respiratory therapy technicians
- Social work
    - Licensed clinical social workers (LCSW)
    - Licensed master social workers (LMSW)
- Speech-language pathology
    - While speech-language pathology does have speech-language pathology assistants, they are not trained for independent practice so they cannot provide treatment on their own as an OTA or PTA can.

Since there is some variation, it's good practice for therapists to be aware of the other healthcare providers and complementary/alternative providers that must have licenses. This is pertinent for all therapists, but especially those who work alongside these professionals or refer patients elsewhere for concerns outside their scope of practice. Therapists must refer to competent, qualified providers, which they can only do by having a general sense of the requirements to practice in other fields.

Since SRBs govern competent practice for certain professions, they must also set forth requirements and standards that all individuals must comply with in order to practice. For occupational therapy, most license applicants must:

- Be over the age of 18 for occupational therapy assistant licensure
- Be over the age of 21 for occupational therapy licensure
- Be of good moral character
- Have graduated from a state-approved and accredited occupational therapy or occupational therapy assistant program
- Hold a bachelor's, master's, or doctoral degree in occupational therapy if you are applying for an occupational therapy license

- Hold an associate's degree in occupational therapy if you are applying for an occupational therapy assistant license
- Complete six months of supervised Level II fieldwork if you are applying for an occupational therapy license
- Pass a basic background check

Some states require all OTR and OTA license candidates to take a jurisprudence test. These states include:

- Alaska
- Michigan
- Missouri
- Nevada
- New Jersey
- New Mexico
- North Carolina
- North Dakota
- Ohio
- Texas
- Virginia
- Washington

This exam is a one-time occurrence in all of the above states except for North Carolina, which requires licensees to retake the test each renewal period. Jurisprudence tests are typically quite short and simply serve to ensure therapy professionals have a working knowledge of the scope of practice, state-specific rules, and policies that pertain to their field.

Although most states do not have this exam, it is good practice since it encourages therapists to be more knowledgeable regarding their scope of practice. It is crucial that providers are aware of therapy-specific and healthcare-specific issues that they

may be confronted with in the workplace. This will help therapists have a better understanding of their expected job duties, what they cannot do, and issues that directly impact their work.

There are several regulatory and professional issues that directly impact the occupational therapy field. Therapists can encourage matters that are still pending legislation (such as the OT Licensure Compact) by advocating and participating in lobbying efforts. Conversely, some professional issues – such as limited workplace resources and high productivity standards – stem from organizational structure and may be out of a therapist's direct control, even if those therapists are in management positions. As a result, all therapists should prepare themselves to do their job in the most ethical and effective way possible despite these concerns. Some of these prevalent issues include:

- Competing with other healthcare professions for jobs, funding, and other workplace resources
- Advocating for consistent Medicaid funding, early intervention programming, healthcare reform, and telehealth coverage, particularly for highly vulnerable populations
- Holding dual responsibilities: a growing number of administrative duties (such as obtaining and establishing new payor sources, performing chart audits, and completing in-services) in addition to maintaining a full-time role as a clinician
- Helping promote legislation for the Occupational Therapy Licensure Compact
- Participating in the creation and modification of state legislature that defines and provides credibility to occupational therapy's scope of practice
- Gaining a better understanding of reimbursement related to private insurance
- Lobbying against issues that stand to jeopardize the profession, including Medicare's OTA payment differential
- Shaping the role of occupational therapy to meet the ever-changing needs of the healthcare system as a whole

- Continually educating others on the abilities of the profession and conveying its value to patients, caregivers, and other partners, which stems from a general lack of knowledge
- Advocating for occupational therapy's distinct role within and legislation related to the behavioral health field

There are also many legislative issues that impact occupational therapy (and other health professions). It's essential that therapists remain abreast of any new, updated, or pending policy and legislation since these greatly influence a therapist's role. Healthcare organizations often hold department meetings, training, and other forums to educate therapists on changes that directly impact their practice and the work they do. However, this is not mandatory nor is it common practice, so therapists must stay up-to-date on current events in order to remain aware of any changes as they arise. In 2022, the most relevant policy updates that impact the field of OT include:

Federal Legislation

- The Allied Health Workforce Diversity Act is in the early stages of passing. If it does, this federal legislation would grant more funding to OT (along with PT, ST, RT, and other healthcare professions) programs for the recruitment of individuals from underrepresented groups. This encourages more racial diversity within the field of OT and, in the long-term, aims to improve health outcomes and reduce health disparities for patients of all backgrounds. This also helps expand the Behavioral Health Workforce Education and Training Program (BHWET) to be included in all OTD and MOT programs nationwide.
- The Stabilizing Medicare Access to Rehabilitation and Therapy Act (SMART) was passed in January 2022 and put general budget reductions into effect. This most notably impacts organizations that employ outpatient therapy assistants (PTAs and OTAs), since these facilities will receive 15% less reimbursement for treatments provided by therapy assistants. This act also eases supervision duties for therapists and therapy assistants in private practices so they do not exceed the standards set forth by state licensing agencies.
- CMS also implemented legislation regarding the OTA/PTA modifiers. This states that the modifier CQ must be added to documentation for all services provided by a PTA and the modifier CO for all services provided by an OTA.

- Another piece of legislation that aims to lessen the impact of mental health disparities is The Primary and Behavioral Health Care Access Act. This bill requires all private health plans to reimburse for three behavioral health and three primary care visits each year without cost sharing.
- Now that occupational therapists fall under the umbrella of mental health professionals, they will be able to benefit from the recently-introduced Mental Health Professionals Workforce Shortage Loan Repayment Act once it gets enacted. This act allows professionals in the behavioral health industry to set up loan repayment schedules if they work in locations identified as having a workforce shortage.
- The Telehealth Extension and Evaluation Act is temporary legislation that allows a range of allied health professionals (namely OTs, PTs, SLPs, and audiologists) to provide services via a telehealth model due to the public health emergency. This act also includes quantitative data analysis to determine the impact that telehealth has on health outcomes and efficacy of care.
- If passed, the Expanded Telehealth Access Act would override the previous telehealth legislation by allowing healthcare providers to permanently provide services via telehealth under Medicare.
- The Telehealth Modernization Act specifically modifies Medicare requirements related to telehealth in a way that allows for more flexibility. Some of the main changes as part of this act include:
    - If the provider chooses to do so, the allowance for providers to always be in rural or federally qualified health clinics when providing telehealth
    - If the patient and provider choose to do so, the allowance for patients to be in their home when receiving all services via telehealth
    - Under the public health emergency authorization, any healthcare provider who can typically bill their services to Medicare can provide telehealth services.

Other Policy Updates

- The American Occupational Therapy Association was added to the National Quality Forum's Leadership Consortium. This allows therapists to have a say in the formation of health outcomes and the provision of value-based care, which directly impacts the work we do.
- Starting in 2021, federal legislation mandated all hospitals to publicly post pricing data for the services they offer under the Health Care PRICE Transparency Act. As of July 2022, all health plans must provide similar information regarding service reimbursement rates.
- The Centers for Medicare and Medicaid Services (CMS) has proposed legislation that includes a - 4.2% reimbursement rate adjustment. This means insurers will not provide as much coverage for certain services and patients will likely see an increase in out-of-pocket fees if they do not have secondary coverage.
- According to the Promoting Health Care Quality Act of 2022, healthcare organizations will see more funding for quality control measures and care initiatives focused on value-based services.
- The OT Licensure Compact is currently enacted in 20 states with legislation pending in an additional 5 states. While the compact is not currently accepting applications, they are gaining traction in many states across the country.
- According to CMS' 2022 Notice of Benefit and Payment Parameters (NBPP) that details marketplace insurance requirements, there will no longer be visit limits and cost-sharing now exists between OT and primary care. OT visits will no longer be applied to deductibles, meaning insurance will provide outright payment for these sessions. This greatly increases patient access to all OT services.
- CMS released the OASIS-E manual to guide therapists and other home health providers in completion of this form. This will go into effect in 2023.
- CMS also updated the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) to improve the data collection process and increase health equity in inpatient rehabilitation centers. This will go into effect in October 2022.

- As of July 1, 2022, Medicare's sequestration of payment reduction will be put into place. This means there will be a 2% reduction in spending across the board. It is yet to be seen the exact impact this will have on therapy and reimbursement.
- Due to the public health emergency (PHE), CMS extended the use of category 3 telehealth codes through December 2023. This includes therapy codes, but therapy professionals can only continue using these codes into 2023 as long as the public health emergency is extended or other legislation regarding telehealth is passed.
- The quality measure governing fall prevention has been removed from the Merit-based Incentive Payment System (MIPS) for 2022, but value pathways will be added in 2023.

There are additional professional issues that are shared among therapists and other healthcare providers such as nurses and physicians. Due to the shared settings they work in, it's possible for these providers to even share similar ethical concerns. Some of the most common concerns in healthcare as a whole center around:

- Finding a balance between offering quality care and being an efficient provider
- Improving large-scale access to care to assist in disease prevention
- Addressing end-of-life (and near end-of-life) decision-making with dignity and a heavy emphasis on patient priorities
- Investing more resources into training healthcare providers to avoid staffing shortages and better serve the growing number of patients in need of care
- Distribution of resources such as medication, personal protective equipment, organ donations, blood donations, and more
- Honoring patient requests such as do not resuscitate (DNR) orders

While concerns such as distribution of resources and DNR orders might fall directly under a registered nurse's scope of practice, ethical dilemmas in these areas also indirectly influence the work therapists do. This is especially the case in hospitals and nursing facilities where the therapy process is impacted by patients who do not receive appropriate medical procedures, medication doses, and more. Patients who

aren't receiving the necessary medical interventions from other disciplines are less likely to engage in therapy and might even demonstrate greater functional impairments.

Section 2 Personal Reflection

How can practicing therapists (without managerial responsibilities) remain ethical while meeting productivity demands?

Section 2 Key Words

Accreditation Council for Occupational Therapy Education (ACOTE) - A regulatory body that accredits occupational therapy and occupational therapy assistant programs according to a set of rigorous standards; this accreditation process often takes up to four years and academic programs must at least be candidates for accreditation before they can accept OT/OTA students; academic programs that receive this accreditation are considered superior to programs without accreditation due to their enhanced ability to prepare students better for the NBCOT certification and employment

Continuing education - A broad term that refers to learning outside of a classroom or set degree program

Dietician - Registered professionals who have education on food science and coach individuals in making diet adjustments to achieve a healthier lifestyle

Do Not Resuscitate (DNR) orders - Orders made by a patient to not administer CPR if their heart stops beating; these orders must be put into writing prior and acknowledged by a doctor before they can be added to a patient's medical chart and put into place by treating healthcare providers

Jurisprudence exam - A test that some therapy professions are required to take in order to receive their state license to practice; this test helps discern someone's knowledge of their state's regulations and policies

Licensed Clinical Social Worker (LCSW) - A social worker who is both licensed and has their master's degree in social work

Licensed Masters Social Worker (LMSW) - A social worker who has a master's degree in social work but is not yet licensed

Nutritionist - Professionals who have some extent of knowledge about food science and nutritional needs and coaches individuals in making diet adjustments to achieve a healthier lifestyle; these professionals may or may not be licensed

OTA payment differential - Medicare changes that will lower the reimbursement rate for any services provided by occupational therapy assistants; similar legislation exists for physical therapy assistants

Public Health Emergency (PHE) - A declaration that allocates resources to assist with impending or existing public health crises

Polysomnographic technology - A profession that focuses on completing sleep tests on individuals struggling with insomnia or sleep-related concerns to assist with diagnosis and monitoring

Professional development activities - Identifying professional goals and areas for growth within your current or future career

Rehabilitation counseling - Helping individuals with mental or physical disabilities to better adjust to their condition, learn new skills, and potentially gain or gain meaningful employment

Section 3: Ethics in the Workplace

24,25,26,27,28,29,30,31,32,33,34

Ethical scenarios can present themselves in nearly any workplace, but they are especially prevalent in healthcare settings. Due to the many regulations, legislative issues, and insurance criteria we previously discussed, ethical concerns arise quite frequently in healthcare. There are many issues that relate directly to a therapist's workplace, job duties, and expectations.

Supervision

Some ethical issues involve requirements surrounding supervision in the workplace. One of the most salient instances of this is mandated supervision of occupational therapy assistants by registered occupational therapists. While AOTA has their own recommendations regarding OT/OTA supervision, this is dependent on state requirements and is based on the occupational therapy assistant's level of

experience. For example, newly graduated OTAs and therapy assistants who have just switched practice settings are good candidates for close supervision. This form of supervision requires them to directly have daily, in-person contact with their supervising therapist at their place of work.

OTAs who have a working knowledge of the field, are demonstrating increased competence, and are within the first year or so of their career often benefit more from routine supervision. This involves meeting with their supervising therapist in person at their place of employment or virtually (via phone, video conference, or email) at least once every two weeks. Most OTAs receive general supervision from occupational therapists, which takes place at least monthly either in person or virtually. This is ideal for seasoned OTAs who have demonstrated competence in their area of specialization. These are general recommendations for supervision, but there are many factors that must be taken into account when determining an OTA's level of supervision:

- The number of patients on an OTA's caseload
- Skills and knowledge of the OTA
- Practice setting type and organization-specific requirements
- Medical complexity, diversity, and other patient health needs

An occupational therapist is not only mandated to provide this supervision according to the above criteria, but they are also required to document all of these supervision encounters. Therapists primarily help OTAs navigate treatment-related issues and review their notes to ensure accurate documentation before cosigning them, which is only required in some

organizations. Supervising therapists must also help OTAs if they present with their own ethical dilemmas and have difficulty determining the best course of action.

Therapists might encounter some of the following ethical concerns related to supervision:

- Leaving an OTA without supervision in the event the therapist gets another job or leaves their position

- Neglecting to regularly supervise the OTA as outlined due to poor time management, workplace absences, or scheduling conflicts on behalf of the supervising therapist
- Knowing that an OTA is engaging in unethical practices (whether unintentional such as incomplete or poorly-written documentation or intentional such as fraud) and not reporting or addressing them promptly
- Not providing appropriate assistance to an OTA who has practice-related concerns, is breaking contraindications or engaging in other activities that put patients at risk, or is experiencing their own ethical dilemma
- Not getting consent or introducing the supervising therapist in the event they need to be present during an OTA's session with a patient
- Keeping detailed notes of supervision encounters, including specific problems mentioned, potential solutions discussed, and OTA plan of action
- Failing to thoroughly read any documentation they are required to cosign or review (this puts therapists at risk of vicarious liability, which makes them indirectly negligent if an OTA is putting a patient at risk of injury)
- Breaking confidentiality surrounding OT-OTA interactions, unless there is mention of child or elder abuse (since all therapy disciplines are mandated reporters)
- Being responsible for supervising too many OTAs; this can result in rushed interactions, excessive therapist documentation, and limited communication between parties, which impacts the quality of the supervision being given
- Supervising an OTA who has several other supervisors or therapists they report to; this leads to discontinuity, poor collaboration, and disorganization
- Providing ineffective supervision to an OTA, such as when there is a major mismatch in communication styles and conflict resolution skills
- Taking over the treatment an OTA is assigned to complete or not allowing an OTA to complete delegated tasks, despite service competence
- Interacting with OTAs who are too independent and decide to take care of all concerns on their own instead of asking for guidance

- Failing to recognize signs of compassion fatigue and burnout in OTAs
- Training OTAs who bring pressing questions to administration, their peers, or other staff members (PTs, RNs, etc.) instead of their supervisor or mentor
- Delegating certain tasks to OTAs who are not competent enough in that area to perform such services
- Bringing manageable OTA concerns to administration instead of proactively dealing with them
- Ignoring or exacerbating a novice OTA's feelings, which may prevent them from bringing up central issues during supervision or otherwise; these emotions might include:
    - A sense of intimidation by peers or superiors
    - Fear of being penalized for lack of experience or uncertainty in ethical dilemmas
    - Hesitation to take action or make any decisions independently
    - Being overly sensitive to patients (e.g. not wanting to encourage patients to do therapy if they initially decline; not wanting to tell patients they aren't doing an exercise or activity correctly; being unnecessarily gentle when providing manual therapies, which renders the treatment ineffective; etc.)

The recommended ratio for a supervising therapist is 1:4, since this allows enough time for them to collaborate with OTAs, observe sessions whenever needed, and offer guidance in certain areas. If a therapist is charged with supervising more OTAs, there is a greater chance ethical concerns will arise simply due to a lack of time for appropriate support. If you are a therapist whose workplace has made you responsible for supervising too many OTAs, this might be an organizational issue. However, many of these supervision-related ethical concerns stem from the parties (the supervising therapist and the OTA) themselves, meaning they can often be addressed by those involved. The following are some solutions that can be helpful in remedying supervision concerns:

- Therapists should have a supervision plan in place if they are to leave their current position, either temporarily for vacation, long-term for a leave of

absence, or permanently due to accepting another role; this plan should allow enough time for them to train whoever is taking their place or be sure their duties are delegated to others if there is no replacement by the time they leave

- Therapists and OTAs should determine a mutually agreeable schedule for supervision to minimize scheduling conflicts and ensure enough time is dedicated to the meeting; this is especially important if it happens more than once per month
- If an OTA has multiple concerns they need to address during each supervision meeting, they should bring notes to remember to discuss each point and record the resolution or plan of action
- In the event that an OTA engages in unethical behavior, therapists should report it according to company policies
- Therapists should have a succinct, clear introduction when approaching patients to describe the supervision scenario, allow the patient to ask questions if they'd like, and provide their contact information in case the patient wants to follow up; they should also document verbal consent from the patient, if received during this encounter
- Therapists should be aware of an OTA's experience, skill level, and knowledge in the practice area they are working in so they can appropriately delegate tasks and train where needed
- Therapists should encourage open discussions with OTAs regarding feelings of hesitancy, anxiety, or anything else that may be impacting their work
- Therapists can proactively provide OTAs with education and training along with practical opportunities to practice and test skills
- Reread HIPAA policies whenever needed to ensure you are exercising the same confidentiality during discussions with OTAs as you are with patients and patient information
- Therapists should get feedback from the OTA and others on their supervision skills so they can best guide OTAs without limiting their autonomy or avoiding opportunities for skill development

- If a therapist is supervising an OTA who has multiple superiors, the therapist and OTA alike are responsible for ensuring the lines of communication are open in terms of scheduling, expectations, and reporting duties
- Therapists who feel they are supervising too many OTAs should speak with their superiors to express their concerns about being able to complete their job duties effectively and efficiently
- OTAs and therapists can advocate to management for more trainings surrounding collaboration, conflict management, learning styles, ethical behaviors, compliance, burnout, signs of secondary trauma, vicarious traumatization, compassion fatigue, and other relevant topics
- Therapists should allot enough time in their day or week to document their supervision meetings and thoroughly read their OTA's notes before cosigning and approach them for clarification on any area, if needed
- When supervising OTAs who are too autonomous from the start, therapists should outline and reinforce expectations for checking in and issues that should be discussed before being acted on
- Therapists should delegate unnecessary functions that prevent them from spending adequate time on their supervisory roles
- Occupational therapists who function as administrators and also oversee OTAs should separate the two roles to give the most effective supervision
- Therapists offering advice and resources for OTAs with burnout including:
    - Employee assistance programs (EAPs)
    - Lower caseload requirements or role changes
    - Judicious use of PTO and mental health days to improve self-care
    - Helping OTAs identify what about the organization or job is causing the burnout
    - Developing a plan to help the OTA remedy the burnout while not impacting patient care
    - Discuss time management to structure down time each day, especially while at work

- Therapists get continual feedback (both positive and constructive) from OTAs on the supervision they are getting
- Therapists should be aware of and work to manage the biases that impact their ability to successfully supervise
- Therapists and OTAs alike should be aware of each professional's scope of practice; this will not only ensure OTRs are delegating appropriately but it will help them provide relevant guidance; this information will help OTAs understand who to approach with certain concerns; for example, if a patient has an OT-related concern, an OTA should notify their supervising OTR; if the patient has a medical concern that needs immediate attention, they should notify nursing and then keep their supervisor informed as to the results
- Serve as an advocate between clinical and administrative staff to open up discussions about organizational-specific causes of burnout
- Identifying the therapeutic modes that align most with your personality and values so you can best work with OTAs
    - Advocating
    - Collaborating
    - Empathizing
    - Encouraging
    - Instructing
    - Problem-solving
- Determining your own supervision style so you can make modifications to suit your supervisees' needs:
    - **Authoritative:** This style involves OTAs viewing the therapist as the expert who has the final say in all decisions
    - **Coaching:** A supervision style that involves offering periodic support and encouragement so OTAs can make the right decisions and navigate certain situations on their own

- **Collaborative:** A combination of direct and indirect supervision where both parties are equal and all problems are solved together
- **Delegation:** Assigning relevant to OTAs who are competent in those areas, thus making them more autonomous and allowing therapists to focus on higher-value tasks they are more skilled in
- **Modeling:** A style where therapists demonstrate best practice, techniques, and other foundational concepts to the OTAs they supervise
- **Observation:** A style that involves therapists encouraging OTAs to observe clinical situations in real-time to identify things done correctly and incorrectly

Fieldwork students

Many practicing therapists also supervise Level I and Level II fieldwork students. There are some similar ethical concerns that may present themselves in this arena. Fieldwork supervisors and fieldwork students alike might find ethical dilemmas including:

- Fieldwork supervisors not realistically portraying the field of occupational therapy to students
- Fieldwork supervisors giving students menial tasks to complete that don't relate to their skill development or putting unrealistic, unsanctioned standards into place that do not promote learning; according to due process laws, students are entitled to clear expectations, orientation to organizational policies and procedures, and have the right to appeal their performance evaluations
- Fieldwork supervisors coercing students into engaging in unethical practices, threatening them to prevent them from reporting unethical practices, or intimidating them so they keep quiet about what they see
- Fieldwork supervisors creating improper power dynamics through the use of intimidation and undue penalization

- Fieldwork supervisors neglecting to provide regular, constructive feedback throughout a student's term; this is especially detrimental if the supervisor gives the student a failing grade at the end of the semester
- Fieldwork supervisors not allowing students to make mistakes early on, e.g. by doing things for them, not offering them feedback, bypassing the learning process within fieldwork
- Organizational structures not allowing clinicians to take fieldwork students; for example, it is rarely profitable or possible for therapists in private practice to take on fieldwork students due to limited resources, so this equates to less student opportunities in this areas as part of their training
- Fieldwork supervisors not alerting patients about the presence of Level I fieldwork students during sessions or getting their consent for them to observe or participate in treatment
- Fieldwork supervisors not getting patient consent for Level II fieldwork students to provide some or all of their treatment
- Fieldwork students deciding whether or not to disclose "invisible" disabilities to fieldwork sites due to concern about being seen as less competent than able-bodied peers
    - FERPA, ADA, and HIPAA all have confidentiality clauses that prohibit OT programs from sharing a student's disability status with fieldwork sites, which makes it the choice of the student
- Students bringing outdated, inaccurate information to the fieldwork site and disseminating it to staff, patients, and other students
- Fieldwork supervisors failing to give students the resources (a desk, computer, materials, required and/or recommended reading, assessment tools, treatment space, etc.) they need to learn within the given practice setting; oftentimes, this is due to lack of organizational funding, insurance reimbursement, or staffing shortages
- Geographic and socioeconomic barriers preventing students from getting well-rounded fieldwork experiences, e.g. seeing and practicing in a range of settings

- Fieldwork students not upholding confidentiality rules related to patients and other service recipients
- Fieldwork supervisors leaving students alone in the clinic without supervision or having limited availability when students need them
- Fieldwork supervisors having difficulty teaching students due to gaps between their academic coursework and practical fieldwork situations
- Fieldwork supervisors using variable, unpredictable, or unclear methods to evaluate fieldwork students
- Fieldwork supervisors experiencing a decline in productivity – which organizations may or may not be accepting of – as a result of supervising students
- Fieldwork supervisors feeling pressure from academic fieldwork coordinators (AFCs) to take on students despite feeling inexperienced or unprepared to do so; this pressure might come from a lack of established fieldwork sites and willing supervisors
- Organizations not reimbursing for or granting paid time off for AOTA fieldwork supervisor training
- Fieldwork supervisors keeping information about fieldwork students (documentation, conversations, etc.) confidential
- Fieldwork sites and training not aligning with a student's academic curriculum
- Administrators and organizations not agreeing to offload a portion of the fieldwork supervisor's clinical responsibilities to allow enough time to dedicate to their training
- Fieldwork students having difficulty interacting with patients, team members, other students, and supervisors due to conflicting values; this is especially complicated if students feel they cannot speak up about such concerns due to their status as a student

There are both individual and organizational causes for ethics-related issues in fieldwork supervision. Therapists and students can work collaboratively to avoid any concerns that might stem from the person. While the organizational causes of ethical dilemmas can be more difficult to remedy, there are still ways to address

them. These are some solutions that can be helpful in remedying supervision concerns:

- Allowing practicing clinicians to co-supervise fieldwork students to offload some of the responsibilities
- Fieldwork supervisors ensuring they gradually increase learning opportunities to guide students at the right pace
- If Level I fieldwork supervisors are allied health providers who do not hold an OTR or OTA title (which does occur at times), they should make strides to be consistently well-informed of their students' disciplines in order to offer the proper instruction
- If Level I or Level II fieldwork supervisors have mismatched titles as compared to their students (e.g. students are training to be OTAs and supervisor is an OTR or vice versa), supervisors should sharpen their knowledge of scope of practice to ensure the direction they give their students is accurate
- Fieldwork supervisors planning and/or attending forums, workshops, and other events with other supervisors to share their experiences and improve their ability to supervise
- Students with disabilities who choose not to disclose their condition to their fieldwork site must ensure they are able to complete fieldwork duties without accommodations while preserving patient safety and effectively providing treatment
- Students who complete in-services at fieldwork sites must relay reliable, accurate information about topics that are evidence-based and relevant to that practice setting
- Encouraging fieldwork supervisors to have two or three students from the same OT program at the same time to maximize learning and have them engage in group projects that can benefit them all
- Fieldwork supervisors must provide students with thoughtful, practical information they can directly apply to the practice setting and the field as a whole

- Fieldwork supervisors must accurately and realistically portray the field of occupational therapy and avoid giving students any biased information
- Fieldwork supervisors must remain self-aware and continually reflect on the work they do and the professional choices they make to best lead students
- Fieldwork supervisors should point out dilemmas that may be present in their environment and use those as teachable moments to encourage problem-solving and ethical decision making
- Fieldwork supervisors should treat students professionally and with respect at all times, allowing for early mistakes to be made and turned into educational opportunities
- Fieldwork supervisors should not only schedule consistent meetings (much more regularly than those required for OTA supervision) with their students to review assignments and engage in discussion, but they should have a plan for evaluation and assessment of students that ensures they are following standards set forth by the students' academic program
- Fieldwork supervisors should allow plenty of opportunities for hands-on and autonomous learning with the right amount of structure
- Fieldwork supervisors should work with their organization – especially if they are in untraditional practice settings that students could benefit from training in – to make scheduling, caseload, or logistical adjustments that allow for the acceptance of fieldwork students
- Fieldwork supervisors must develop an informed consent process, emphasize the protocol as soon as students begin, and adhere to it themselves before students begin interacting with patients
- Students should adequately prepare themselves for every fieldwork experience by completing required or recommended reading about that practice setting and relaying only current, evidence-based information as part of assignments, in-services, and other forums
- Before accepting any students, fieldwork supervisors should work closely with administration and overcome any organizational barriers to getting resources the students require for a good experience

- Organizations wishing to host students can offer incentives, such as free or discounted room and board, a food allowance, gas stipends, etc. to ease the transition on students who are unable to work or need to travel far to get to the site; this allows students to focus more readily on their fieldwork experience rather than finding a form of employment or commuting a long distance
- Academic fieldwork coordinators should do more outreach to access potential sites and supervisors while emphasizing the advantages of fieldwork supervision for all parties involved
- Fieldwork students should adhere to all fieldwork policies according to their academic program and the organization where they complete their fieldwork, especially regarding professional conduct in the workplace and social media
- Fieldwork supervisors should identify any major gaps between academic curriculum and experiential learning offered by the site, bring this to the attention of the academic fieldwork coordinator, and collaborate to create a plan that remedies the gap in accordance with accepted fieldwork standards
- Sites should work with department staff as a whole or individually to adjust the caseload of fieldwork supervisors in a way that allows enough time to complete their supervisory duties with students; these changes can be permanent to accommodate an ongoing influx of students or temporary in that certain duties are assigned to other staff therapists for one semester and then switch to another staff member for following semesters, etc.; any solution must be agreed upon by the entire department to avoid any conflict
- Fieldwork supervisors should keep open lines of communication with academic fieldwork coordinators so they can discuss any pertinent student issues, provide ongoing updates, and inform the academic program if and when they are unable to accept students
- Organizations should offer fieldwork supervisors reimbursement and paid time off for continuing education courses related to supervision
- Fieldwork supervisors should undergo basic training (both initially and on a regular basis) to review fieldwork standards, code of conduct for all parties, and any relevant updates, including but not limited to professional behavior,

confidentiality related to students, and best practices related to evaluation of students

- Fieldwork supervisors should take stock of an academic program's curriculum before accepting students to determine if the school's values are aligned with those of the clinician and their workplace and if there are any gaps in learning
- Students should be informed of how and when to report discrepancies, inability to fulfill duties, interpersonal conflicts, safety concerns, ethical dilemmas, and more to their academic fieldwork coordinator

Therapist conduct

Professionalism is a critical skill for therapists in any setting. This applies not only to the way therapists interact with patients, but also how they generally behave in the workplace. Therapists are expected to carry themselves in a certain way since they represent the profession at every turn. If therapists are not behaving diplomatically, they might be seen as unprofessional but they also put themselves at risk of certain ethical concerns. Some issues related to therapist conduct may include:

- Misrepresenting yourself in work settings; this is most commonly done by incorrectly using the title "doctor" without identifying the profession in which the degree was granted; this can also occur by not clarifying that occupational therapists cannot diagnose
- Openly having disagreements or unprofessional conflicts with colleagues
- Misdirecting patients and caregivers to unreliable, outdated, or purely inaccurate information, whether it be neglecting to correct what they say or giving them improper sources to do their own research
- Engaging in Medicare fraud, which has some overlap with standard fraud and can include:
    - Billing for visits that never occurred
    - Accepting kickbacks, bribes, and other forms of payment for patient referrals
    - Documenting false reimbursement claims

- Refraining from any and all illegal activities, including being an accessory to illegal behaviors
    - Abuse of recreational or prescription drugs
    - Crimes related to professions that require someone to hold a professional license (e.g. occupational therapy)
        - Fraud (e.g. falsification of documentation, incident reports, continuing education completion, billing; providing false information on a therapy license application; practicing under someone else's name; providing medical treatments without a license)
        - Implementing services without patient consent
        - Practicing outside of the scope of occupational therapy
        - Completing evaluations and treatments without a referral or prescription
        - Applying physical agent modalities (PAMs) without the appropriate certification, which is required in some states
        - False marketing
        - Gross negligence of patients
        - Failing to comply with continuing education requirements outlined for license renewal
        - Engaging in sexual relations with an active patient
        - Failure to fulfill supervision requirements
        - Coercing, harassing, or threatening patients
        - Failing to report known licensure violations of peers
        - Accepting bribes, kickbacks, or other illegal payments
- Inappropriate use of social media, the internet, and social networking sites

- Posting any sensitive patient information (patient name, phone numbers, any account numbers, address, pictures, etc.) in public places
- Using unprotected messaging channels (text messaging, WhatsApp, and other forums) to relay identifiable patient information to colleagues or lay persons
- Therapists using their personal platform to read, spread, and promote health misinformation
- Therapists using the internet to search for information about their patients, including but not limited to personal information, social habits, risk-taking behaviors; this is not only inappropriate but it threatens the patient-provider relationship by breaking trust
- Displaying images or text that are sexually suggestive; images that show the provider with weapons, drugs, or alcohol; text or images that show the provider engaged in illegal behaviors
- Interacting with patients on social media platforms from your personal account

Ethics surrounding professional therapy conduct is often easier to understand than in other areas of occupational therapy, which may have more gray areas. Therapists looking to remediate or prevent conduct-related ethical concerns can take some of the following steps:

- Clearly defining your role and responsibilities in any setting, especially if they do not align with your background or you are functioning in a lesser-known role (e.g. you are working solely as a case manager but are licensed and registered as an occupational therapist)
- Respecting copyright laws whenever using information (online or in print) that is not originally yours
- Avoiding patient interactions on any form of social media
    - Organizations and department heads should hold regular social media training that includes an overview of HIPAA and HITECH as well as the negative impact of social media (and electronic use in general) on

productivity; training should also cover what constitutes harassment, confidentiality breaches, and damage to the reputation/character of a colleague, patient, or organization; discussions should also extend to the consequences that will result from each infraction

- Having training or reference materials that outline updates to federal and/or state privacy laws as they arise
- Separating personal and professional profiles on social media and other websites
- Refraining from providing medical advice to anyone who is not a patient
- Employers must outline employee expectations regarding professional behavior in the community, reporting responsibilities within the workplace, and the use of organizational copyright such as work email addresses, logos, and graphics
- If providers work for a larger organization where they are considered staff and not an executive and they post on social media to build their professional brand, they must identify themselves independent of their workplace and make a disclaimer that they are not speaking on behalf of the organization
- Avoiding any non-relevant discussions about patients; when they must occur for the sake of collaboration and treatment, limit them to in-person conversations (whenever possible) and maintain a respectful tone
- Identifying yourself accurately and using the appropriate credentials on any professional or personal forum
- Forming a list of reliable, trusted online sources for information so they can be given out when patients request them and using only trustworthy sources when creating patient education materials; the most trusted sources are websites ending in .gov (which are government agencies), .org (nonprofit organizations), and .edu (educational institutions); some reliable sources include:
    - Mayo Clinic
    - Cleveland Clinic
    - National Institute of Health

    - MedLine Plus (National Institute of Health's Library of Medicine)
    - Centers for Disease Control and Prevention
    - U.S. Food and Drug Administration
    - The American Cancer Society
    - The American Lung Association
    - The American Heart Association
    - The American Diabetes Association
    - Drugs.com
- Ensure that all documentation is completed entirely, on time, accurately, and is universally understood by any therapy professionals who may read it
- Disclosing any conflicts of interest (e.g. any association with competing organizations, a business relationship with any company that gives you financial compensation, etc.)
- Adjusting privacy settings on personal social media profiles to prevent patients from searching for them
- Therapists who are small business owners and are looking to build a social media presence for their company should hire marketing or social media experts to handle online engagement; therapists can also use online tools to schedule and automate posts and responses during their working hours
- Using strong conflict resolution skills to remain tactful and professional whenever having a disagreement with a colleague or business partner
    - First and foremost, do not let the disagreement impact your ability to treat patients (e.g. do not openly discuss it in front of patients, do not neglect a patient to engage in the disagreement, etc.)
    - Until you are able to discuss the matter with the other person involved, keep the issue between yourselves
    - If the issue starts as a minor one, address it as soon as possible (without it impacting your work duties) before it turns into a larger concern

- If emotions are running high and no one is in immediate danger, wait a short time until both parties have calmed down before discussing it
- Have any discussions about the issue in person to avoid any confusion or miscommunication
- When discussing the issue with the relevant party, speak clearly, directly, and calmly
- Begin by noting things you each may value about the other person or things that have gone well in your interactions thus far
- Do not come off accusatory and remain objective; try to focus on the things you do agree on and go from there
- Be patient and listen to the other party
- Identify several potential solutions
- Out of what has been discussed, try your best to find a resolution that allows both parties to be amicable
- Schedule a few follow-up meetings (ideally a week and a month after the conflict resolution took place) to determine its effectiveness and see if there are any remaining issues that need to be addressed
- If you still cannot reach common ground after following these steps, contact a third party; a supervisor is often the next best person to be involved, but sometimes it's necessary to bring in a representative from human resources
    - The best time to contact human resources is if the conflict has become personal, the other party is harrassing you or engaging in discriminatory behaviors, the conflict is impacting other team members, productivity is declining, or one or more parties are discussing the potential of resigning

Systems Issues

Many ethical concerns that impact therapists stem from organizational policies, structural changes, or administrative issues. Unfortunately, these concerns are the

ones that are most often out of a therapist's control, even if they take on management roles and work their way up in a company. There are a range of systems issues that can present themselves as ethical concerns, including:

- Dealing with organizational healthcare needs that do not align with resource allocation; this can be company-wide fiscal deficits, poor staff retention rates, unrealistic productivity demands, high acuity patients that staff are not equipped to adequately treat, insurance companies denying coverage for patients with high or unresolved needs, and understaffing that leads to fewer providers than are needed to care for the facility's census
- Management being inexperienced or having difficulty building and sustaining a full department of healthcare staff
- Issues with equipment vendors, which causes delays in equipment arrivals, prescriptions, and evaluations
- Being coerced or instructed by management to preferentially treat certain patients, either those who are family members of management or hospital VIPs or those who are donors to the organization
- Management (especially those who have clinical backgrounds) struggling to balance profit with serving patients and offering quality care
- Organizations failing to maintain or retain the complete spectrum of patient records for at least six years, as mandated by law
- Improper etiquette related to chart audits that must be completed in accordance with company policy
    - Clinicians ignoring errors when doing chart reviews for the sake of time and/or not wanting to report colleagues responsible for the documentation in question
    - Management instructing therapists to ignore instances of fraud or other errors to avoid paperwork and additional documentation
    - Therapists not adjusting documentation after receiving a denial or clarification letter from an insurance company, which places a patient's coverage and reimbursement status in jeopardy
    - Neglecting to complete audits altogether

Some therapists might find the best way for them to cope with the ethical dilemmas that result from these systems is by entering a management position. It's possible for clinicians to find a greater sense of autonomy by assuming a position such as director of rehabilitation, regional supervisor, or possibly an even higher role. Therapists must be aware that entering a management position is not a cure-all and ethical concerns out of their control will still arise. Some of this can be remedied by clinicians seeking employment at an organization whose values align better with theirs. However, bureaucratic issues (such as those related to insurance) will always be present and are difficult to entirely avoid. This is even the case if a therapist enters the self-pay arena, since their clientele will likely be more limited and they might struggle to make as great of an impact as they aim to.

Some clinicians find that management responsibilities allow them to get things done in a way that sidesteps ethical concerns for themselves and those they oversee. For example, duties such as heading up chart audits, assisting with budget development for departmental needs, and having a large part in the hiring process can help them shape the department in a way that mutually benefits patients and therapists. This can also be a good way to boost morale, especially if the previous director of rehab was not a healthcare provider and was focused more on profits.

Therapists and management alike can navigate these ethical concerns with some of the following methods:

- To remedy vendor-related concerns that are impacting patient care, management can explore the possibility of utilizing other vendors or online companies with faster delivery time
    - Improve the lines of communication between therapists and managers at the healthcare organization and account or supply managers at the vendor to help ease the process
    - Therapists can give vendors early notice (such as before a patient's prescription comes in) if they might need certain equipment, especially those that must be specially ordered, to make the vendors aware of what's coming down the pipeline
    - Offer patients continual updates along with strategies and modifications to help improve their function until the equipment arrives

    - Don’t only ask vendors for the status of the equipment, rather ask them if there is anything else they need from you
    - Get everything (feedback given, terms of negotiation, projected timeline, scheduled arrival date, etc.) in writing
    - Escalate major concerns up the chain of command to get more answers and make others aware of your experience
    - Recognize when it may be time to end your relationship with that vendor (e.g. when it’s having a major impact on the quality-of-life of patients) and look for another
    - If you are looking for another vendor to work with, try sourcing recommendations from therapists who work in the same geographic area
    - If you are looking for another vendor to work with, aim for a therapist-owned company that is more receptive to the needs of clinicians and patients alike
- Encouraging management to take training that helps their management skills in some of the following areas to lessen the likelihood of placing the department in ethical binds:
    - Recruiting abilities
    - Improving retention rates
    - Conflict resolution
    - Networking skills
    - Forming new referral sources
    - Improving company morale and boosting employee well-being
- Management and clinicians alike should assert the importance of treating all patients equally based on their medical needs; this is the best way to avoid prioritizing one patient over another based on VIP status, insurance coverage, or other factors

- Management should complete in-services that emphasize the importance of chart audits not only for quality improvement but also as measures that help prevent insurance denials
- Administrative staff should use a clear and specific process when auditing medical records
    - Since audits are intended to point out errors, areas for improvement, or irregularities, management should identify an objective
        - Objectives should be measurable, specific, and relate directly to the quality of care your organization wishes to offer patients
    - Determine what criteria should be looked at; management may select one or more criteria, depending on how large of an audit the department is looking to do or what type of errors they are looking for; examples of criteria include but are not limited to:
        - Patient diagnosis
        - Patients who present with one specific functional deficit
        - Age range
        - Patients with at least X visits in the last X months
        - Patients who were recently discharged from therapy
        - Gender
        - Time elapsed since the start of the patient's plan of care (POC)
        - Length of stay
        - Those receiving individual or group therapy
        - Patients who are also receiving another therapy discipline
        - Patients who were given evaluations only
        - Patients who sustained falls while under a therapist's care
    - Once you have narrowed the list of patients down based on one or more of the criteria above, identify your sample size for this particular

audit; this may be calculated by taking a percentage of the list (the standard is 10%); some departments choose their sample in a more simplistic way by selecting an arbitrary portion of patients from an alphabetical list or choosing all of the patients that were seen on a particular day

- Choose or create an audit-tracking tool
    - Some larger companies with more established programs may have software that helps automate this process and is dedicated specifically to audits
    - Other organizations may choose to use a spreadsheet to track results, which can also be helpful with calculations
    - Another option is paper tracking
- Decide on the audit details such as the dates, times, clinicians who will participate, and other staff who may need to be involved to assist
    - For example, medical records professionals, data analysts, and release of information specialists may all need to be involved when audits are performed in hospitals that still utilize paper charts
- Summarize the results and determine how they will be used
    - Find a way to translate the results into lay man's terms so administrators and other relevant parties can understand the information
    - Compare these findings to national and local benchmarks and standards to determine where the department or organization as a whole lies
    - Plan what initiatives, in-services, new programs, and other outcomes will help remedy any deficits that are found
    - If certain practices are found to be associated with more positive patient outcomes, this may be an opportunity to adopt those practices as part of standard protocol

- To avoid issues related to high productivity standards, focus on:
    - Remaining organized
    - Using any down time throughout the day to document, even if for a short time
    - Completing point-of-service documentation
    - Planning the work week out before it starts and doing even a bit more planning before each day starts
    - Setting boundaries with those around you; for example, allot 5 minutes at the end of each session for patient questions or caregiver training and minimize outside conversations with colleagues
    - If productivity standards are becoming too unmanageable and you feel they are negatively impacting the care you provide, consider employment in a similar setting with more reasonable productivity expectations or a different setting that doesn't have any productivity requirements (e.g. schools, mental health hospitals)
- If the department is experiencing poor staff retention rates, management is encouraged to:
    - Use analytics to track fluctuations in capacity
    - Improve forecasting and planning around these changs and use outlined strategies
    - Reassess scheduling to ensure its consistently meeting demands
    - Use more technology to automate certain processes and shift worker focus to prioritized duties
- Management's ability to address company-wide fiscal deficits may be limited; however, they may be able to assist in lowering the burden their department poses to the company in some of the following ways:
    - Devising a new or modified departmental budget to help increase revenue

    - Implementing cost-saving measures that help the department decrease spending without having a major impact on their role within the organization, including but not limited to changing vendors for office supplies, limiting holiday parties and birthday events or combining them with other team events such as trainings, making personnel adjustments (e.g. assigning additional duties to those with less work, ensuring staff still focus on completing valuable tasks that are less enjoyable or more difficult), better manage miscellaneous spending or costs that are unaccounted for in the budget, hold some meetings virtually, eliminate paper wherever possible, remove the department's landline (if they have one) and opt for online phone conference apps
        - As a general rule, most departments are able to cut up to 10% of costs without a major or negative impact on their function
        - Management should do their best to maintain cost-of-living increases, raises, and promotions, which will ensure employee satisfaction, assist with efficiency, and maintain morale
    - Be prepared for a certain degree of "organizational disruption," which usually develops based on the extent of the budget cuts or revenue-making changes
- Management should develop a screening process to ensure newly-hired providers have the knowledge and experience to handle medically-complex patients or those with certain diagnoses that might be seen at their organization
- Management should offer mentoring or other on-the-job training to hone and maintain the skills of current staff so they can sufficiently manage the caseload
- When healthcare organizations do not have the resources (e.g. staff, funding, space, treatment materials, programming, etc.) to properly care for patients, rehab management should collect information to give higher-level administration to relay its impact on service
    - Start by identifying the specific issues that are preventing the department from hitting benchmarks and improving outcomes

    - Provide several potential options and opportunities to address the concern(s) and outline the costs, pros, and cons of each
    - Begin to use software that helps track resource usage over time, manage workload accordingly, create and monitor project timelines to view progress, and track productivity with available resources
    - Analyze existing processes to cut down on waste, either in terms of time, money, or manpower
    - If they are willing, work with administration to develop a course of action
    - Take another look at how the department is delegating tasks and reevaluate if this could potentially be done differently to better utilize resources
    - Prioritize tasks to ensure the department is focusing on the right things
- If your organization has paper documentation, find a secure and confidential storage location and develop procedures surrounding recordkeeping
    - The location and procedures should be organized while allowing providers to access all documentation when needed for the purpose of audits, patient record requests, or legal reasons
    - Many ethical concerns related to paper recordkeeping can be eliminated be switching to electronic records, so making that switch is the best choice for patients, providers, and organizations as a whole
    - The best option is to find an electronic medical record (EMR) that is user-friendly and comprehensive enough to include billing and scheduling as features

Section 3 Personal Reflection

What is an example of a workplace ethical dilemma that might prompt a therapist to willfully leave their place of work?

Section 3 Key Words

Academic Fieldwork Coordinators (AFCs or AFWCs) - A professor within an OT/OTA program who serves as a liaison between the academic program and the fieldwork site; they are in charge of setting up the initial placement and should be the point of contact if any major issues (related to the fieldwork supervisor or the site itself) arise throughout the fieldwork

Cost-of-living raise/pay increase - A bump in pay that most employers offer their workers to assist with increased costs resulting from inflation; it is good practice for workplaces to offer this sort of raise, but they are not required to

Due process clause/due process law - A legal requirement that prevents the state from breaching any of a person's legal rights; according to the sixth amendment, due process covers four main rights: someone's right to an attorney, their right to be given notice, the right to know who accused you and what you are being charged with, and the right to a quick and fair trial among an impartial group of one's peers

Electronic medical record (EMR) - Digital programs that collect and store patient information

Employee Assistance Programs (EAPs) - A benefit many workplaces offer that gives employees resources, coaching, and other forms of help for work or personal problems that may negatively influence job performance or overall well-being

Health Insurance Portability and Accountability Act of 1996 (HIPAA) - Federal legislation that protects the sensitivity and confidentiality of patient health information; HIPAA includes five main sections that detail how this information is to be protected: a privacy rule, a transactions and code sets rule, a security rule, a unique identifiers rule, and an enforcement rule

Health Information Technology for Economic and Clinical Health Act (HITECH) - Federal legislation that offers healthcare organizations incentives for meaningfully utilizing health information technology, including but not limited to electronic medical records; HITECH is part of the American Recovery and Reinvestment Act (ARRA) of 2009

Human resources department (HR) - A department within most companies that is responsible for the entire "life cycle" of an employee; this includes recruiting, interviewing, hiring, onboarding, training, and termination or firing; HR departments

are also responsible for managing and providing employee benefits, such as EAPs, health insurance, life insurance, etc.

Mandated reporter - A professional who is required to report suspected cases of abuse (any form of child or elder abuse); each state has slight variations in the type of professionals who are mandated to report these instances, but the list typically includes doctors, teachers, therapists, child care workers, nurses, and police officers

Physical Agent Modalities (PAMs) - Treatment modalities that use various forms of energy to alleviate symptoms; for example, electrical stimulation (or e-stim) uses mild, gentle electrical impulses to strengthen tissue and relieve discomfort by interrupting pain signals in the body; some states require all therapists to have a separate certification in PAMs in order to perform any of these modalities on patients

Plan of care (POC) - Also known as a treatment plan, a plan of care outlines a patient's goals and the intervention methods a therapist (or other healthcare professional) will use to address patient symptoms and functional deficits

Point-of-service or point-of-care (POS, POC) documentation - Completing a patient's documentation during their treatment session; some professionals view this as a good way to minimize errors, promote information transfer, keep up with productivity standards, and get paid for documentation that is otherwise non-billable; other providers feel it takes too much time away from the patient and is difficult to do well; either way, POS/POC documentation is strongly encouraged by many healthcare organizations to support a provider's ability to meet productivity standards

Release of information specialist (ROI specialist) - A healthcare specialist that facilitates all requests for the release of medical records; these requests may come from state agencies, other healthcare providers/organizations, lawyers, or patients themselves; someone might request medical records for lawsuits, personal use, chart audits, or the transfer of care from one provider to another; ROI specialists are almost exclusively found in hospitals, which is where the bulk of these requests are made

Sample size - The number of participants included in any given study; many times, sample size refers to participants in a research study, but this can also describe records in a chart audit

Vicarious liability - Secondary liability that makes someone partially guilty or responsible for the actions of someone they are associated with; this terminology is often used during malpractice lawsuits and cases involving negligence where a more senior professional (for example, an occupational therapist) who is responsible for an assigned colleague (for example, an occupational therapy assistant) is labeled an accessory; also called imputed liability

Section 4: Ethics in Patient Care

23,35,36,37,38,39,40,41,42,43,44,45,46,47,48

In addition to ethical dilemmas that arise within the organizational structure of healthcare facilities, there are also many within the realm of patient care. These are some of the most prevalent scenarios and the ones therapists commonly learn about when they take healthcare ethics courses in college or bring up the topic of ethics.

Treatment-related

Ethical dilemmas have the ability to majorly impact the patient-provider relationship. As such, many ethical dilemmas concern treatment sessions in particular. Therapists should refrain from making any false, fraudulent, deceptive, or misleading claims to their patients. They should also never guarantee them any sort of cure. This behavior applies to their verbal interactions with patients (e.g. therapists should never tell patients certain modalities will cure them, their ailments will entirely go away as a result of treatments the therapist offers, etc.) as well as their documentation. For this reason, therapists should follow the same principle when creating educational documents and completing therapy documentation. This content must be accurate in all ways and therapists should specifically avoid writing assessments or interpreting results using the following terms:

- Cure
- Heal
- Diagnose
- Prescribe

- Remedy
- Eliminate
- Eradicate

Examples of false claims from therapists include making overstatements or using black-and-white language when writing patient notes, such as “this will never happen” or “you should never expect to see that.” Therapists can use words like “never” or “only” when creating patient education sheets or home exercise programs (e.g. “When applying cold to your injury, be sure to wrap the cold pack in one or two towels to make the temperature more tolerable for you. Never apply ice to the abdomen, as this can cause a vasovagal response.”). However, these terms are not ideal for medical documentation.

Therapists should also take care when using phrases that suggest patients are not making progress or do not demonstrate the potential for improvement. While such terms might be necessary to demonstrate a plateau leading up to a patient’s discharge, they should not be used for an extended period of time while a patient remains on caseload. Examples of these phrases include:

- Slow progress
- Stable, stabilizing, plateauing
- Maintaining
- Chronic
- Little change
- No change in status
- Uncooperative, noncompliant
- Confused, disoriented, agitated
- Unable to follow instructions
- Repeated directions or treatment
- Severely depressed affect, unmotivated
- Custodial care needed or recommended

- Poor treatment potential due to chronic disease
- Generalized weakness

Another ethical issue that might arise within treatments themselves is the use of unwarranted tests or treatments. Therapists must not recommend, plan for, or provide treatments that do not benefit patients or are not needed. This is not only a waste of facility resources (staff time, equipment usage, etc.), but it is not ethical to bill a patient's insurance for any treatment that is not medically necessary. In a similar vein, therapists might experience an ethical dilemma related to the suitability of therapy tools, including evaluation methods or treatments. This might occur if therapists attempt to use outdated tools with faulty methodology, a poor basis of evidence, and no positive outcomes that can be verified.

Therapists can also encounter an ethical dilemma when implementing a treatment they aren't knowledgeable in or adept at. This might include basic treatment methods that the therapist has a working, but not advanced knowledge of. In some cases, this refers to treatments that are protected by certifications. For example, some states require therapists to be certified in Physical Agent Modalities (PAMs) in order to implement them in practice. Other states consider this entry-level knowledge and allow registered occupational therapists to perform PAMs on patients as part of their standard scope of practice once they graduate. PAMs covers specialized modalities in the following categories: superficial thermal modalities (hot packs, cryotherapy, fluidotherapy, contrast baths, whirlpools, light therapy, and paraffin baths), deep thermal modalities (ultrasound, diathermy, and phonophoresis), and electrotherapeutic agents (TENS, NMES, FES, and iontophoresis).

There are also a range of ethical concerns that surround telehealth, particularly confidentiality both during and after treatments. Confidentiality concerns also pose an issue with other forms of health technology, such as patient messaging portals and electronic medical records. There is a chance that security on apps, devices, and programs that store patient health information (PHI) can be breached, which exposes sensitive data. Similarly, any form of health technology that doesn't have security measures in place is a major risk to patient privacy. These issues jeopardize patient safety, negatively impact the patient-provider relationship, and decrease patient trust in therapy. Management and other administration might also push therapists to use telehealth with patients who are not a good fit for this method of service delivery. They may do this to increase the department's revenue or improve

the reputation of the department as a whole. Regardless of the reasons behind this, utilizing telehealth with patients who are unsuitable for it ultimately leads to substandard care. Additionally, telehealth often limits the specific treatments someone can provide, so therapists may be unable to address certain areas that are patient-identified goals or major safety concerns for patients.

Therapists may feel pressured by management or even higher-up administration to provide treatment to patients who have refused care. This is an ethical dilemma since it's part of the occupational therapy code of ethics to make the patient's preferences a priority. A therapist might also be impacted by similar issues with nurses and other providers involved in patient care. Nursing staff might be faced with an equivalent ethical dilemma surrounding a patient's medical directives. They may also feel pressure from hospital administration or even the patient's family to deviate from a plan the patient outlined prior to their illness. This may have a trickle-down effect that impacts a therapist's ability to implement treatment.

In the same vein, end-of-life issues may place therapists in ethical dilemmas. For example, administration might pressure therapists to treat patients who are near expiration or do not meet the medical necessity criteria for therapy. This might be against the wishes of the patient and/or their family and might actually do them harm in some instances.

Therapists can avoid ethical dilemmas related directly to treatment by following some of these best practices:

- Whenever creating patient education content or describing their role, therapists should avoid any misleading terms that are not within their scope of practice and instead opt for terms such as:
    - Educate
    - Train
    - Teach
    - Instruct
    - Alleviate
    - Remediate
    - Lessen

    - Improve
    - Enhance
    - Coach
    - Guide
    - Facilitate
    - Promote
    - Encourage
    - Grade
    - Modify
    - Adapt
    - Monitor
    - Assess
    - Engage
    - Stabilize
    - Direct
    - Reduce
    - Establish
    - Compensate
    - Elicit
    - Inhibit
    - Utilize
- Therapists should create an occupational profile with each patient to determine their basic strengths, weaknesses, likes, dislikes, and medical needs; this will help them choose the best assessment tools to use and allow

them to interpret the results properly and plan the most appropriate interventions

- Therapists should resist any pressure from management to provide treatment to anyone who doesn't need it; they should report any who is suspected of committing billing fraud or who encourages others to do so to Medicare or other relevant parties
- Therapists should use their clinical judgment to complete an evaluation-only session if they receive a referral for a patient who doesn't have any skilled treatment needs
- Management should emphasize and educate therapists on the concept of medical necessity and how to effectively relay this in all documentation
- Therapists should search for research and evaluation and treatment materials using only trusted, reliable databases and peer-reviewed articles; some of the most common, reputable databases include:
    - PubMed
    - EMBASE
    - Cochrane Library
    - PubMed Central
    - UpToDate
- Therapists should always stay abreast of their state's regulations and scope of practice, both when they begin working in a new state and regularly throughout their employment; they should specifically learn about speciality certifications, advanced areas of practice, and scope of practice to ensure they are always working within their abilities
- Therapists must stay current on requirements related to certifications such as their NBCOT registration and PAMs; they also must continue to stay updated on the practice of all physical agent modalities and other specialized treatments to feel confident using them with patients
- Therapists can request basic telehealth training for patients or work with management to devise a "how-to guide" for patients before their first visit;

therapists might benefit from doing this themselves with individual patients if their organization does not have such advanced infrastructure set up for this method or is not willing to put something in place; this training should cover some of the following areas:

    - Educate patients to look for a lock icon at the top of the screen, which indicates the current page is a safe place to enter confidential information
    - Remind patients to use headphones whenever possible
    - Teach patients how to install or update antivirus software on their electronic devices
    - Ask patients if their internet connections are password-protected; if not, instruct them to contact their internet provider to put this safeguard in place
    - Tell patients to avoid using public wifi, shared devices, or devices belonging to other people for any telehealth services
    - Inform patients on how they can avoid phishing, malware, and other cybersecurity threats; first and foremost, they can do this by not opening any emails from unknown senders or anything they are suspicious of; patients should be instructed to report these emails as spam and block the sender(s)
    - Remind patients to turn off all microphones, cameras, and other accessory devices after telehealth sessions end
    - Ask patients to remove any smart devices (home assistants such as Alexa or Echo, smart outlets, smart TVs, or anything else that is voice-activated) from the room prior to sessions to prevent them from hearing sensitive information

- Providers should engage in their own privacy training before starting to provide services via telehealth
    - It's good practice for therapists to state their name and credentials before each session to confirm their identity
    - Therapists should also confirm the patient's identity

- Providers should scan the room before beginning services and/or ask patients if they are alone to ensure privacy; if anyone else remains in the room, therapists can confirm with the patient if the third party is a caregiver who will be assisting them during the session
- Once a session begins, therapists should close out as many applications as they can (e.g. those that are not needed for the session) to minimize security risks
- Therapists should verify that their telehealth platform has end-to-end encryption for the safety of both parties
- Therapists should follow the same advice regarding emails: do not open anything that is suspicious and report those messages
- Therapists should stay up-to-date on HIPAA's data privacy rules, specifically those related to health technology
- Therapists should not use personal devices for any work tasks
- When providing information to patients, therapists should take caution to limit content to only what is required to treat the patient

Patient Comfort and Preferences

There is a lot more to patient care than simply providing treatment. Therapists must also establish a rapport with their patients, judiciously utilize their therapeutic use of self, respect a patient's autonomy, ask about certain preferences, and more. There are instances when ignoring these basic tasks will lead patients to be dissatisfied with care. However, if a therapist is grossly negligent of a patient's priorities and preferences, this can also result in an ethical dilemma. Some of the following dilemmas may occur related to a patient's comfort levels and wishes:

- Therapists may observe colleagues disrespecting patients and not stand up for them or report them to management; therapists may also engage in these behaviors themselves
- Therapists may ignore basic or integral patient preferences (e.g. not accommodating certain scheduling requests, ignoring patients when they ask for a male vs. a female provider or vice versa, etc.)

- Despite patients refusing or politely declining certain treatments, therapists may still provide them against better judgment due to perceived accountability for patient progress and a focus on health outcomes
- Therapists not respecting a patient's reasoning for declining certain treatments; for example, some therapists may not accept that a patient cannot or will not participate in certain modalities due to religious practices, spiritual beliefs, or other worldviews that are a part of their life
- Therapists not fulfilling their obligation to provide culturally competent care and protect the social justice of all patients
- Therapists not aligning their own values with patient rights in a way that allows for quality treatment

Therapists can avoid some of these dilemmas by adhering to the following best practices:

- Treat patients with compassion and empathy even in light of complex situations or difficult behaviors
- Request or attend sensitivity training to ensure therapists are mindful and respectful of all patient concerns
- Therapists should do their best to fulfill all reasonable and realistic patient needs; this is rarely an issue in larger departments with multiple therapists, since this makes it easier to assign patients to other therapists who better meet their needs or who they are more comfortable with
- Attend cultural sensitivity training regularly to learn more about interacting with people of different cultures, engage in periods of self-reflection, and practice speaking with others in a culturally appropriate manner

Patient Welfare/Safety

Many of the ethical dilemmas that come up during treatment sessions involve a patient's safety and well-being. If therapists do not respond properly to this type of dilemma, patients may be at risk. Some of the main dilemmas related to patient welfare include:

- Therapists not reporting confirmed or suspected abuse or neglect on behalf of a patient
- Therapists being told by management to only provide treatment to high-acuity patients; therapists taking heed of this instruction by neglecting or not providing treatment to patients with less complex or less severe medical needs
- During interprofessional team meetings, therapists may not express their clinical opinion about a patient's progress, remaining safety concerns, and readiness for discharge if it goes against the opinions of other team members; this may be more common with newly-graduated providers or those who are just starting in a new practice setting
- Therapists, administration, and support staff not properly managing patients with difficult or dangerous behaviors; research shows this occurs more often in mental health settings, but it is still a concern across all practice settings
- Therapists withholding treatment from patients who need immediate care, either in lieu of other patients, due to management's direction, or simply out of neglect for certain individuals on their caseload
- Patients experiencing worsening symptoms, difficult behaviors, increased caregiver burden, and decreased quality of life as a result of being on a waiting list for therapy
- Therapists neglecting to assess their patient's health literacy and offer appropriately graded health education
- Therapists not communicating properly with a patient's healthcare proxy when patients do not have the capacity to make care-related decisions; similarly, ethical dilemmas can arise when therapists fail to advocate for patients who are unable to do so themselves and cannot avoid major safety concerns
- Therapists and other staff not appropriately flagging or identifying patients who have high-risk traits (e.g. those who are a fall risk, at risk of dysphagia, a flight risk, aggressive and are likely to demonstrate violent behavior)
- Therapists abandoning patients with no plan in place, either due to personal illness, reassignment, resignation, or termination

- Patients experiencing poor access to care across various geographic and socioeconomic classes
- Therapists performing treatment without proper tools, a confidential space, and personal protective equipment (PPE), if needed
- Therapists not taking the right measures to ensure for patient safety
- Therapists engaging in inappropriate interactions with patients or creating a boundary violation instead of a boundary crossing
    - Initiating or participating in a romantic relationship with a patient
    - Initiating or participating in sexual activity with a patient
    - Revealing too much personal information to a patient
    - Reversing roles
    - Exploiting a patient's vulnerabilities by taking advantage of them financially, sexually, and/or emotionally

A good rule of thumb for therapists trying to avoid ethical dilemmas that place patients at risk is to always act in the best interest of the patient. There are other steps therapists can take to sidestep ethical dilemmas related to patient safety:

- For cases of confirmed abuse and neglect, therapists should call the abuse hotline specific to their state and follow organization-specific protocols for documenting such abuse
- For cases of suspected abuse and neglect, therapists should use the RADAR screening tool to assist with getting more information from patients about potential abuse and neglect in adults and older adults; while this is specifically made for victims of domestic violence, it can be pertinent to all types of abuse:
    - R = routinely screen all patients to ensure their safety
    - A = ask direct questions with a non-judgmental attitude
    - D = document all responses in the standard way according to your discipline
    - A = assess each patient's safety continually

    - R = respond appropriately according to the results of the screening, review several options with the patient, and make referrals as necessary

- Therapists who want to improve their ability to act quickly and effectively in times of crisis can join their facility's rapid response team (RRT)
- Identify patients who might need additional counseling for medication (either new or existing ones), disease management, care plans, and more
- Therapists should communicate consistently with interdisciplinary team members to relay information about each patient's status, especially if they are declining and it appears they need additional intervention
- All healthcare providers should demonstrate proper use of PPE to keep themselves and patients safe
- All providers should follow basic hand hygiene practices and isolation protocols for any patients with transmissible illnesses
    - Hand hygiene: When hands are visibly soiled, use soap and water to cleanse; if there is no access to soap and water, use alcohol-based hand sanitizer
    - Contact precautions: providers must wear gowns and gloves when entering the room of a patient with contact precautions
    - Airborne precautions: providers must wear surgical masks, face shields, and respirators (in some cases)
- Always take steps to ensure patients are physically safe and can access what they need to get help, in the event of an emergency
    - Give patients bed alarms if they are a fall risk
    - After providers in hospitals and nursing facilities leave a patient's room, they should place their tray table next to them with water (unless they cannot have anything to drink due to medical restrictions) and the call bell on it
    - In hospitals and nursing facilities, providers should consistently update the whiteboard in a patient's room with basic information (e.g. date,

time, important phone numbers, time of upcoming appointments, etc.) to improve their orientation and decrease some confusion that may occur

- When therapists treat patients at home who live alone and have minimal support, they should address home safety and emergency protocols; it's also good to write down phone numbers, upcoming appointments, and contact information for therapists to change visits, if needed; whether caregivers are present or not, therapists in this setting should complete ongoing assessments of patients for their ability to live alone to ensure they have the right level of assistance
- Providers should use remote monitoring technology whenever possible to keep tabs on patients, their vitals, and health status when no one is directly with them

- All therapists should ensure the information they are giving to patients is comprehensible, not only to the general public but according to each patient's learning capacity; this applies to home exercise programs, assistive device training, health management techniques, or simply information about their diagnosis; therapists can do this in many ways:
  - Use the teach back method whenever specifically training patients on something
  - Write all printed materials with the help of the Flesch-Kincaid Grade Level test to ensure it's as clear as possible
  - Provide patients with information according to their learning style (e.g. show a patient how to don their shoes if they are a kinesthetic learner; tell a patient how to pursed lip breathe if they are an auditory learner)
  - When giving patients information verbally, speak clearly in simple sentences with chunked information
  - Always encourage patients to ask questions or even take notes, if they are able, to improve their recall and comprehension of information
  - Use visual aids when helping patients learn certain concepts

A therapist's compassion and intentions may come into question if they place a patient in physical or emotional harm. In some cases, this can extend beyond hurting patients and can actually give therapists legal trouble. Some ethical dilemmas that can arise from legal issues involving patients include:

- A therapist writing a fraudulent incident report or providing false testimony regarding a patient incident
- Therapists being discriminated against for reporting personal COVID-19 symptoms and subsequently following isolation protocols; therapists being discriminated against for following COVID protocols (both in and out of the workplace) or correcting misinformation regarding COVID
- Therapists not reporting COVID symptoms and risking the safety of patients and colleagues
- Therapists failing to report conflicts of interest such as those related to treating family members, entrepreneurship positions, being on the board of directors at a competing company; therapists might also experience a conflict of interest with their patient-facing role if they work for or consult with insurance companies or other payers
- Therapists billing a patient's insurance for providing unskilled treatments, treating patients who have plateaued, or adding patients to caseload if they aren't a good candidate for therapy
- Therapists violating HIPAA policies related to confidentiality
- Therapists skipping the informed consent process before beginning treatment or not reviewing the confidentiality policies and rights a patient has under HIPAA

Therapists can avoid legal issues related to patient care by taking some of the following steps:

- Therapists must take individual responsibility not only for their personal health, but also the health of the patients they treat and the community at large
- Therapists should have a thorough understanding of what constitutes a conflict of interest and how they must make their organization aware of those

conflicts; some companies require therapists to fill out paperwork, while others simply require them to disclose the names of the organization(s) considered conflicts of interest

- Therapists should be familiar with the documentation and verbiage their organization has created for informed consent so they can effectively summarize treatment to patients and explain the risks, benefits, alternatives, and mechanism of action
    - For therapists in private practice who are responsible for developing this paperwork, they should take information from several reliable sources and have family members, other therapists review the documents for clarity before finalizing them
- Therapists should understand the relationship between the informed consent process, health education and patient empowerment, positive health outcomes
- Therapists should be well-versed about the protocol for writing an incident report; they should follow the rules they would for writing standard documentation (keep all information accurate and clear in chronological order) while still following the report-writing process for their organization; therapists should also keep in mind the following:
    - The SOAP note style of writing is not appropriate for incident reports; therapists should opt for narrative format
    - Avoid abbreviations of any kind and use terminology the general public will understand
    - Include information such as the date, time, and specific location of the incident
    - Take note of all individuals who were present during the incident, including their name and role
    - Be entirely objective; do not interpret or analyze anything that is mentioned in the report, but focus only on the facts
    - Mention any follow-up that takes place after the incident (e.g. supervisor was notified, police report was completed, etc.)

- Add any actionable information or corrective action plans at the end of the report

There are additional ethical dilemmas that involve patients but don't quite fall into the categories of patient welfare and legal concerns. These include:

- Therapists accepting large or elaborate gifts or money from patients
- Therapists struggling to balance concern for their patients with concern for their own health, especially for therapists working in high-contact environments such as hospitals in light of highly-transmissible conditions such as COVID
- Therapists withholding information from a patient's caregivers and family at the request of the patient
- Therapists being asked to withhold medical information (e.g. new diagnoses) from patients

Due to the ethical dilemmas that can result from accepting or expecting gifts from patients, most organizations prevent therapists from taking anything from their patients. Money is the one gift therapists are universally prohibited from taking from their patients. However, therapists are encouraged to use their judgment to determine whether it's acceptable to take a physical gift from a patient. The general rule is that therapists can typically feel comfortable taking homemade gifts, such as cards, food, or artwork, from patients. Regardless, therapists should always evaluate whether or not taking a patient gift will change the power dynamics or negatively impact the therapeutic relationship.

For example, it is considered more appropriate if a patient gives their therapist a gift at the end of therapy just before they are discharged. It is less appropriate if a gift is given at the start of care, since this might be indicative that a patient is attempting to get a higher quality of care from the therapist. Therapists working in mental health settings should be especially careful of the power dynamics that come up as a result of gift-giving. Similarly, therapists employed by work rehabilitation programs or who see patients with active worker's compensation cases should especially use good judgment when taking gifts from patients. In these settings, gifts may be construed as a bribe to get therapists to exaggerate a patient's symptoms for the sake of prolonging their case and indirectly getting them more benefits.

In terms of responsibility toward patients and oneself in regards to transmissible diseases, therapists should carefully evaluate all circumstances in the event they are sick. Their number one priority should be patient safety, so therapists should not treat any patients if they are personally experiencing minor or major illness. This also applies to exposure to illness, so therapists who have been exposed to someone who tested positive for a transmissible disease should not be in any contact with patients or colleagues until they confirm they are negative for the disease. This minimizes the risk of spreading such diseases to patients and anyone else they interact with in the workplace. These practices also keep therapists accountable for their own health, since not treating patients or being present at work allows them time for recovery. If understaffing is an issue, therapists can always remotely assist with scheduling to ensure coverage for patients in their absence.

Information sharing is another related concern that may place therapists in an ethical dilemma. While this is more commonly an issue with nurses and doctors, therapists may be pressured by these healthcare providers to hide certain diagnostic information from patients or keep this data from their family. It's the patient's decision whether or not they want to disclose this information to their family and other lay persons involved in their care, but they have every right to get updates on their own care. When patients do not get essential information about their medical and treatment status, this negatively impacts the therapeutic relationship. This breach also prevents the patient from their right to autonomy, since they must make care-related decisions according to such information.

Section 4 Personal Reflection

How can a therapist be sure the information they disclose to patients is boundary crossing and not a boundary violation?

Section 4 Key Words

Boundary crossing - Harmless deviations from standard therapeutic behavior; in many cases, boundary crossings can even enhance the therapeutic relationship

Boundary violation - Unethical and oftentimes illegal behaviors therapists engage in that are not in alignment with the therapeutic process nor do they benefit the patient; these activities often involve the exploitation or vulnerability of patients and ultimately cause the patient harm

End-to-end encryption (E2EE) - A security feature that many online platforms utilize to allow safe data transfers that prevent any third-party access or unauthorized information sharing; this feature is required in order for telehealth platforms to be HIPAA-compliant

False testimony - When someone who is under oath gives an inaccurate or incomplete account during a legal trial

Flesch-Kincaid Grade Level - A test that rates written text based on educational level, which indicates how much standard education someone must have to comprehend the information

Functional Electrical Stimulation (FES) - The use of low-level electrical impulses to stimulate motor nerves and improve active movement in individuals who have paralysis resulting from stroke or a spinal cord injury; this modality does not address pain (unlike TENS) and targets functional activities (unlike NMES)

Malware - Short for malicious software, malware is designed to destroy single computers or entire networks; malware is an umbrella term that includes ransomware (software used to blackmail the victim), spyware (used to take information from the user), adware (used to send the user an influx of ads), trojan viruses (used to covertly access the user's computer), and worms (intended to spread from one computer to others on the same network)

Neuromuscular Electrical Stimulation (NMES) - The use of low-level electrical impulses to stimulate motor nerves and improve active movement in individuals with paralysis; this modality does not address pain (unlike TENS) and does not target functional activities (unlike FES); for this reason, it is best used on individuals in the early stages of paralysis who are just beginning to regain motor function

Patient Health Information (PHI) - Any information that pertains to a person's health status, health insurance, or care provided; this information is protected under HIPAA's data privacy rules and is often referred to as protected health information

Personal protective equipment (PPE) - An umbrella term used to describe equipment that professionals must wear on-the-job to protect themselves from workplace hazards; this will vary based on a person's occupation and the type of hazards they are exposed to; for example, healthcare providers interacting with someone who has an airborne disease might wear masks and face shields while a

healthcare provider treating someone who has contact precautions might wear gloves, a gown, and use disposable equipment

Phishing - The act of sending an email posing as a trusted source in an attempt to gain confidential information from someone

Plateaued - A static state characterized by little to no change; in the rehabilitation industry, plateau is used to describe a patient who has been receiving therapy and is no longer making significant progress to justify the continuation of services

RADAR screening - A protocol to help therapists and other healthcare providers assess for abuse and respond accordingly

Rapid response team (RRT) - A group of clinicians who can provide intensive medical intervention to hospitalized patients in need of immediate treatment

Social justice - The concept of equality in regards to the privilege, opportunities, and wealth a person receives

Transcutaneous Electrical Nerve Stimulation (TENS) - The use of low-level electrical impulses to stimulate motor nerves and improve active movement in individuals with paralysis or other minor motor injuries; this modality can also be used to interrupt pain pathways and relieve discomfort in those with acute injuries

Section 5: Ethics in Academia

49

Many therapists think ethical dilemmas can only arise if you're treating patients or working in clinical settings. However, therapy students and therapists working in academia are also susceptible to these concerns. For this reason, any prospective or working therapists in academic settings must be aware of the gray areas that can present themselves. Some of the following ethical dilemmas can impact students and providers in academia:

Due to the high level of responsibility that professors have, there are many opportunities for ethical dilemmas. In particular, professor-related dilemmas can result in the following areas:

- Professors neglecting to inform students of their failing status when required and not properly advising to help them recover their grade(s)
- Professors ignoring obvious ethical dilemmas that arise with students and/or colleagues or not following the organizational protocol for such dilemmas; this may occur if they want to avoid paperwork, uncomfortable conversations, or criticism from other staff and/or students
- Professors poorly or impractically planning curriculum without consideration for the students' learning or skill development
- Professors not allotting time for office hours or making themselves available for students in need of assistance
- Professors not maintaining requirements needed to continue holding teaching roles; for example, most universities require occupational therapy professors to maintain an active license in the state where they teach, regardless of if they are still practicing in clinical settings
- Professors discussing student issues (academic or otherwise) with colleagues, other students, or university staff
- Professors offering tutoring or other academic assistance outside of classes for a fee
- Professors accepting money, gifts, or other bribes from students or students' parents in exchange for passing grades
- Professors submitting false grades to keep class statistics high and preserve the reputation of the university and, more specifically, that school's therapy department
- Professors giving out gifts or other incentives at the end of the semester to secure good teacher evaluations/reviews
- Professors exploiting junior staff members who want to advance themselves in an academic setting
- Professors bullying or threatening students with failing grades
- Professors teaching classes but not assessing exams or other graded materials

- Professors demonstrating favoritism and preferential treatment toward certain students

Ethical dilemmas may also arise specific to academic performance and assignments:

- Students completing assignments improperly, either not completing them entirely or using incorrect information to create the assignment
- Students reviewing past notes or test answers from someone who has previously taken a course they are currently enrolled in
- Students committing any form of plagiarism (either completing work for someone else or being the one who submits another person's work as their own)
    - **Accidental plagiarism:** forgetting or neglecting to cite references
    - **Complete plagiarism:** taking an entire assignment written by someone else and submitting it as your own
    - **Self-plagiarism:** taking content from previous work you've done and adding it to other assignments without citing appropriately
    - **Source-based plagiarism:** citing sources that are either inaccurate or cannot be found

Within universities, colleges, and other academic institutions, there are certain expectations related to professor-student conduct. It's important to note that professors should address all conduct issues tactfully in a way that does not stifle the student's creativity or negatively impact the learning process. As a result, students and professors should avoid any of the following ethical dilemmas:

- Professors should adhere to a zero-tolerance policy for social issues such as discrimination and bullying
- Professors and students inappropriately interacting with each other in public settings with alcohol, illegal drugs, etc.
- Professors and students having sexual or romantic relationships
- Professors and students communicating on personal social media channels
- Inappropriate power dynamics developing between professors and students

Additionally, prospective therapists may find ethical concerns with universities themselves. For example, academic institutions may neglect to follow the outlined processes and procedures necessary to obtain accreditation or they may ignore certain legislation that is in place to make curriculum accessible for all students. It's also possible that therapy professors engage in such behaviors, either of their own volition or as a result of coercion from higher authorities.

An example of an ethical dilemma in this category is therapy professors not honoring accommodations outlined in a disabled student's 504 plan. The university itself would create an ethical dilemma by failing to mandate professors to create a curriculum that allows inclusive education for students with disabilities. Social inequity can create another ethical dilemma among therapy students if professors and other university staff do not treat students equally. Equal treatment within a university setting means students should not be discriminated against in any way due to socioeconomic class, health status, ethnicity, race, religion, age, or any other factors.

The institution would also create an ethical concern by neglecting to evaluate the quality and appropriateness of curriculum professors develop, especially in relation to accessibility. Therapy students may also find ethical conflict if their personal values do not align with the values the school sets forth or the policies they create. Similarly, it may be considered unethical for academic institutions to implement policies or initiatives that hold no practical or theoretical value for students' learning, performance, or skill development.

Section 5: Personal Reflection

Who is the best person to contact if you encounter an ethical dilemma within your therapy program?

Section 6: Ethics in Research

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Academic settings can bring about ethical concerns, but the research arena can bring about an entirely different set of ethical dilemmas. Some are related to issues such as plagiarism, especially if the research is taking place as part of a research project or academic program. However, there are a host of other considerations

since the research process can be complex and comes along with many rules and regulations. Just as with patient care, it's crucial for therapists and researchers to comply with these protocols in order to ensure the well-being of research participants.

Before identifying ethical dilemmas that can occur when therapists do research, therapists must know the process related to research projects. Therapists looking to do research must first follow these guidelines:

1. The researcher should choose a topic based on their area(s) of interest, specialty, or gaps that have been observed. When determining the details of the topic, they must take into consideration how much time they have for the project, resources at their disposal, and any requirements set forth by the university or organization sponsoring the research.

2. Complete a review of existing literature on the topic. Have a general idea of what related or similar studies have been completed. In order to guide their study, researchers must understand how others were structured and what results they yielded.

3. Define the topic by identifying the problem and writing a problem statement. A good problem statement describes what the problem is, why there is a need for additional research in this area, and how the proposed research helps solve this problem.

4. Develop one or more research questions that help determine what someone hopes to find out as a result of their research. The idea is for the question(s) to be easily understood by those reading it, but complex enough that a simple "yes" or "no" answer will not suffice. Research question(s) should also be specific enough that they can apply to quantitative or qualitative research.

5. Create the framework for the research project. A major part of this framework is determining:

    a. What the methodology will be: qualitative, quantitative, using primary data, using secondary data, etc.

    b. What inclusionary and exclusionary criteria will be used to select participants

    c. What procedures and tools will be needed in advance of the study

    d. How you will collect, analyze, and interpret the data

6. Draft a research proposal, which should consist of:
    a. Background information and a literature review on the topic
    b. The problem statement(s)
    c. The research question(s)
7. Submit the research proposal to the research ethics board. In most cases, this is called the Institutional Review Board (IRB). This committee must approve all studies that involve human participants.
8. Submit the research proposal to several funding agencies. Try to find agencies whose work and mission statements align with the topic of the research. This step is usually only necessary if the researcher is not affiliated with a university or other organization, since they often provide funding and materials as needed for students and employees.
9. Complete the research.
10. Decide what to do with the results. Researchers have the following options for disseminating their research findings:
    a. Creating and publishing toolkits or programs
    b. Developing policies
    c. Sharing information online
    d. Publishing the results in scholarly journals
    e. Presenting at local or national conferences
    f. Presenting results to existing or potential stakeholders to get funding for related ventures
    g. Writing project briefs, progress reports, and other documentation for agencies that offered funding for the project
    h. Planning and hosting events for health promotion based on the results

i. Discussing the results on the radio, television, in the newspaper, or via a press release to help with public health promotion and other preventive efforts

After these steps, researchers must begin the informed consent process. In some cases, organizations will have a template for researchers to follow. But independent researchers will usually need to create this document on their own. This is an area where an ethical dilemma may arise, since researchers who offer inaccurate education to participants or do not include all the necessary components required in an informed consent may place the patient at risk. All informed consents should include the following sections:

- A summary of the research and its purpose written in lay man's terms
    - How long the participant will need to be part of the study (e.g. how many visits are needed, how long each visit will be, what time period the visits will span); if this frequency deviates from what is clinically suggested, researchers should note this
    - Specific details about the procedures that must be followed
    - Information about what procedures are for the sake of research and what procedures are therapeutic, diagnostic, or preventive in nature
    - Approximate number of participants involved in the study
    - Information about any experimental procedures
- Risks/discomforts that may result from the study; these can include:
    - Physical pain or injury – such as shock, exposure to heat or cold, etc. – which can occur from certain physical agent modalities, violence from social situations
    - Psychological suffering, such as anxiety, depression, low self-esteem, guilt, sleep deprivation, sensory deprivation, and altered behavior
    - Social losses, such as a damaged reputation, embarrassment, or negatively impacting the opportunities available to someone

    - Economic damages, such as a loss of wages due to being out of work or payment for procedures to treat physical or psychological injuries that occur as a result of the study
    - Confidentiality losses, which result from the release of sensitive information
    - In the event a study places participants at major risk, researchers should also include a list of the available and appropriate medical treatments available.
    - While this is not often the case for OT studies, there is the potential that certain modalities or procedures may come along with unforeseeable risks (for example, those that apply to a fetus)
- Cost of participation
    - If the study is out of state, researchers might pay transportation costs for participants
    - If parts of the study are taking place at an institution that is not sponsoring the research, participants should be aware whether or not they will be responsible for co-payments. Insurers such as Medicare and Medicaid will not cover treatment provided solely for the sake of research.
- Benefits of participation
    - Some studies offer cash incentives or gift cards for participants
    - Participation in the study contributes to society and healthcare as a whole
    - Researchers must clearly state if direct benefits are not anticipated
    - Researchers should avoid using words like “may” or “can” when implying outcomes
- Conflict of interest (COI)
    - Researchers must disclose any partnerships, funding sources, relationships with relevant organizations (e.g. pharmaceutical companies, medical device companies, etc.)

- Treatment alternatives
    - Depending on the type of research study, this may mean no treatment at all
    - In some research studies that focus on specific disorders or injuries, researchers must tell patients what their alternatives are according to best practices; for example, researchers should notify participants in a study on the impact of strengthening programs on the progression of Parkinson's disease that dopamine agonists, adaptive equipment, weighted utensils, and neuromuscular reeducation are potential alternatives to the treatment offered in the study
- Voluntary engagement and termination of participation; researchers must emphasize the following points:
    - Each participant's consent is entirely voluntary
    - There will be no penalties or losses if the participant refuses to consent after the study is explained to them
    - Participants are free to withdraw from the study at any time for any reason and will not experience any penalties or losses
    - Withdrawal from the study will not affect the participant's relationship with or reputation within the organization; for example, if the research is being conducted in conjunction with a large health system or teaching hospital, participants will still be able to go there as a patient if they choose
    - Potential or anticipated scenarios where the subject's participation might be terminated (e.g. if the researcher found out that the participant lied about their demographics, diagnoses, etc., which now prevents them from meeting the study's inclusionary criteria)
- HIPAA
    - This should include a statement of the methods being used to keep all study-related information confidential.

    - Researchers should discuss any methods used to anonymize the data, where it's being stored, security measures used to protect the information, and other methods.
    - For example, the standard protocol is to encrypt all digital files, keep all physical documents (e.g. signed consent forms and other papers) in a locked file cabinet, and remove any identifiers as soon as the researchers analyze the data.
    - Researchers should cite 45 CFR 164.508(b)(5)(i) when mentioning that researchers may continue to use de-identified information obtained from this study for the purposes of continued research unless the participant has withdrawn their consent.
- Contact information for all parties responsible for the research (e.g. primary investigator, co-investigator, research assistants, students)
    - This information should come along with what questions should be directed toward each party. For example, questions about the details of the research itself are often best directed to the primary investigator. If participants have questions about scheduling conflicts or compensation, they should contact the research assistant since this is who usually guides them through the informed consent process.
- Significant new findings
    - If researchers become aware of any new findings over the course of the study, they should inform the participants (since this may impact their consent) and the IRB (since this may impact the study's approval status)
- Debriefing, which involves the researchers reporting certain relevant results to participants

As you can see, there are many guidelines that therapists must abide by to successfully and ethically complete research studies. There are also principles that assist therapists in the pursuit of ethical and effective research. Many of these principles mirror those set forth in the profession's Code of Ethics, which serves as a reminder of how crucial they are to the work therapists do. The principles of research ethics include:

1. Minimizing the risk of harm
    a. This coincides with beneficence (OT Code of Ethics)
    b. Any aspect of research that can place participants at risk should be carefully weighed and must be heavily justified in the research proposal
    c. Researchers must do extra planning to describe the ways they will reduce harm and lessen discomfort for participants
    d. The informed consent process is one of the main ways researchers can pay mind to this principle along with avoiding any deceptive practices and emphasizing each participants' right to withdraw from the study at any time
2. Getting informed consent
    a. This coincides with autonomy (OT Code of Ethics)
    b. Researchers must ensure that all participants not only have detailed information about the study but also specifically understand what is required of them
    c. Researchers should anticipate a variety of participant questions and preemptively include these, especially information that might impact a participant's decision
    d. Researchers should be able to explain why they did not receive informed consent from a participant, if they decline to consent
    e. In some instances such as naturalistic research settings, requirements for informed consent are not needed since this would impact the integrity of the research
3. Preserving confidentiality and anonymity
    a. This coincides with nonmaleficence (OT Code of Ethics)
    b. Researchers should determine what information must be anonymized, what must be kept confidential, and what data does not need any protection

c. Researchers can anonymize participant information by removing any names, nicknames, date of birth, person- or location-specific vernacular, geographic location or mention of notable landmarks that can be traced back to certain states, cities, etc.

d. Researchers might find they or someone else reviewing data observe a correlation between certain variables even after the information is anonymized; if this occurs, researchers can use tables with aggregated data or not presenting data until a minimum unit has been met

4. Not engaging in deceptive practices

    a. Deception is sometimes a part of research; for example, in the case of blind studies or covert research where the intent of the study and/or the identity of the researcher are not shared

    b. Researchers should be sure this is an integral part of the study

    c. For example, if participants are aware of the research's purpose or know that certain aspects of their participation are being monitored, this will negatively influence the quality of the results and, therefore, the study

5. The ability to withdraw

    a. A vital part of the informed consent process is informing participants of their right to withdraw from the study; however, this is not always possible due to the aforementioned reasons (e.g. covert research studies)

    b. Researchers should never attempt to convince participants to remain in the study aside from asking the reason for withdrawal to write down for the study's records

The National Institutes of Health (NIH) similarly stresses the importance of informed consent as a central part of ethical research. The NIH also states ethical research should be scientifically valid, possess clinical and social value, and demonstrate respect for all prospective and current participants. Additionally, the NIH's principles emphasize researchers should fairly choose participants and carefully weigh all study risks versus benefits before moving forward.

Clinical equipoise is another relevant concept that therapists should be mindful of when performing research. Clinical equipoise is the assumption that neither intervention provided in a given study is superior or more suitable for certain participants. This ideal specifically relates to randomized controlled trials (RCTs), which involve a control group that receives no intervention and an experimental group, which is made up of participants who do receive intervention. In order for clinical equipoise to play a role in this type of study, therapists should ensure they control their biases and allow the results to speak for themselves. For this reason, clinical equipoise is another guiding principle researchers can use to conduct unbiased studies that weigh the efficacy of two separate treatments.

In the area of ethical dilemmas pertaining to research, confidentiality breaches and participant mistreatment are some of the prevalent concerns. Therapists may also create ethical dilemmas when reviewing research to inform their clinical practice. Ethical dilemmas may result if therapists begin using new treatments after consulting poor quality research (e.g. studies that are not well-controlled for reliability or validity) or if they entirely neglect to review literature before implementation. Therapists may also inappropriately rely on research with a small sample size or studies that have too little or too much variation in terms of populations and diagnoses. Regardless of a practitioner's experience with research, all therapists should effectively appraise evidence in order to use it appropriately in practice.

Section 6 Personal Reflection

Why is research such an important part of a clinical occupational therapist's job?

Section 6 Key Words

Aggregate data - Information presented as a summary rather than separate, individual statistics

Blind study - A type of study where the researcher is the only party that knows what treatment (or lack of) each participant is receiving

Conflict of interest (COI) - The disclosure of partnerships, funding sources, and relationships with relevant organizations that may impact a therapist's ability to provide equitable care or perform research

Covert research - A type of research that is performed without participants knowing (and, in many cases, consenting)

Dissemination - Researchers summarizing and sharing the results of a research study with participants

Evidence appraisal - Reviewing research and assessing it based on its validity, reliability, relevance, and application to your specific clinical work

Internal Review Board (IRB) - A committee within a certain organization that reviews and regulates research studies involving human participants; these agencies may exist within universities, hospitals, and other healthcare institutions

Inclusionary criteria - Demographic information and other features participants must possess to be included in a target population as part of a research study

Informed consent - The act of a patient or participant agreeing to be treated or be part of research; for treatment, this involves patients signing a consent form agreeing to care; in research, the process is much lengthier as consent forms include detailed information about the study

Naturalistic research - A type of study that involves researchers observing participants in their natural settings (e.g. home, work, school, or other familiar locations) to glean a more realistic picture of their behaviors, functioning, and impairments

Qualitative research - The gathering and analysis of conceptual data free of numbers, such as audio, video, or textual information; this data is used to help expand upon concepts and detail experiences of a certain population

Quantitative research - The gathering and analysis of numerical data for the purpose of identifying patterns, testing relationships, and formulating hypotheses

Randomized controlled trial (RCT) - A type of research study where participants are randomly selected to be part of an experimental group that receives an intervention or a control group that does not receive any intervention or receives a more common intervention; RCTs are commonly used to compare the impact of pharmaceuticals, diagnostic or surgical procedures, rehabilitative therapies, or assistive devices

Section 7: Ethics & OT Practice

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There are instances when an organization will witness a therapist engaging in unethical behaviors or practices and take action. But it's also a therapist's responsibility to report any unethical behaviors they witness or become aware of. AOTA has outlined the process for therapists to file ethics complaints for other therapists who are active members of AOTA or were members at the time of the situation in question. Therapists must first fill out a form with the contact information for each party involved, since AOTA will not accept anonymous reports. Therapists should also submit supporting documentation that offers facts related to the complaint. Therapists must ensure all confidential documents submitted are de-identified to remain in compliance with HIPAA. The complaint itself and the associated documentation must cover the following areas:

- Date and time of the incident, if applicable
- Information on how the reporting therapist became aware of the incident or violation
- A list of the therapist's actions that are of concern and the standards from the therapist code of conduct that these actions violate
- A copy of all corrective action plans, reports, documentation (from the facility, police, or other involved parties), and/or communication regarding the incident or violation and its outcome(s)
- Statements from witnesses, if applicable

AOTA will review the complaint within 60 days of receiving it. Each member of the ethics committee will review the information and determine whether there is reason to believe a violation may have occurred. Based on the initial impression of the committee members, the complaint will either be dismissed or active pending further review. The committee may dismiss a complaint for several reasons:

- The therapist in question is not or never has been an AOTA member, so AOTA would have no jurisdiction over the case
- No ethics violation is present, regardless of whether the complaint itself is proven true

- There is not enough evidence to make a clear determination

After doing an initial review of the complaint, the committee may choose to open an investigation if the complaint does not identify a specific code violation. If the committee determines a violation has occurred, they will then issue nondisciplinary actions or disciplinary actions accordingly.

The choice a therapist makes when they are in an ethical dilemma can potentially lead to disciplinary action and even more severe outcomes. This is why therapists faced with an ethical dilemma should not only carefully weigh all options before making a decision, but also have a thorough grasp of the consequences associated with each choice.

Consequences of Ethical Misconduct from AOTA

For certain ethical complaints deemed not to be in violation of the Code of Ethics, AOTA will issue nondisciplinary actions. The first of these is an educative letter, which is sent privately and serves to educate the reporting therapist and complainant about appropriate standards and professional behavior. The other nondisciplinary action is an advisory opinion, which is not directed at the parties who filed the related complaint. Rather, an advisory opinion is a general mention of AOTA's viewpoint on certain ethical issues. An advisory opinion is presented as an official publication to all AOTA members.

Disciplinary Action

The next level of consequences resulting from ethical misconduct includes disciplinary sanctions from AOTA. These disciplinary actions do not impact a therapist's ability to practice, rather they influence their standing within AOTA. Therapists may face any of the following sanctions depending on the nature of the misconduct:

- Reprimand - A formal letter from the AOTA ethics committee, which is not shared with the public, state licensing agency, or NBCOT
- Censure - A public report of disapproval from AOTA
- Probation - A public report of misconduct and allowance of continued AOTA membership if someone meets the following conditions:

    - Completion of a remedial activity or program that pertains to the misconduct that took place
    - A corrective action plan and implemented corrected behavior
- Suspension - A public report of misconduct and temporary period of ineligibility for AOTA membership
- Revocation - A public report of misconduct and permanent loss of AOTA membership

When AOTA makes public reports of misconduct, the scenarios and related outcomes are mentioned in their official publications for the sake of educating current members.

Therapists will have 30 days to respond to any of the above sanctions they receive from AOTA. Therapists can (1) accept the decision and waive their right to an appeal, (2) ask for mitigation or a reduced sanction by writing a statement and sending supporting documentation, (3) request a hearing, or (4) not respond, which is construed as acceptance of the sanction.

If a therapist accepts, AOTA will move forward with the sanction as planned. If the therapist asks for a lesser sanction, the ethics committee must review the new information provided at their next meeting and vote on the matter. The therapist can also appeal the decision made, at which time AOTA will schedule a hearing to be held virtually. During the hearing, the committee will review only the information that has previously been submitted and may call certain witnesses to the stand. The decision is made via a majority vote taken by an independent panel, who can choose to affirm, modify, or reverse the decision initially made by the ethics committee. The decision made by the panel is considered final.

Legal Action Due to Ethical Misconduct

Legal action is the next category of outcomes that can result from ethical misconduct. Depending on the nature and gravity of a therapist's actions, they may face civil charges or criminal charges. As a general rule, civil charges are considered less severe than criminal charges. Individuals can differentiate civil charges from criminal charges based on who files the charges (an individual, the state, or a business), whether a jury or judge makes a ruling on the case, and the type of penalties that result from the charge.

When an individual has civil charges filed against them, the intent is typically to "right the wrongs" that victims have experienced. This typically falls under the category of torts, which are a type of wrongdoing where injury occurs due to an omission or an erroneous act. Torts can be classified as intentional (resulting from an erroneous act) or unintentional (as a result of omitting a certain practice).

Intentional tort

Intentional torts that may arise in the therapy industry include fraud, confidentiality breaches, embezzlement, assault, and battery. Many therapists assume assault involves laying hands on patients in an inappropriate way, but assault is defined as saying or doing something that causes someone to fear non-consensual touching. Battery, on the other hand, involves non-consensual touching that may or may not lead to injury. The central issue with battery is the lack of consent, whereas assault results when someone fears being harmed by another person. Assault and battery may take several forms within patient care:

- Transporting a patient from one place to another without their permission
- Placing hands on a patient and forcing them to move, walk, etc. if they are unwilling to
- Threatening patients for not participating in therapy
- Performing tests on patients or using their information to complete assessments without their consent
- Implying patients will be harmed or face negative consequences if they do not comply with treatment
- Providing treatment to a patient without their verbal or written consent

Another intentional tort is imprisonment, which involves a therapist subduing, controlling, or confining a mentally-capable patient against their will. Some examples of therapists falsely imprisoning their patients include:

- Using pharmacological, physical, or other restraints to restrict a patient without clinical justification

- Not allowing a patient to leave a healthcare institution if they express the desire to do so, unless they are involuntarily committed to a psychiatric facility per a court order
    - All patients have a right to do this regardless of their medical status; this is called leaving against medical advice (AMA)
- Unreasonably delaying a patient's release from a healthcare institution despite them being medically cleared for discharge

Unintentional tort

When therapists commit an unintentional tort, this most commonly refers to negligence, which is considered the failure to properly care for patients. As with other legal actions, four criteria must be met in order for an organization or patient to file an unintentional tort claim. Firstly, when a therapist begins treatment with a patient, they establish a duty to care for them. This must be present in order for the second component to exist: a breach of this established duty. A duty breach occurs when a therapist fails to exercise the sound clinical judgment that is expected of them. Breach of duty can be broken into three categories:

- Misfeasance, which is a basic mistake
    - For example, accidentally writing the wrong patient's name on an assessment form and not correcting it before signing and submitting the document
- Nonfeasance, which is a failure to respond appropriately in urgent situations
    - For example, not calling a code on a hospital patient who begins having a seizure
- Malfeasance, which involves the therapist having hidden motives or unknown intentions when engaging in negligent behavior
    - For example, pulling a crying, agitated child up from the floor by their hands and dislocating (or potentially dislocating) their shoulders

In order for a therapist to be charged with negligence, causation must also be present. This means the patient's injury must be directly connected to the therapist's actions or lack of proper action. The fourth component of negligence is

damages, which is the injury the patient experienced from the incident. From there, the court will determine the rightful compensation and other appropriate rulings for the patient.

Civil issues related to contracts

Contract law is another aspect of civil law that has the potential to impact a therapist's work. Some therapists may sign contracts with their place of employment, which sets forth terms that both parties must follow. In most cases, these contracts require therapists to work for the employer for the term of the contract (typically one year). But contracts can put other terms into place, such as non-compete clauses and non-disclosure agreements.

Therapists who have a non-compete clause in their employment contract must refrain from doing any work for their employer's competitors. While most non-compete clauses are only valid for 6 to 12 months after the end date of the contract, this type of clause is rarely enforced by employers. Regardless, therapists should still be mindful of who they work for following the completion of their contract and act accordingly. If a therapist is not comfortable moving forward with a contract that has this clause, they can ask their employer to remove this section from the contract before they sign.

Employers may also ask therapists to sign a non-disclosure agreement (NDA), either separately or as part of their contract. NDAs offer protection for employers who must share confidential or proprietary information with therapists as part of their job duties. This agreement says employees cannot use this information for their own purposes or share it with anyone outside of the company from that point forward, even in the event they stop working there. NDAs are more commonly seen outside of standard patient care in places such as start-up companies and health technology roles.

Criminal charges

Criminal charges serve the same purpose as civil charges in that they aim to bring justice in light of a person's wrongdoings. However, these cases are also meant to manage individual behavior in an effort to protect society. Under the heading of criminal law, someone may be charged with a felony, misdemeanor, or they can receive an infraction. Felonies are the most severe crimes, including rape,

manslaughter, murder, burglary, kidnapping, and arson. Misdemeanor crimes are considered lesser offenses and include simple assaults, trespassing, vandalism, shoplifting, drug possession, resisting arrest, and minor sex crimes. For some misdemeanors, individuals are fined double the amount the state believes they gained from the crime, which may be up to $1,000. Criminal misdemeanors also apply to therapists, since any violations of an OT's scope of practice fall under this category. A therapist may face a criminal misdemeanor charge if they participate in certain illegal behaviors. Some examples include engaging in fraudulent practices to get a therapy license, demonstrating significant incompetence or neglect in practice, or being charged with a felony due to non-practice-related illegal behaviors.

Infractions are one step lower and include basic legal breaches such as parking violations and speeding tickets. Infractions rarely involve any sort of jail time, but someone may face imprisonment if they have multiple infractions that have not been resolved over time.

Section 7 Personal Reflection

What charges and/or disciplinary actions might be brought against a therapist who engaged in both fraudulent and negligent behaviors with patients?

Section 7 Key Words

Assault - Saying or doing something that causes someone to fear non-consensual touching

Battery - Non-consensual touching that may or may not lead to injury

Civil law - Cases between two individuals as a result of a minor legal offense

Criminal law - Cases between an individual and the state that arise due to a serious offense that caused major injury to another person

Disciplinary action - The lowest tier of consequences resulting from ethical misconduct, including a reprimand (warning), censure (citation), probation (contingency plan), suspension (hold), or revocation (permanent loss) of a therapist's AOTA membership

Felony conviction - A major criminal offense that results in a prison or jail sentence of one year or longer

Imprisonment - Subduing, controlling, or confining a patient against their will without medical justification

Intentional tort - A wrongdoing where injury occurs to a patient due to an erroneous act

Misdemeanor conviction - A minor criminal offense that comes along with a jail sentence of up to one year, three years of probation, and/or a fine

Negligence - The failure to properly care for patients

Non-compete clause - A part of a contract that states an employee must refrain from working for their employer's competitors after their current employment ends

Non-disclosure agreement (NDA) - A part of a contract that states employees cannot use proprietary information for their own purposes or share it with anyone outside of the company at any point

Unintentional tort - A wrongdoing where injury occurs to a patient due to failing to take proper action; this is also known as negligence

Section 8: Guidelines and Standards for Making Ethical Decisions

60

Occupational therapy, like many other healthcare professions, is very situation-specific and unique. This can make ethical dilemmas trying because it may seem as if there is no resolution that benefits all parties involved. While there are a wide range of ethical principles, standards, and codes of conduct for therapists to follow, these unfortunately give therapists little to no specific guidance during times of ethical ambiguity. The best way to navigate these scenarios is through learning more about the field and its nuances, either experientially or through research and practical case studies. However, ethical dilemmas can still prove difficult even for the most seasoned practitioners.

One of the biggest takeaways regarding ethics is that there is rarely a "correct" answer, but there is often one option that is better than the others. Thankfully, there

are ways for therapists to engage in critical thinking to help them make the ideal decision given the present circumstances.

First and foremost, therapists must know the difference between ethics and morality. People often assume these concepts are the same, which is why many people use the terms interchangeably. Ethics and morality are closely related in that both set forth standards for right versus wrong and good versus bad. The two concepts differ mainly in the impact these standards have. Ethics exists on a larger scale and is defined as what is good and bad within the realm of society or a community. For example, lawmakers and others in government are responsible for the federal legislation that sets these standards for all of society. Morality, on the other hand, is a more subjective sense of right and wrong, which varies from person to person. For example, one person's morality can differ from that of another person since each individual is responsible for setting their own moral standards. This distinction is important, since a person is likely to experience ethical distress if their moral standards differ from the globally-accepted ethical standards in their society.

Due to their similarities and a central aspect of occupational therapy being personal interactions between providers and those they serve, the lines between morality and ethics can sometimes be blurred within patient care. For this reason, it's essential that therapists understand where morality begins and ethics ends. This is not only necessary for the sake of patient well-being, but it can also help therapists avoid ethical dilemmas that result from a misalignment of values. This is where moral sensitivity comes into play, which is defined as the ability to pinpoint a moral concern and evaluate all the consequences in terms of their impact on patients. If at any time, a therapist experiences a disagreement between their morality (personal views and beliefs) and ethics (what is in the best interest for the patient), they should exercise sound judgment by setting their priorities aside to focus solely on the patient.

Since ethics within the field is our focus, therapists must have tools to help with the ethical decision-making process. There are basic guidelines that can be helpful for anyone with ethical dilemmas, but they can also be applied to ethical dilemmas therapists may encounter in practice. Before therapists settle on an action in response to an ethical dilemma, they should run through the following tests:

- The legal test

    - Is the option legal? If the answer is no, it might not be the most ethical choice
- The professional standards test
    - Is this course of action acceptable and/or in line with my professional standards? If the answer is no, it might not be ethical
- The front page test
    - How would you feel if your name was mentioned in association with these actions on the front page of a newspaper? If your response would be negative, it might not be ethical
- The role model test
    - Would your role model make the decision you did? If so, how would you view your model as a result? If you answer no or that you not hold your role model in as high regard afterwards, it might not be ethical
- The gut feeling test
    - Does this course of action feel intuitively right? If the answer is no, it might not be ethical

At the end of the day, it's crucial for therapists to remain adaptive to the ever-changing dynamics of the healthcare industry. As a result, therapy professionals must do whatever they can to expose themselves to opportunities that enhance their critical thinking skills. Therapists can do this by:

- Registering for continuing education courses that further hone both soft and hard skills
- Attending hospital rounds and interdisciplinary meetings to get various perspectives on patient cases
- Following all local legislation (and remaining aware of updates to this legislation) rather than applying broad guidelines to practice
- Openly discussing ethical dilemmas with others to help weigh the options
- Effectively collaborating and communicating with other professionals
- Engaging in professional development activities

- Seeking out mentoring opportunities
- Mentoring new therapists
- Attending workshops

Section 8 Personal Reflection

What is the most important factor for therapists to keep in mind when weighing the options before them in an ethical dilemma?

Section 8 Key Words

Experiential learning - Learning that takes place by doing something or engaging in hands-on activities

Hard skills - Skills that can be taught, measured, and evaluated; some examples include typing, machine operation, and software programming

Morality - A person's individual beliefs regarding what is right and what is wrong, which is used to guide their behaviors and views on the world

Soft skills - Personality traits or characteristics that individuals possess to help them relate to others in the workplace; some examples include conflict resolution and adaptiveness

Section 9: Case Study #1

An OTA goes to the hospital room of a 15-year-old patient who they have been treating for 6 weeks. This patient lives at home with her mother, stepfather, and younger sister. She was hospitalized after a car accident, which left her with a broken tibia and fibula. She is currently in a large hard cast and is minimally ambulatory. The OTA notices that the patient is more withdrawn and less motivated for therapy today, which is a different presentation than the therapist usually sees from this patient. The OTA prompts her by asking how she is feeling today. The patient discloses abuse from a stepfather that has been occurring for 2 years with the most recent incident happening last night when he visited their room. The patient asks the OTA to keep this between them and states that her stepfather threatened her with further abuse if anyone else found out.

1. What is the best course of action for the OTA in this situation?
2. How should the OTA respond to the patient after this abuse has been disclosed?
3. Should the OTA include this information in her therapy notes? Why or why not?

Section 10: Case Study #1 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What is the best course of action for the OTA in this situation?

   Since therapists are mandated reporters of all forms of abuse, the OTA must initiate an incident report. The best thing for the OTA to do is to explain the situation to their supervising OTR and ask if there are any specific steps that must be taken. Once the OTR educates the OTA about that state and/or facility's procedures for reporting, the OTA should move forward while keeping the OTR in the loop each step of the way.

   According to these instructions, the first thing the OTA should do is call the mandated reporter hotline, which puts them in contact with a statewide registry of child abuse (or elder abuse, if applicable). This is a toll-free number that varies across states, but this will initiate the process of filing a report and getting the abuse victim to safety. Most states will accept an oral report (telling someone about the incident over the phone), which must be followed up by written documentation shortly after.

2. How should the OTA respond to the patient after this abuse has been disclosed?

   The OTA should notify the patient that they filed a report for their own safety. The therapist should reassure the patient to quell any fears over being further harmed by her stepfather. The therapist should educate the patient about the next potential steps: that a case manager or abuse specialist will likely reach out to schedule a visit, come by the hospital to speak with her, or visit her at

home once she is discharged. The OTA should inform the patient that this visit will help them get the information they need, so the patient should be honest and specific (about types of abuse experienced, frequency of abuse, etc.) with this specialist in order to get the best results.

3. Should the OTA include this information in her therapy notes? Why or why not?

   It's important that the OTA includes this information in her therapy notes. This might even warrant a therapist writing a second, more detailed note to effectively elaborate on the situation. The therapist should also include any copies of reports filled out for the state child abuse agency, police reports, or other forms of correspondence with outside agencies. It's important that this information is replicated in the patient's medical records for several reasons. This helps inform other professionals on the patient's team so they can respond accordingly in their own interactions and it ensures the patient's safety. Additionally, the occurrence of abuse (especially its continuation while the patient is injured) will likely negatively impact the patient's therapy progress so this is a barrier that insurers and other providers will want to know about.

Section 11: Case Study #2

An occupational therapist becomes aware that one of his colleagues has been drinking on the job. The therapist is also personal friends with the colleague and they often go out for drinks after work. The therapist confronts their colleague about the issue after smelling alcohol on her breath and noticing that she was slurring her words and acting more lethargic than usual. The colleague denies that she is under the influence and simply states she had a long night staying up with her sick child. While the colleague still does not admit to being under the influence, she later begs the therapist not to report them to their supervisor. She says she can't afford to get fired due to having expensive medical bills for her child, who was born with a genetic disorder. The therapist knows that his colleague has a lot of high acuity patients on her schedule today and is worried about the safety of those she treats if he doesn't report her.

1. What's the first thing this therapist should do after learning about his colleague's problem?

2. How can this therapist attempt to help their friend after learning about her situation?

Section 12: Case Study #2 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What are the first two actions this therapist should take after learning about his colleague's problem?

   If an ethical dilemma has the potential to place patients at risk of injury or other harm, maintaining or restoring patient safety should be a therapist's main priority. For this reason, the therapist's first course of action should be to report this behavior to their supervisor. This is an urgent matter that the supervisor should also prioritize, which will most often result in the colleague being sent home from work. From here, patients are not at risk, but there is the possibility they will not get treatment (for that day and potentially longer, depending on if the supervisor pursues disciplinary action). The therapist can either offer to take on some of their colleague's patients or assist their supervisor in assigning a few patients to other therapists' caseloads. This will help fill in the gaps

2. How can this therapist attempt to help their friend after learning about her situation?

   The therapist has already done what is ethically right in this situation, as described in the previous answer. However, they may still feel compelled to help their friend on the basis of what is morally right. If so, the therapist should encourage their friend to seek treatment for potential alcohol use disorder. This may already be a forthcoming requirement from her employment in order to keep her job, but telling her this ahead of time sets a different precedent. This not only lets her know you're concerned for her health, but it also can help her see she has a problem that is interfering with her job and the wellbeing of others. By gently and kindly informing your friend of this, she may be able to accept that she has a problem and warm up to the decision of treatment on her own, which is the ideal outcome. The

therapist can also tell their colleague about respite care for her chronically-ill child, both to assist the family while she is receiving treatment and afterwards to help offset some responsibilities while she focuses on her recovery.

It's important that the therapist maintains clear boundaries between helping their friend and their own job responsibilities. This is not only for the health of the friendship but also for the sake of the therapist's job. For example, it may be appropriate for the therapist to offer to take some of her patients for the first day or two until the supervisor rearranges the schedule. However, it is neither ideal nor feasible for the therapist to take on all of their colleague's job duties in their absence, since that would impact the quality of their own work performance.

Section 13: Case Study #3

An OTR with 18 years of experience recently moved in the midst of a family emergency. Though she moved from her current home to a part of town less than 10 minutes away, this was a permanent transition. The therapist changed her address for basic accounts such as her utility companies, but she forgot to change the address on her occupational therapy license. She was scheduled to receive two renewal notices within the first 2 months she was in the new house. However, she did not because they went to her old address and her mail was not forwarded. As a result, her OT license lapsed and she found out one month later when she finally contacted the board to change her address. She has been working at the same hospital for 10 years and kept the same job through her move. The human resources department at this hospital typically sends clinicians reminders via email when requirements such as licensure, physicals, vaccinations, etc. are coming due. The human resources department was recently outsourced, so there was no infrastructure set up for these reminders yet.

1. Who will be held accountable for this therapist while she was practicing without a license?
2. What is the best course of action for this therapist to take?
3. What steps should this therapist take to avoid this issue in the future?

4. Will this therapist be able to continue practicing?

Section 14: Case Study #3 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. Who will be held accountable for this therapist while she was practicing without a license?

   In this case, the therapist will be held accountable for practicing without a license. Regardless of safeguards (reminders, automated processes, etc.) that might be in place to help with this process, it is still the responsibility of the therapist in the event any of those safeguards fail. Therapists must fulfill all requirements set forth by their employer, state agencies, and national licensing boards in order to continue practicing.

2. What are the best courses of action for this therapist to take?

   First and foremost, the therapist must stop providing treatment until the issue is resolved. This means she must go home from work without pay. Therapists may want to stay at work to complete non-clinical duties (such as documentation) so they can still get paid. However, a therapist without a license can't even complete tasks such as writing notes since they cannot technically sign paperwork using their credentials.

   The therapist should reach out to the state licensing board again and explain the situation leading up to missing her renewal period. The therapist should also ask what needs to be done to get her license reinstated as soon as possible. Since the license has been expired for less than the standard renewal period (usually 2 to 3 years), the therapist will likely need to complete a portion of continuing education to compensate for the time that has passed.

3. What steps should this therapist take to avoid this issue in the future?

   This therapist should set up calendar reminders (both physical and digital) to keep track of their license and certification. They should also be more

organized during periods of transition such as moves, so that all of their therapy-related requirements are in order. It can be helpful to have a file folder with all current licenses and certifications stored in any easily accessible place for the therapist to refer to whenever needed.

4. What consequences will this therapist face? Will she be able to continue practicing?

   This therapist will likely be charged with practicing without a license. Depending on the state where she is working and the severity of the crime as determined by a judge, this may mean she is given:

   - A fine (if she's charged with a misdemeanor, this will be between $500 and $1000; if she's charged with a felony, this can be over $5,000)
   - Probation (at least 12 months)
     - This may come with or without restitution, where the therapist pays damages to the victims
     - This may also come with or without community service
     - A therapist cannot practice in their given profession for the duration of their probation
   - Jail time (up to 1 year for a misdemeanor; at least 1 year for a felony)

   The therapist will also receive some form of disciplinary action from AOTA regarding her membership status, which will be based on the severity of the therapist's charges (felony vs. misdemeanor).

   As long as the therapist fulfills all the requirements given to her by the court, she will be able to continue practicing after her sentence is complete. She may also be able to get her AOTA membership back (if applicable) as long as she follows AOTA's requirements.

Section 15: Case Study #4

A therapist working in a large acute rehabilitation facility is attending rounds with all of the healthcare providers on the floor. The attending physician starts the meeting off with a

50-year-old chronically ill patient that the occupational therapist has been treating for three weeks and knows well. The physician believes this patient should be discharged home with the 10 weekly hours of personal care assistance he was receiving prior to being hospitalized. The therapist believes that, despite continuing to attend daily therapy, the patient is not ready for discharge due to unsafe behaviors and new cognitive impairments. After mentioning this to the team, the discharge planner says she agrees with the physician. The discharge planner also informs the therapist that she is under a lot of pressure from administration to release patients so there are more beds for patients whose insurance plans pay more.

1. What should the therapist's first response be?
2. What other professionals might a therapist want to get involved in order to make their case?

Section 16: Case Study #4 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What should the therapist's first response be?

   A therapist should bring their concerns to the director of rehabilitation, who can either do a review of the patient's record or speak with the treating therapist to learn about their concerns. Once the therapist gets feedback from their director, they should gather evidence (test results, daily notes, etc.) that shows the patient is unsafe and not able to return home with their prior level of assistance. This may mean showing proof of a decline in progress or completing separate cognitive or independent living skills assessments that specifically outline their ability to care for themselves. The therapist should present both the discharge planner and the physician with this information, since it is likely that insurance will approve continued hospitalization if the planner submits the documentation to them. If the discharge planner is unwilling to do this or insurance denies continued stay, the therapist should use the test results as a way to gain additional support (from a home health agency, caregiver, etc.) at home for this patient.

2. What other professionals might a therapist want to get involved in order to make their case?

   In the event they are not successful with the above courses of action, the therapist may want to contact the insurance company themselves to explain the situation and send supporting documentation. They may also want to bring the case to the attention of administration to explain the liability this case creates not only from a financial standpoint but also a legal one since it places a patient at risk.

Section 17: Case Study #5

A group of second-year occupational therapy students are enrolled in a course on professional issues. The teacher for the course is an adjunct professor who is very well-respected in the field. She is the director of rehabilitation at a large teaching hospital locally and has been practicing for 25 years. This is her first semester teaching at the university level and many students have complained about her approach to the dean of the program.

Students report that she appears to be biased when speaking about clinical work and is making intimidating statements to certain students. When certain lower-performing students expressed they wanted to work in a neurological rehab setting, she told them they shouldn't pursue that goal because "they would never be able to keep up." She also frequently makes statements that entering the therapy field is not worth it. She tells students they will barely get to help patients and most of their time will be spent dealing with insurance companies and filling out paperwork. There are times when she speaks at length about situations she encounters as a rehab director and this usually involves her complaining about all the red tape in the healthcare system.

When this professor was confronted about the statements she has made, she simply said the students need to know what they're getting themselves into and that "there are too many prospective therapists in the field who don't know the truth." The students came back by saying their concerns are more over the quality of the instruction they are receiving rather than feeling hurt or uncomfortable.

1. What recourse do the students in this situation have?

2. What is the best option for the university to take as a result of these student reports?
3. Is the professor justified in what she is telling the students?

Section 18: Case Study #5 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What recourse do the students in this situation have?

   If the students felt intimidated or threatened by being told they should never work in a neurological rehab setting because they'd never be able to keep up, they can ask to transfer to another class. This transition may or may not be possible depending on the availability of other professors teaching the same course. Although it appears the professor was directing these statements at students who are not doing well academically, there does not appear to be any discrimination present.

   It is unlikely the other students will have personal recourse based on how the professor acted during class. The students acted appropriately by expressing their concerns related to the quality of their education rather than their personal reactions to the statements.

2. What is the best option for the university to take as a result of these student reports?

   The university should start by gathering as much relevant information (e.g. quotes, statements, etc.) as possible from each student so they can gain a better understanding of how the professor behaved. They also have the right to send an impartial party to observe a regularly-scheduled class and take note of what the professor says around students.

   Once they have this information, the dean of the program and likely a representative from human resources should have a discussion with this professor about the student reports, the findings from the observed class, and how the university will be dealing with the situation. This is likely not a

cause for firing, but the university should emphasize to the teacher the importance of giving students objective information with relevant anecdotal evidence. They should encourage the teacher to focus on the syllabus to assist them, set forth additional expectations surrounding the structure of the curriculum, and possibly implement a probationary period going forward.

3. Is the professor justified in what she is telling the students?

   It is the professor's responsibility to do right by the students, which includes preparing them to enter the rehabilitation field. Based on the information given, it does not appear the professor is justified in portraying the field in this way, regardless of if she has good intentions. In keeping with this ideal, the professor can give students realistic information about how much paperwork they will have to deal with each day and answer questions they might have about the field.

   Since the course is regarding professional issues in the field, it is acceptable for the professor to discuss specific scenarios therapists may encounter in the field based on her own clinical experience. However, this case study states the professor often complained about her job. This is not only unprofessional, but irrelevant to the course. If the professor brought up salient takeaways related to each scenario, that would have been a more constructive use of their time. But it appears the professor may be experiencing job-related stress (or potentially even burnout) from her role and is using class time as an opportunity to vent. This should be addressed outside of class time, either as part of an employee assistance program through her place of work or via therapy sessions with a counselor.

Section 19: Case Study #6

A therapist goes to his local high school reunion and sees several former classmates. He begins talking with those at his table and briefly mentions his career when they begin catching up. This segues to him mentioning that he recently treated a former classmate and once-mutual friend who is not at the reunion. The therapist states he was seen for carpal tunnel syndrome. Upon being asked more questions from those at the table, the therapist also shares that he read this patient's entire medical record and discovered he was also recently treated for an STI.

Later, the therapist learns that the former classmate he treated is in close contact with many people who were at the reunion. Word got back to him what his therapist said and he got angry. He began telling people that he has never had an STI and the information is incorrect. He approaches his therapist and threatens him for spreading rumors. As it turns out, the information about the STI is not true, since the therapist was confusing his former classmate with another patient who has a similar name.

1. What ethical dilemma is this therapist in?
2. Is there a possibility this therapist will face legal charges?
3. What is the best course of action for the therapist to take?

Section 20: Case Study #6 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What ethical dilemma is this therapist in?

   First and foremost, this therapist violated HIPAA by revealing the identity of someone they are currently treating or have treated in the past. On top of sharing protected patient information, this therapist also made disclosures that were untrue, which stands to damage the reputation of their former patient.

2. Is there a possibility this therapist will face legal charges?

   HIPAA is one of the most basic policies a therapist must uphold at all times, since this protects patient information. Since the therapist in this scenario intentionally brought up the name of one of their former patients, this is considered a willful violation of HIPAA. As a result, this therapist can face criminal charges that come along with a fee between $50,000 and $250,000. It is also very likely the therapist will face a jail term for this violation, since HIPAA is considered a federal law.

   Depending on whether or not the former patient decides to file charges, the therapist may also be found guilty of defamation of character, specifically

slander. In the realm of defamation, slander refers to orally communicating untrue information and libel describes writing/publishing information that is not true. In order for this therapist to be sentenced for slander, lawyers must prove that (1) the information was untrue, (2) the therapist willfully knew or should have known the data was untrue, and (3) the information caused injury to the patient. It has already been established that the information is not true and that it has spread throughout the community, causing potential damage to the patient. The court would need more information to determine the motives of the therapist and whether or not they were aware of the mistaken identity.

3. What is the best course of action for the therapist to take?

   In the case of most HIPAA violations, therapists must notify any and all patients affected within 60 days. However, the therapist is exempt from that in this situation since the patient was made aware by other means. The therapist should also notify their employer of the breach, specifically the privacy officer, if they are not already aware. This allows their employer to start the disciplinary process for this therapist, which may entail suspension or termination. The therapist should also take the necessary steps to mitigate any further damage from occurring, though that may not be relevant in this situation since the patient found out on their own.

Section 21: Case Study #7

A newly-graduated therapist is working as an independent contractor for several pediatric clinics. Since independent contractors are 1099 positions, workers are not considered employees, so they do not get benefits of any kind and are paid per visit. This therapist recently took on a child whose family frequently no-shows. Their company policy, which is in accordance with most independent contractor positions, is that therapists and therapy assistants are not paid for any no-shows or cancellations that take place with less than 24-hour notice.

The family did not show up to therapy for the past three weeks and the therapist made contact with them to check in, see if they need to set a new appointment time, or ask if they want to reschedule the missed visit(s). Each time, the mother returns the therapist's call the next day and states that several of the children in their family are sick and they just can't make it to the clinic because she doesn't

have anyone to babysit them. The therapist offered to accommodate the family via telehealth, a potential in-home visit, or even after-hours visits once they are recovered. However, the mom declines and simply says she would like to pick services back up once her children are well.

The therapist is frustrated by this, partly because she feels the child will fall behind since the mom is not compliant with home recommendations and partly because she is losing money and can't fill that slot with another child to compensate. After some consideration, the therapist decides to bill for these missed visits. The therapist supervises a COTA who sometimes treats this family when the therapist is on vacation. The COTA is friends with someone who is related to this family, so she knows that the family is sick and did not come to their most recent visits. The COTA confronts the therapist about this, who comes back saying the family felt better and decided to come to the clinic at the last minute.

1. What ethical dilemmas are present in this situation?
2. What legal charges might the therapist face?
3. Can the COTA be held legally responsible or accountable for the therapist's actions?
4. Would the therapist be able to continue working as a contractor for this company? What about the other companies she is contracted with?

Section 22: Case Study #7 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What ethical dilemma(s) are present in this situation?

   The therapist wrote a note that claimed treatment was provided when it was not, so the ethical violation in this scenario is insurance fraud.

2. What legal charges might the therapist face?

   This therapist will face charges of fraud. If the therapist is found guilty of misdemeanor fraud, they will face between 1 and 4 years of prison time. If

the therapist is found guilty of criminal fraud, they will face between 5 and 25 years of prison time. The length of these sentences depends on the state where the crime occurs.

3. Can the COTA be held legally responsible or accountable for the therapist's actions?

   No. According to scope of practice rules, the OTR can be held accountable for the actions of their COTA, but the same rule doesn't apply to COTAs and the actions of their OTR. The COTA may feel partially responsible since they work closely with the OTR, but they should feel comfortable reporting this sort of information to their supervisor.

4. Would the therapist be able to continue working as a contractor for this company? What about the other companies she is contracted with?

   After being charged with fraud, the therapist will be terminated from this position. While we have no knowledge about her behaviors at the other companies she is contracted with, they will most likely also terminate her since this behavior is not acceptable for a therapist.

Section 23: Case Study #8

An occupational therapist with 6 years of experience just began working in an inpatient hospital. Overall, she had a good impression of the rehab department and the hospital staff. However, late in her first week she was approached by the rehabilitation director who asked her about a new patient. The patient in question is a 55-year-old male who lives with his wife and was admitted to the hospital for spinal surgery. He had an OT evaluation done two days ago and the evaluating therapist found that he was not appropriate for therapy since he has no cognitive or safety concerns and is independent in bed mobility, all ADLs, and functional ambulation. The evaluation was a single visit and the patient was not added to therapy's caseload.

The director of rehab wants the therapist to reopen this case and provide intervention addressing leisure, since the director is familiar with this patient from previous hospital admissions and believes he could benefit from some productive

leisure activities. The therapist is confused about how to respond to this request, since the patient was already found to not need therapy.

1. What is the ethical dilemma present in this situation?
2. What is the best way for the therapist to respond to this request?
3. What type of proof may be necessary to support the therapist's response, regardless of what it is?
4. Will the therapist face legal charges or disciplinary action from AOTA?

Section 24: Case Study #8 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What is the ethical dilemma present in this situation?

   The director of rehabilitation is instructing a therapist to provide services to someone who does not need them, which is not only a poor use of resources but also considered insurance fraud. One could argue that this may even be considered operating outside of OT's scope of practice, since leisure is not considered one of the foundational skills therapists address during short-term hospitalization.

2. What is the best way for the therapist to respond to this request?

   The therapist should decline this request and tell their supervisor that it's not ethical since this patient was already determined to not need treatment. If the rehabilitation director persists, the therapist can offer to screen the patient to see if they have a different clinical opinion than the therapist who completed the evaluation. If this therapist sees major ADL, cognitive, or safety concerns that warrant therapy, they can re-evaluate the patient and provide treatment. However, it still isn't ideal to provide treatment surrounding leisure function in this setting.

   If the supervisor continues to pressure the therapist into providing treatment in a case where it's not recommended, the therapist can report them to their

hospital's compliance officer for attempting and/or encouraging insurance fraud.

3. What type of proof may be necessary to support the therapist's response, regardless of what it is?

   If the therapist is trying to support the stance that this patient does not need therapy, she will need a copy of the previous therapist's evaluation as evidence. The therapist may also need to write a note stating they screened the patient again and they are still not appropriate for services. If they do this, that note would also be needed as proof.

4. Will the therapist face legal charges or disciplinary action from AOTA?

   If this therapist decided to blindly follow her supervisor's instructions, she could potentially face legal charges and AOTA disciplinary sanctions for committing insurance fraud. Since the director of rehabilitation is the one who gave the instruction, this would happen if an administrator or colleague accidentally found out or learned about it after doing an audit.

Section 25: Case Study #9

An occupational therapist recently accepted a position working in a school district. The terms of the contract were for one school year and state that the therapist must travel between more than one school to treat children. This therapist has two years of experience and was not only asked to do this at his previous school-based role but has been told from other school-based therapists that this is the industry standard. After hearing this, he agreed and signed the contract. However, he neglected to read the fine print, which stated the therapist who accepts this position will travel between 4 schools that are 15 minutes apart and is expected to manage a caseload of 50 students.

The OT has been working in this role for 1 month and is struggling to provide quality treatment for each child due to the demands of the job, specifically the commute and the number of students he is required to treat. He feels that he is not giving his best to these children and is experiencing moderate to severe burnout with the development of several physical health concerns (insomnia, weight gain, body aches, low energy). He wants to bring his concerns up to administration, but he does

not have a therapy supervisor at any of the schools he works and is the only therapist at each school in the district.

1. Has the therapist demonstrated any ethics violations in this scenario?
2. Does the therapist in this situation have any recourse?
3. What is an ideal plan of action for this therapist?
4. What are some strategies the therapist can use to avoid burnout and provide better care until there is a resolution to his problem?
5. What can the therapist propose is a more realistic way to get his job done?

Section 26: Case Study #9 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. Has the therapist demonstrated any ethics violations in this scenario?

   While the therapist feels as if he is not doing the best he can for his students, there have not been any ethical violations in this scenario. Yet, if the therapist does not get outside help or make a change, there is the potential for this situation to become unethical. The administration who created the contract also have not technically committed any ethical violations, since they are not therapists and are likely unaware of a realistic caseload for a therapist. However, it can be argued the administration should have exercised due diligence to determine an appropriate expectation for incoming therapists since it is part of their job to create job positions and outline duties.

2. Does the therapist in this situation have any recourse?

   In terms of the contract the therapist signed, he has a few options to get out of the agreement. First off, he should check his state's laws to ensure that the contract is actually valid. Some states have at will employment, meaning any contract can be terminated by the employer or employee for any reason as long as appropriate notice is given. Appropriate notice is typically two weeks. If there is no recourse with that option, the therapist should see a doctor,

since the symptoms he is experiencing are likely related to chronic stress. These health concerns may warrant an end to the contract if they are severe enough and impact his physical or cognitive ability to work. If this is not a viable option, the therapist can contact the human resources department at the district to discuss the potential for a mutual end to the contract. However, there is no guarantee the school will agree to this choice, especially if they have had difficulty retaining therapists in the past, the district has a hiring freeze, or there is a workforce shortage.

3. What is an ideal plan of action for this therapist?

   While he is still employed, this therapist should firstly focus on taking better care of himself to perform better in his job. Despite his job having unrealistic expectations, he should still strive to do his best and make ethical decisions when treating students (e.g. not billing for treatments that never happened, spending the appropriate amount of time with each student based on their IEP, etc.). If the therapist is truly not happy with the role he is in, he can consult with a lawyer to assist him with early termination of his contract. This will allow him to search for other positions.

4. What are some strategies the therapist can use to avoid burnout and provide better care until there is a resolution to his problem?

   The therapist can seek out help from a mental health counselor to begin managing his burnout, since it appears to be in the later stages and may not respond as well to lifestyle changes such as more regular self-care. In terms of performing better at work, the therapist can take a look at the students on his caseload and their classes to determine if he can arrange their schedules in a way that helps him. For example, the therapist can spend two days treating children at one school then one day at another school to treat most of the children there.

5. What can the therapist propose is a more realistic way to get his job done?

   The therapist can request that the administration hire a COTA to assist with his caseload. He can also speak with local universities to take on a Level II fieldwork student. While this will give him some additional work duties (e.g. supervising, reviewing notes, providing guidance on treatments, etc.), the therapist should consider how many children a student would realistically be able to treat without ending up in the same position he is in. This will help

the therapist determine whether or not this would save him time or make his position even more difficult. By no means is this a long-term solution, since there will certainly be semesters when he is not able to take a student and needs to resume the full extent of his job duties. However, this can be an option for making the best out of his situation and guiding a student in the process.

Section 27: Case Study #10

A young professor at an OTA program is required to hold 5 weekly office hours for students to ask questions and get extra help on course materials. This 5-hour weekly requirement stands for each class the professor teaches. The professor has worked a lot of long hours over the past month, so he decides to hold his office hours at a local restaurant. The professor sends out an email to all of his students and asks them to come to the restaurant if they have any questions or concerns. The restaurant is popular with college kids and these students are familiar with the restaurant, so they choose to attend. They speak with the professor for a short time about class-related issues, which then leads to them getting dinner and drinks together. All of the students who visit the professor are over the age of 21, so they feel comfortable doing that.

1. Are there any ethical violations in this scenario?
2. What parties are in the wrong in this situation?
3. What consequences might either party in this scenario face?

Section 28: Case Study #10 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. Are there any ethical violations in this scenario?

   It is unethical of the professor to hold his office hours outside of the university. Firstly, this is not ethical because it forces students to go out of their way to get the help they need. But this first ethical misstep can also lead

to professors socializing with students outside of the university, which has occurred in this situation. This is not advised because it crosses the acceptable boundaries set between students and professors.

2. What parties are in the wrong in this situation?

   First and foremost, it is the responsibility of the professor to act professionally and ethically toward his students, regardless of how young he is and how much experience he has. Therefore, the professor behaved wrongly by holding office hours outside of the university and by having dinner and drinks with students afterwards. Even if this was simply a friendly interaction without any romantic intentions, this is still not professional behavior for a professor and current students to engage in. The students were also in the wrong, since they should have requested office hours on-campus and avoided the interaction altogether.

3. What consequences might either party in this scenario face?

   The professor will be terminated for violating several boundaries set by the university. If he has an active AOTA membership, the professor will also receive a disciplinary sanction from AOTA if someone reports him. The students who attended office hours solely for the sake of class concerns, adhered to those intentions, and left after discussing class matters will likely be given a warning and told to report this sort of behavior in the future. The students who attended office hours followed by having dinner and drinks with the professor will likely be removed from the program for unprofessional behavior.

Section 29: Case Study #11

An occupational therapist just got hired by a tech company to develop a telehealth program for rural communities across four adjacent states. Many of the patients in this program will be using telehealth for the first time ever. This therapist starts by assisting in the hiring process for incoming therapists. She also collaborates with the chief technology officer to ensure all programs, software, and applications are fully HIPAA compliant. She completes and submits the company's Medicare application so they can receive reimbursement for services provided. She only has experience working with paper documents so she creates several paper forms for therapists to

complete as documentation. She educates each incoming therapist that the only current practice requirement for their company is an OT license in the state where they reside. However, this telehealth company will not provide services in the states where the incoming therapists are currently living.

1. 1What other requirements should the therapist be educating the incoming therapists about?
2. Are there any ethical concerns present in the early stages of this program launch?

Determine whether it's in the best interest of clients/get safeguards in place for privacy/licensure in home state and all other states where referrals may come in from/documentation must meet all payer requirements

Section 30: Case Study #11 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What other requirements should the therapist be educating the incoming therapists about?

   The lead therapist should be telling therapists they must be licensed in all four states the program will serve (in addition to the state where they reside). Otherwise, they cannot provide treatment to patients in these states. The lead therapist should also develop a set of procedures for therapists to use when guiding first-time telehealth patients through the care process. This should also come along with a checklist of items patients may need and things they may need to do to prepare for their visits (e.g. finding a private place to complete the session).

2. Are there any ethical concerns present in the early stages of this program launch?

   The lead therapist is neglecting to inform therapists of all the requirements necessary for them to practice with this company. If this therapist hires clinicians who have experience in telehealth, they may be more aware of the

requirements and have those in place on their own. However, if the therapist hires newer practitioners who are not as knowledgeable, they are more likely to rely solely on guidance from the lead therapist. As a result, those providers will begin working without these things in place and are at risk of losing their license for not meeting practice requirements. If and when these therapists discover they have not met all the requirements and cannot start treating on the day they are expected to, they will be losing out on several weeks of pay.

Both parties are likely to be charged with negligence. This is not ethical on behalf of the lead therapist, but both parties will be held accountable since they are licensed

professionals who are responsible for fulfilling practice standards. Additionally, it's unethical for the lead therapist to have accepted this position without having the proper experience or doing the right research to get the job done correctly.

Section 31: Case Study #12

A fieldwork supervisor is speaking with the academic fieldwork coordinator (AFWC) from the university where she takes students. They are close personal friends, but only recently began working together in this capacity. During one of their coffee dates on the weekend, the fieldwork supervisor asks the AFWC about her student that just began at the hospital. While the student's engagement is great and she is considered one of the group's highest performers, she says the student is slow to respond to directions, takes a lot of bathroom breaks, and constantly says she's fatigued. The AFWC begins telling the supervisor that this student has a diagnosis of depression and Crohn's disease. She is also undergoing testing for suspected ovarian cancer. At the start of the semester, this student previously expressed to the AFWC that she did not want to disclose this information to her supervisor unless she felt it was impacting her ability to perform. The AFWC also mentions that the student's family is going through a lot of transitions with her sister getting divorced, parents involved in a custody battle over her younger siblings, and they are potentially discussing an out-of-state move.

1. Is this information relevant to the student's performance?
2. Should the AFWC have told the supervisor about this?

3. Was the student required or obligated to tell her supervisor or AFWC about these diagnoses and family concerns?

Section 32: Case Study #12 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. Is this information relevant to the student's performance?

   No, this information is not relevant to the student's performance because the fieldwork supervisor already said this student is one of the highest performers in the group. The supervisor and AFWC should not have discussed this at all because it's irrelevant to either of their jobs and is simply being talked about as gossip. If the two parties did need to discuss it to determine a plan of action to help the student, they should have done so in a private setting within the university to maintain confidentiality.

2. Should the AFWC have told the supervisor about this?

   According to ADA, it is the decision of the student whether or not to disclose diagnostic information to their employer, professors, and/or fieldwork supervisors in the event they are seeking accommodations. The student is performing well, so it would also be their decision to get accommodations if and when they feel this is changing. So, no, it was not the role of the AFWC to give this information to the supervisor in this instance nor would it be in the future if circumstances were different.

3. Was the student required or obligated to tell her supervisor or AFWC about these diagnoses and family concerns?

   According to ADA, the student can make this decision on their own. While the family concerns discussed in this scenario do not fall under the umbrella of ADA, this is also not something the student is obligated to share.

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