The Revised APTA Code of Ethics for the Physical Therapist and Standards of Ethical Conduct for the Physical Therapist Assistant: Theory, Purpose, Process, and Significance

Laura Lee Swisher, Peggy Hiller; the APTA Task Force to Revise the Core Ethics Documents

Introduction. In June 2009, the House of Delegates (HOD) of the American Physical Therapy Association (APTA) passed a major revision of the APTA Code of Ethics for physical therapists and the Standards of Ethical Conduct for the Physical Therapist Assistant. The revised documents will be effective July 1, 2010.

Purpose. The purposes of this article are: (1) to provide a historical, professional, and theoretical context for this important revision; (2) to describe the 4-year revision process; (3) to examine major features of the documents; and (4) to discuss the significance of the revisions from the perspective of the maturation of physical therapy as a doctoring profession.

Process of Revision. The process for revision is delineated within the context of history and the Bylaws of APTA.

Format, Structure, and Content of Revised Core Ethics Documents. The revised documents represent a significant change in format, level of detail, and scope of application. Previous APTA Codes of Ethics and Standards of Ethical Conduct for the Physical Therapist Assistant have delineated very broad general principles, with specific obligations spelled out in the Ethics and Judicial Committee’s Guide for Professional Conduct and Guide for Conduct of the Physical Therapist Assistant. In contrast to the current documents, the revised documents address all 5 roles of the physical therapist, delineate ethical obligations in organizational and business contexts, and align with the tenets of Vision 2020.

Significance. The significance of this revision is discussed within historical parameters, the implications for physical therapists and physical therapist assistants, the maturation of the profession, societal accountability and moral community, potential regulatory implications, and the inclusive and deliberative process of moral dialogue by which changes were developed, revised, and approved.
In June of 2009, the House of Delegates (HOD) of the American Physical Therapy Association (APTA) took a decisive and historic action when it passed a major revision of the Code of Ethics and Standards of Ethical Conduct for the Physical Therapist Assistant. In passing the revised documents, the HOD included a proviso that the new documents would not take effect until July 1, 2010, in order to provide time to educate members about the new ethical standards. This action was historic because of the substantive change in format of the documents and the inclusive and deliberative process of moral dialogue by which the changes were developed, revised, and approved. The purposes of this article are: (1) to provide a historical, professional, and theoretical context for the revision; (2) to describe the 4-year process involved in the development of the revised Code of Ethics and Standards of Ethical Conduct for the Physical Therapist Assistant; (3) to examine major features of the revised documents; and (4) to discuss the significance of the revisions from the perspective of the maturation of physical therapy as a doctoring profession.

It is generally recognized that codes of ethics are important to professionals, professionals, and the public. Indeed, most physical therapist students learn that the development of a code of ethics represents one of the characteristics necessary for an occupation to be considered a profession. However, there is significantly less agreement about the purpose and format of codes of ethics and the roles that they play in promoting ethical conduct. In the following paragraphs, we provide a theoretical and historical background for the discussion of the revised core ethics documents.

A significant body of literature has evaluated the societal role played by codes of ethics from the sociological perspective on professions. Paul Starr summarized this literature in this way: “A profession, sociologists have suggested, is an occupation that regulates itself through systematic, required training and collegial discipline; that has a base in technical, specialized knowledge; and that has a service rather than a profit orientation, enshrined in its code of ethics.” For Starr, these characteristics of professions parallel the 3 different types of professional legitimacy or authority: collegiate, cognitive, and moral. Some sociologists would expand upon Starr’s definition of a profession by highlighting the social-political process of attaining the status of being considered a profession (professionalization). Others might note that the autonomy implied by Starr’s description of self-regulation is a litmus test for “real” professions that is granted in exchange for public accountability as part of the “social contract.”

On the other hand, Pellegrino has argued that it is the vulnerability of those who seek assistance that creates special ethical obligations for the professional: Those who seek out helping professionals share a certain common phenomenological ground. They all deal with a human being in compromised existential states. The persons they see are dependent, anxious, in distress, and lacking something essential to human flourishing. Humans in these compromised existential states are eminently vulnerable and exploitable. Persons in that state are invited to trust the professional....

A number of scholars have elaborated upon the purposes of professional codes of ethics. Fullinwider described the role that professional codes play in providing a “vocabulary for intraprofessional argument, self-criticism, and reform,” stimulating public discussion of professional obligations, fostering “moral self-understanding,” and creating a professional moral community. Similarly, Frankel stated that “a profession’s code of ethics is perhaps its most visible and explicit enunciation of its professional norms. A code embodies the collective conscience of a profession and is testimony to the group’s recognition of its moral dimension.” Table 1 summarizes the multiple purposes of codes of ethics discussed in the literature under 3 major categories: articulating a moral vision and self-understanding; educating and providing guidance to members of the profession; and promoting the “social contract,” public accountability, and societal expectations.

Although most of the literature about codes of ethics focuses on their positive purposes, it also is widely accepted that codes of ethics may be self-serving or function in negative ways within society. For example, Starr noted that occupational groups may create a code of ethics in order to achieve professional recognition or authority, and, as Table 1 indicates, codes of ethics may contain items with the primary purpose of protecting the profession or working in the self-interest of its members. Beauchamp and Childress elaborated on the weaknesses of professional codes of ethics, noting that they may be too vague, simplistic, or rigid to provide appropriate guidance. Likewise, some professional codes might more appropriately be seen as codes of professional “ etiquettes” rather than “ethics.”
Schwartz17 examined the influence of corporate codes of ethics on behavior. Interviews with employees, managers, and ethics officers revealed 8 primary metaphors for the manner in which a code of ethics may influence behavior: (1) rule book (clarifies expectation for behavior), (2) signpost (alerts one to seek clarification), (3) mirror (focuses need for caution and reflection), (4) magnifying glass (focuses need for caution and reflection), (5) shield (protects those who challenge pressure for unethical conduct), (6) smoke detector (convincing others of unethical practices), (7) fire alarm (contacts appropriate authority), and (8) club (forces compliance).17(p255) These metaphors may provide additional insight into how individuals experience the multiple purposes, strengths, and weaknesses of codes described in the literature.

Some professions and scholars distinguish between “codes of ethics” and “codes of conduct.” When this distinction is made, the code of ethics typically outlines the general ethical principles or ideals and the code of conduct provides specific rules for behavior.16(p9) Although this differentiation highlights a distinctive characteristic of a code of ethics (explicit focus on ethics and not merely rules of etiquette), Beauchamp and Childress suggested that a rigid distinction between ethical principles and ethical rules may not be theoretically sound: “We treat principles as the most general and comprehensive norms, but we draw only a loose distinction between rules and principles. Both are general norms of obligation. The difference is that rules are more specific in content and more restricted in scope than principles.”16(p13) Beauchamp and Childress argued that general principles require specification in order to provide helpful and meaningful guidance. Specification is the process of spelling out what actions are required by whom and under what circumstances.16(p17) Given the importance of specification to clarify the meaning of ethical principles, therefore, it is not surprising that many codes combine general and specific principles in a single document.18(p9)

Relatively little has been written in the physical therapy literature about the APTA Code of Ethics.19 In her classic 1977 article, Ruth Purtilo outlined the historical foundations for the Code of Ethics of the APTA, noting that the first ethical code was the Code of Hammurabi, a Babylo-
nian document written in 2500 BC. In this same article, Purtilo recognized the roots of modern codes of ethics in the Hippocratic Oath and the Oath of Maimonides, both of which provided a foundation for subsequent formal codes of ethics. Purtilo credited Percival's textbook on medical ethics published in England in 1803 and Florence Nightingale's nursing text in the same century with developing awareness of ethical issues: ‘In short, the ethics emphasis in the textbooks of Percival, Nightingale, and others, must be viewed as exerting an important influence in the development of an ethics awareness among health professionals of the 19th and early 20th centuries.’ Purtilo noted that the American Medical Association's Code of Ethics published in 1846 became a ‘prototype’ for subsequent professional codes, including the first Code of Ethics of APTA (then the American Physiotherapy Association [APA]) published in 1935 (Fig. 1).

Ten years later, Purtilo revisited the concept of the code of ethics in an article whose purpose was to examine the usefulness of codes of ethics in reference to professionalism and practical guidance in physical therapist practice. She observed that a code of ethics serves 2 important functions. Because having a code of ethics is considered a hallmark of being a profession, one function is to legitimate the claim that an occupational group has attained the status of being a profession. The second function is to provide guidance for practitioners. Regardless of these functions, Purtilo stated that the test of being a true code of ethics is having a true ethical standard: “Therefore, the more a document actually reflects ethical standards, the closer it comes to being a genuine code of ethics.” From this perspective, the first Code of Ethics was, in her estimation, not successful in passing this litmus test:

Declaring a document a code of ethics does not in itself assume that one has a code of ethics! Elsewhere I have shown that the early attempts of the American Physical Therapy Association to design a code of ethics was gallant in its intent though unsuccessful in its outcome: one can hardly judge this document's set of rules designed solely to show devotion and complete deference to the physician as being grounded in any specifically ethical standards, even in the 1930s. While serving as a guide for good etiquette befitting the young ladies of the time, and while serving some other important ends, nonetheless it did not serve as an ethical guide (Purtilo, 1977). For this perspective, the first Code of Ethics was, in her estimation, not successful in passing this litmus test:

However, Purtilo also observed that a code of ethics may be deficient at the other end of the spectrum by being ‘vaguely-stated ideals, or are too narrowly conceived to be of much help with everyday problems.’

Linker’s analysis of this first physical therapy code of ethics provides insight into the historical and inter-
professional context that may have contributed to the early leaders of the physical therapy profession producing a code of ethics that was clearly deficient in its concern for patients and the public, even for those early times. Linker observed that “codes of ethics are dynamic documents that provide a unique window into the workings of interprofessional conflicts and negotiations. For the historian, codes of ethics are, above all, statements of professional, economic, and gender-related pressures that contributed to the wording in the first code, noting that APA was one of the first “ancillary” professions to produce a code of ethics during this period of time:"

The history of codes of ethics in health care has almost exclusively been told as a story of how medical doctors developed their own professional principles of conduct. Yet telling the history of medical ethics solely from the physicians’ perspective neglects not only the numerous allied health care workers who developed their own codes of ethics in tandem with the medical profession, but also the role that gender played in the writing of such professional creeds. By focusing on the predominantly female organization of the American Physiotherapy Association (APA) and its 1935 “Code of Ethics and Discipline,” I demonstrate how these women used their creed to at once curry favor from and challenge the authority of the medical profession . . . . [C]ontrary to historians and philosophers who contend that professional women have historically operated under a gender-specific ethic of care, the physiotherapists avoided [Victorian] rhetoric construed as feminine and instead created a “business-like” creed in which they spoke solely about their relationship with physicians and remained silent on the matter of patient care.22(p520)

In effect, the 1935 Code of Ethics sacrificed professional autonomy for stability in relating to the medical profession. Based on her reading of association publications and correspondence, Linker believed that the omission of a service orientation and focus on the patient were most likely strategic rather than merely an “oversight.” As Linker described it: “Although such an agreement required that the therapists subvert their tendencies toward a feminine rhetoric of care and relinquish a considerable degree of autonomy as health care providers, APA therapists willingly paid the price of adhering to the rules of medical professionalism. They wanted to maintain their professional identity and keep their occupation afloat in a tumultuous marketplace, and with their code of ethics, they said as much.”22(p352)

Consistent with Linker’s analysis, Purtilo described the 1935 APA Code of Ethics as focusing primarily upon establishing our professional identity:

These therapists had read, correctly, a shifting social landscape that was enduring a worldwide depression and would, a few short years later, feel the corrosive effects of a world war and the challenges of social reconstructions following it, as well as face the global ravages of the polio epidemic. Indeed, the entire social terrain of the western world would force physicians down from the mountaintops to labor shoulder to shoulder with nurses and whoever else would share the crushing burden of health care in these extreme circumstances. They found physical therapists ready. Be-

---

**Ethical Self-Identity (1935)**

Care and accountability to health care providers

**Patient-Focused Identity (1950s)**

Care and accountability to patients

Partnership with patient

Emphasis on patient rights and teamwork

**Societal Identity (Evolving and Future)**

Partnership with community and institutions

Self-identity and patient-focused identity “nested” in societal priorities

---

Figure 2.

Three seasons of physical therapy ethics described by Purtilo.23
cause physical therapy had planted a professional ethical identity, however new and fragile and however constrained its arena of accountability may seem today, its members were positioned to move from servitude to strong moral partnership.23(p115)

Baker24 theorized that professional codes of ethics evolve in 3 distinct stages: traditionalism, formalization, and professionalization. In the traditionalism stage, there is no formal code of ethics, and ethical decisions are based on “traditions of practice.”24(p34) During the formalization stage, there is an attempt to formulate rules and oaths, but adherence is voluntary and there is no mechanism for enforcement or regulation. An example of this stage within physical therapy might be the Loyalty to Country oath taken by students at Reed College described by Linker.22 The professionalization stage is characterized by the formal public promulgation of autonomy and ethical ideals consistent with maturation into a profession. In comparison with medicine,24 law,24 and nursing,25 it is striking how quickly the early physical therapists moved to the stage of professionalization with regard to developing the early code of ethics. Nevertheless, as both Purtilo and Linker pointed out, this early code did not, in fact, fully articulate the ethical ideals of the profession. In this way, there remained unfinished business for physical therapy with regard to full maturation in the professionalization stage.

The last 20 years has witnessed a remarkable evolution of the physical therapy profession in the United States. During this period, the profession has defined its scope of practice, secured direct access in most state jurisdictions, and articulated a vision of physical therapists as doctorally educated and evidence-based professionals serving as practitioners, educators, consultants, researchers, and administrators. The APTA published the Guide to Physical Therapist Practice26 in 1997, Vision 202027 in 2000, and Professionalism in Physical Therapy: Core Values,28 endorsed by the HOD, in 2007. The core ethics documents that are currently in force were adopted in 1973 and had been revised 5 times (1977, 1978, 1981, 1987, and 1991) before the most recent previous revision in 2000.

This section of the article has attempted to delineate the theoretical and historical context for the revision of the core ethics documents. As Linker suggested, a code of ethics provides a “window” into the profession in a historical context. Internal communications within APTA suggest that there was growing concern about the adequacy of the Code of Ethics as early as 1999. A review of the annual reports of the Ethics and Judicial Committee (EJC) for 199929 and 200030 reveals that the EJC, Board of Directors (BOD), and HOD began a dialogue about the core ethics documents in 1999. These reports indicate that each of these bodies had at different times recommended changes to the core ethics documents. These efforts apparently culminated in the revisions completed in 2000. The 2000 Annual Report of the EJC described the resulting documents as “much more patient-centered than their predecessors. They articulate that a basic obligation a physical therapist or physical therapist assistant owes a patient is trustworthiness, a term introduced into the document.”30

Reflecting back on these annual reports, it may be that the 2009 revision of the core ethics documents represents the culmination of an increasing awareness within the profession and the professional organization of the ethical implications of the maturation of the profession. At the same time, the dialogue among the EJC, BOD, and HOD did not necessarily engender widespread reflection on the core ethics documents. In retrospect and using Purtilo’s language, it may be that the “seeds” of the 2009 revision were sown in the 1999 period following the adoption of the Guide to Physical Therapist Practice and Vision 2020.

**Process of Revision**

Frankel12 and Pritchard14 both noted that the process of development or revision of a code of ethics can be important in the maturation of a profession. As they implied, the process for revision may be as important as the actual product.

It would be unfortunate if the emphasis on a code of ethics as a product obscured the value of the process by which a code is developed and subsequently revised. This process is a time of critical self-examination by both individual members and the profession as a whole. The profession must institutionalize a process whereby its moral commitments are regularly discussed and assessed in the light of changing conditions both inside and outside the profession. The widespread participation of members in such an effort helps to reinvigorate and bring into sharp focus the underlying values and moral commitments of their profession . . .. This process of self-criticism, codification, and consciousness-raising reinforces or redefines the profession’s collective responsibility and is an important learning and maturing experience for both individual members and the profession.12(pp112–113)

As the quote by Frankel suggests, the value of revising a code of ethics does not reside merely in the resulting documents but also, just as importantly, in the individual and collective learning, maturation, and professional development that result from engaging in the process of revision. For this reason, it is important to describe the events and processes involved in revising the core ethics documents. We believe that the process of revision of the core ethics
documents that culminated in approval by the HOD in June 2009 was indeed a learning and maturing experience for our professional association. It is especially noteworthy that the profession consciously engaged in self-critical moral dialogue based on actual ethical situations encountered by physical therapists in this most recent revision process. This dialogue spanned a 4-year period, and sought the input of members and nonmembers through forums at national and state conferences, Internet feedback surveys, and debate before and during the HOD meeting.

In this section of the article, we discuss the process and timeline for the revision process. After delineating specific responsibilities and authority within the association, we describe the process in detail, identifying 4 major phases: code critique, revision process, professional and stakeholder comment, and BOD action and HOD approval (Tab. 2).

**Table 2.**

<table>
<thead>
<tr>
<th>Date</th>
<th>Events</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Code Critique (EJC)</strong></td>
<td>APTA EJC completes an extensive review of APTA core ethics documents and codes of ethics of other professions. EJC recommends to APTA BOD that a task force of internal and external stakeholders be funded to revise core ethics documents.</td>
</tr>
<tr>
<td>March–November 2006</td>
<td>Revision Process (Task Force to Revise Core Ethics Documents)</td>
</tr>
<tr>
<td>March 2007–April 2008</td>
<td>APTA BOD contracts project manager and external ethics consultant and appoints Task Force to Revise the Core Ethics Documents. Task force meets to draft documents. BOD approves draft documents for review and comment by APTA leadership, membership, and communities of interest.</td>
</tr>
<tr>
<td>June 2008–March 2009</td>
<td>Professional and Stakeholder Comment: Surveys and Feedback</td>
</tr>
<tr>
<td>June 2008–March 2009</td>
<td>APTA Department of Research develops and posts online surveys. Survey data tabulated and task force co-chairs revise draft documents based on survey feedback. Revised drafts reviewed by task force and submitted to BOD.</td>
</tr>
<tr>
<td>March–June 2009</td>
<td>BOD Action and HOD Adoption</td>
</tr>
</tbody>
</table>

*EJC—Ethics and Judicial Committee, APTA—American Physical Therapy Association, BOD—Board of Directors, HOD—House of Delegates.

The EJC is charged with proposing revisions of the ethical principles and standards of the Association, interpreting the ethical principles and standards, and making revisions, as necessary, to the documents that interpret the ethical principles and standards of the Association.1 The documents that interpret the ethical principles are the *Guide for Professional Conduct*3 and the *Guide for Conduct of the Physical Therapist Assistant*.4 Each group (BOD, HOD, and EJC) has authority over specific aspects of the ethics process, and none of the 3 entities enjoy absolute authority over the documents and process (Tab. 3).

Beginning in 2005 and concluding in 2006, the EJC conducted a thorough and systematic review of these core ethics documents, as well as the ethical codes of other health care professions, to see how such codes compared with APTA’s *Code of Ethics and Standards of Ethical Conduct for the Physical Therapist Assistant* in content and arrangement. In summary, the EJC found that the ethics documents: (1) focused primarily on the physical therapists’ and physical therapist assistants’ roles in patient client management, with limited attention to their other roles as educators, researchers, consultants, and administrators; as articulated in the *Guide to Physical Therapist Practice*; (2) did not provide guidance for the expanded responsibilities of the physical therapist related to autonomous practice as described in Vision 2020; (3) did not address the complexities encountered by physical therapists and physical therapist assistants in the contemporary health care environment that includes individual, organizational, and societal obligations; (4) did not capture a contemporary notion of relationships with other health care providers; and (5) did not articulate the unique moral self-understanding of the physical therapy professional.5 As a result of this critical analysis, in July 2006, the EJC recommended that the
APTA BOD appoint a task force of internal and external stakeholders to develop new core ethics documents reflective of elements outlined in Vision 202027 and guided by APTA’s *Professionalism in Physical Therapy: Core Values*28 (Tab. 2). In November 2006, the BOD adopted a 2007 budget that included funding for a task force as envisioned by the EJC (Tab. 2).

**Code Revision Process**

In March 2007, the BOD appointed an 18-member task force that included physical therapy leaders and emerging leaders, clinicians, educators, regulators, consumers, a project manager, a DPT student representative, and a non-physical therapist ethics consultant. The Task Force for Revision of Core Ethics Documents met in September 2007, working under the following key assumptions36,37:

1. The drafting should begin with the identification and assessment of frontline ethical factors/issues derived from the “firsthand” experience of physical therapists and physical therapist assistants in a variety of roles and settings. The task force members gener-
ated more than 350 ethical issues addressing all aspects of physical therapist practice, reimbursement, policy, technology, and professional relationships.

2. The revised documents should set forth principles for the ethical practice of physical therapy that address the multitude of physical therapist and physical therapist assistant practice settings and roles applicable to individual, organizational, and societal realms.

3. The revised documents should be fully congruent with the relevant elements of APTA’s Vision 2020 and a doctoring profession.

4. The documents should include both foundational principles as well as interpretive guidelines as to the intent, meaning, and application of ethical behaviors.

5. APTA’s core values (Professionalism in Physical Therapy: Core Values\textsuperscript{68}) should be embedded in the principles.

As indicated in Table 2, the draft documents of the task force were reviewed, refined, and edited by a subgroup of the full task force. The resulting draft documents ultimately were reviewed and edited by all members of the task force and the members of the EJC prior to submission of an Interim Report to the BOD in March 2008. In April 2008, the BOD approved the drafts contained in the Interim Report for review and comment by APTA leadership, membership, and targeted communities of interest (Tab. 2).

**Professional and Stakeholder Comment: Surveys and Feedback**

Following approval of the draft documents for distribution and comment, APTA’s Department of Research, working in collaboration with the task force leadership, developed surveys for soliciting feedback from professional and targeted public stakeholders. The APTA staff created an online survey using the Vovici\textsuperscript{68} (formerly WebSurveyor) survey and data management software platform. The surveys were designed around a Likert scale whereby respondents could indicate their level of agreement regarding the clarity and need for inclusion of the preambles, principles and standards, and interpretive guidelines of the proposed revisions. The survey included a total of 128 Likert items for the Code of Ethics and a total of 114 Likert items for the Standards of Ethical Conduct for the Physical Therapist Assistant. In addition, there were areas for open comment in each section that encouraged submission of suggested revisions, additions, or deletions. A final question asked whether the revised Code of Ethics and Standards of Ethical Conduct for the Physical Therapist Assistant represented an improvement in articulating the ethical standards for physical therapists and physical therapist assistants compared with the current versions (Tab. 2).

The surveys were posted on APTA’s Web site in 2 phases: a first mailing occurred in early September 2008 (Tab. 2) to a targeted group of approximately 400 physical therapy leaders, inviting them to complete the online surveys by October 1. Included in this first group were APTA component (chapters and sections) presidents and executive personnel; EJC members; chapter ethics committee chairpersons; the Federation of State Boards of Physical Therapy (targeting state physical therapy licensing board members and executive directors); APTA panels, committees, and liaisons to other groups; academic administrators; certified specialists; APTA BOD; and physical therapist staff members. In early October 2008, APTA members were invited to complete the surveys, with responses requested by October 31. The goal of this survey strategy was to solicit feedback from APTA members, APTA staff, and public stakeholders. Data from the 2 survey phases were aggregated without identification or differentiation of the source of individual responses or comments. As indicated in Table 4, a total of 1,137 responses were received addressing the proposed revisions.

Table 4 summarizes the results of the survey for each of the documents. The task force co-chairs, in collaboration with the staff project manager, met on December 12 and 13, 2008, to analyze the aggregated descriptive data and comments from both phases of the survey. Because the data were not identified by source, comments of each group were given equal weight. Each principle and standard was examined to determine whether the preponderance of feedback indicated the need for editing, rewriting, or deletion. Particular attention was given to principles and guidelines that received a favorable rating (Likert scale scores 4 and 5) of less than 70% or a negative rating (Likert scale scores 1 and 2) of more than 10%. Both the Code of Ethics and Standards of Ethical Conduct for the Physical Therapist Assistant changed substantively in light of survey feedback. The goal of the task force co-chairs was to produce a document that was consistent with the general themes of the majority of survey comments. A number of the comments reflected concerns about the overall length of the draft documents, the number of interpretive guidelines, and perceived redundancies within the documents. In response, the editors reduced the number of words in both documents by 33% and reduced the number of interpretive guidelines in the Code of Ethics and the Standards of Ethical Conduct for the Physical Therapist Assistant by 35% and 30%, respectively. Overall, 48% of the state-
ments, inclusive of both principles and guidelines, were edited, rewritten, or deleted. The edited drafts and a comprehensive summary of actions were distributed to the entire task force in January 2008 for final review and comment. In March 2008, the task force submitted its final report to the BOD with a recommendation that the BOD submit motions to amend by substitution the Code of Ethics and Standards of Ethical Conduct for the Physical Therapist Assistant to the 2009 HOD.

BOD Action and HOD Adoption

At its March 2008 meeting, the APTA BOD voted to send motions to the 2009 HOD to amend the Code of Ethics and Standards of Ethical Conduct for the Physical Therapist Assistant. Following review by the Reference Committee of the HOD, 2 substantive changes were made to the format of the documents prior to submission to the HOD. The task force had originally referred to the more specific, lettered principles as “interpretive guidelines” because their purpose was to clarify the meaning of the more general principles. However, the BOD removed all references to “interpretive guidelines” because the term “guideline” is defined in the APTA Standing Rules as “a statement of advice” and distinct from the “binding statements” that articulate “ethical standards” (Tab. 3). In addition, the BOD hoped to avoid confusion between the specific lettered principles in the Code of Ethics and Standards of Ethical Conduct for the Physical Therapist Assistant and the “interpretive” documents produced by the EJC (Guide for Professional Conduct and Guide for Conduct of the Physical Therapist Assistant). The BOD further noted that all of the items (numbered and lettered) were principles with equal weight and obligation. A proviso was added to both documents so that the amended Code of Ethics and Standards of Ethical Conduct for the Physical Therapist Assistant, if adopted, would not take effect until July 1, 2010, to allow for education of the profession concerning the significant changes encompassed in the revised ethics documents.

The debate and adoption of the revised Code of Ethics and Standards of Ethical Conduct for the Physical Therapist Assistant during the 2009 HOD meeting spanned 2 days, during which the entire representative body engaged in meaningful and substantive analysis of the current and future moral foundations of physical therapists and physical therapist assistants within the context of a changing health care environment. The co-chairs of the task force and the chair of the EJC were present during the HOD meeting to address questions about the revision process.

### Table 4.
Results of American Physical Therapy Association Online Survey

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Code of Ethics Number (%)</th>
<th>Standards of Ethical Conduct for the Physical Therapist Assistant Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical therapists</td>
<td>808 (91.5)</td>
<td>182 (71.7)</td>
</tr>
<tr>
<td>Physical therapist assistants</td>
<td>12 (1.4)</td>
<td>56 (22.0)</td>
</tr>
<tr>
<td>Non–physical therapists/non–physical therapist assistants on state regulatory board</td>
<td>8 (0.9)</td>
<td>1 (0.4)</td>
</tr>
<tr>
<td>Other</td>
<td>36 (4.1)</td>
<td>7 (2.8)</td>
</tr>
<tr>
<td>Not identified</td>
<td>19 (2.2)</td>
<td>8 (3.1)</td>
</tr>
<tr>
<td>Total</td>
<td>883 (100)</td>
<td>254 (100)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Responses</th>
<th>Percentage</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revision represents an improvement</td>
<td>77.9</td>
<td>8.4</td>
</tr>
<tr>
<td>Preamble clearly stated</td>
<td>84.7</td>
<td>9.3</td>
</tr>
<tr>
<td>Preamble should be included</td>
<td>83.1</td>
<td>10</td>
</tr>
<tr>
<td>Mean of all survey responses¹</td>
<td>85.6</td>
<td>9.4</td>
</tr>
<tr>
<td>Standard deviation²</td>
<td>4.1</td>
<td>1.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agree (4–5)ᵐ</th>
<th>Disagree (1–2)ᵇ</th>
<th>Agree (4–5)ᵐ</th>
<th>Disagree (1–2)ᵇ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revision represents an improvement</td>
<td>77.9</td>
<td>8.4</td>
<td>82.5</td>
</tr>
<tr>
<td>Preamble clearly stated</td>
<td>84.7</td>
<td>9.3</td>
<td>85.6</td>
</tr>
<tr>
<td>Preamble should be included</td>
<td>83.1</td>
<td>10</td>
<td>85.9</td>
</tr>
<tr>
<td>Mean of all survey responses¹</td>
<td>85.6</td>
<td>9.4</td>
<td>88.7</td>
</tr>
<tr>
<td>Standard deviation²</td>
<td>4.1</td>
<td>1.9</td>
<td>3.7</td>
</tr>
</tbody>
</table>

ᵃ Figures represent the percentage of respondents who responded “agree” (4) or “strongly agree” (5).
ᵇ Figures represent the percentage of respondents who responded “strongly disagree” (1) or “disagree” (2).
ᶜ Figures represent the mean or standard deviation of responses to all Likert items (clarity and inclusion) for the preamble, principles, standards, interpretive guidelines, and overall reaction to the Code of Ethics (128 Likert items) and Standards of Ethical Conduct for the Physical Therapist Assistant (114 Likert items).
cess, clarify content of the documents, and consult with delegates regarding ethical implications. A description of the depth and breadth of debate is beyond the scope of this article, but the debate included discussions about personal biases and discrimination, patient empowerment and collaboration, exploitation of all individuals over whom physical therapists and physical therapist assistants have influence, personal boundaries, impaired colleagues, reimbursement for services, and advocacy for health care services.

The HOD had traditionally left the process of specifying ethical principles to the EJC through the interpretations in the Guide for Professional Conduct and the Guide for Conduct of the Physical Therapist Assistant. Delegating the important process of specification of principles to the EJC had the practical effect of confining moral dialogue about the meaning of the principles to a relatively small group of members: the 5 appointed members of the EJC. Despite the clarity of the APTA Bylaws about the responsibility of the HOD for the core ethics documents, a number of delegates had legitimate practical concerns about the ability of such a large group (approximately 400 delegates) to effectively review and edit both documents, especially in light of the expanded content of this revision. These concerns were effectively handled by the HOD leadership through the creative use of parliamentary procedure that permitted discussion of the document as a whole and in seriatim before proceeding to a vote on adoption of each document.

**Format, Structure, and Content of Revised Core Ethics Documents**

**General Numbered Principles, Core Values, and Specific Lettered Principles**

Much of the discussion before and during the HOD meeting focused on the expanded format of the proposed revisions. Throughout the history of APTA, the format of the Code of Ethics and Standards of Ethical Conduct for the Physical Therapist Assistant had been limited to a few general principles. The final revised core ethics documents (Appendixes 1 and 2) have the following general structure: preamble followed by 8 general numbered principles, each followed by specific lettered principles. In the Code of Ethics, the numbered principle also is followed by the most relevant core values. As described in the theoretical discussion of codes with regard to specification, the lettered principles specify what is meant by the more general numbered principle. For example, principle 3 states, “Physical therapists shall be accountable for making sound professional judgments.” The lettered principles under principle 3 educate readers that the general numbered principle is related to the core values of excellence and integrity and would entail behaviors enumerated in the lettered principles of “independent and objective judgment” (principle 3A), “judgment informed by professional standards, evidence (including current literature and established best practice), practitioner experience, and patient/client values” (principle 3B), “within their scope of practice and level of expertise” (principle 3C), avoiding “conflicts of interest that interfere with professional judgment” (principle 3D), and providing “appropriate direction and communication with physical therapist assistants and support personnel” (principle 3E). In essence, the lettered and numbered principles interpret each other, specifying what is meant by “sound professional judgment.” Table 5 summarizes the differences in format and content between the current Code of Ethics and Standards of Ethical Conduct for the Physical Therapist Assistant and the revisions that will become effective in July 2010.

In addition to these differences in format, the revised documents also have distinct topical content. Overall, the 8 numbered principles and their associated lettered principles deal with the following topics:

**Principle 1: Ethical obligations to all people**

**Principle 2: Duties owed to patients and clients**

**Principle 3: Accountability for making sound professional judgments**

**Principle 4: Integrity in relationships with other people**

**Principle 5: Fulfilling legal and professional obligations**

**Principle 6: Lifelong acquisition of knowledge, skills, and abilities**

**Principle 7: Promoting organizational and business practices to benefit patients/clients and society**

**Principle 8: Meeting the health needs of people locally, nationally, or globally.**

As described in the example, a full understanding of these general obligations would require reading both numbered (general) and lettered (specific) principles. The revised core ethics documents also attempt to integrate ethical guidance for all of the roles of the physical therapist delineated in the Guide to Physical Therapist Practice: management of patients/clients, consultation, education, research, and administration.
Significance

The passage of time undoubtedly will provide insight into the impact and enduring contributions of these most recent revisions to the Code of Ethics and Standards of Ethical Conduct for the Physical Therapist Assistant. Likewise, it is premature and perhaps impossible to determine whether the revised documents will facilitate enhanced ethical behavior. It is reasonable, however, to articulate the significance of these revisions within historical parameters, the continued maturation of the physical therapy profession, the significance of revisions for practitioners, the openness of the process for revision, the theoretical basis for the changes, the experiences of individuals and groups involved in the effort, and the potential regulatory implications of the revised Code and Standards.

In different ways, Linker and Purtilo described codes of ethics as products of the social landscape of the times. From a historical perspective, they recognized that the early physical therapists first secured the survival of the fledgling profession before attending to ethical matters. Indeed, Linker suggested that the early leaders muted their ethical knowledge and suppressed any hint of an ethic of care. Despite these early ethical omissions, both authors noted that the profession later returned to the pressing ethical issue of patient-focus that was missing from their first attempts. Given this history, it is not surprising that in this most recent period of professional maturation, the physical therapy profession first addressed issues of professional autonomy, direct access, standards of practice, and communicating the contemporary role of the physical therapist before returning to ethical concerns. From that perspective, these revisions represent a similar backtracking to attend to ethical issues inherent in the maturation of the profession.

In the previous section, we noted that the expanded format of the revisions had engendered a significant amount of debate before and during the HOD meeting. We believe that the deliberate process of discussion, debate, and moral dialogue is a significant indicator of the maturation and professionalization of physical therapy. The primary arguments advanced for the expanded format of the documents were the educational value of more specific guidance for physical therapists and physical therapist assistants, the enhanced public accountability of publishing consistent normative standards of conduct, and the opportunity for the membership and their representatives in the
HOD to have greater input into on-going dialogue about ethical matters.

Just as the revised ethics documents reflect the maturation of the profession, so too can the revisions serve as scaffolding for the members of the profession to assess and enhance their individual ethical maturation. Many of the features of the revised ethics documents have particular significance for physical therapy practitioners. Practitioners may use the Code of Ethics and Standards of Ethical Conduct for the Physical Therapist Assistant to obtain more specific guidance to inform ethical decision making in their interactions with patients and clients, colleagues, other health care professionals, employers, and organizations. For example, the revised documents spell out more clearly the ethical behaviors that are consistent with being “trustworthy,” “respecting others,” and making “sound professional judgments.” Likewise, the expanded documents may assist practitioners in bringing ethical concerns forward within health care organizations. As indicated in principles 7 and 7A through 7F, a primary goal of both the EJC and the task force was to provide more guidance for ethical situations in business and organizational settings. These principles could provide an opportunity for practitioners to indicate to others within their health care organizations where policies may conflict with the accepted ethical standards of the physical therapy profession. The revised format also may benefit educators and students who have experienced difficulty in distinguishing how the revised documents might be used by practitioners.

We have previously discussed the metaphors for using codes of ethics that Schwartz17 developed based on interviews with employees and managers. These metaphors also may suggest ways that physical therapists and physical therapist assistants might use the revised core ethics documents to clarify expectations for ethical behavior (rule book), to seek clarification in areas that are unclear (signpost), as a basis for self-evaluation (mirror), as a stimulus for reflection or caution (magnifying glass), as protection against organizational pressures for unethical practices (shield), to alert others within organizations about questionable practices (smoke detector), as a stimulus to report unethical conduct (fire alarm), and to leverage organizational support for compliance with professional ethical standards (club).17 Noting that the 4 areas in which health care professionals are most likely to have regulatory infractions (boundary violations, misrepresentations, financial, and other), Bloom39 recommends that members of the Health Policy and Administration Section use the revised documents as a basis for self-evaluation. Kirsch also offered suggestions as to how the revised documents might be used by practitioners.

Despite the strengths and positive qualities that we have identified in the revised core ethics documents, it is undoubtedly true that they also have limitations and weaknesses. One important limitation is that the documents (like other ethical codes) focus on principles, duties, and rules for behavior, and they constitute only one aspect of professional ethics and virtuous practice. A significant body of ethics scholarship has documented the limitations of “principilism.”43–45 This literature observes that focusing on principles overemphasizes deductive rational processes and pays too little attention to other important ethical processes such as caring, relationships, intuition, virtue, character, emotions,46 and moral courage. Several other limitations were identified throughout the revision process. Would expanding the documents lead members to bring numerous proposed edits to the core ethics documents before the HOD on an ongoing basis? Although limited revision on an ongoing basis would contribute to maintaining relevancy, constant major revision would perhaps prove to be a distraction to the HOD and would make it difficult for members to know the current ethical obligations. Likewise, does publication of extensive, detailed documents erroneously suggest that the documents capture all that is required from an ethical standpoint? A final consideration is that a definitive format and role for the Guide for Professional Conduct and Guide for Conduct of the Physical Therapist Assistant requires further clarification.

Several times in this perspective, we have returned to the point made by both Frankel12 and Pritchard14 that the process of revising a code of ethics is important. We believe that this is especially true of the revisions passed by the HOD in June 2009, with implementation in July 2010. Although there is little written about the process involved in previous APTA revisions, it appears that the process begun in 2006 and completed in 2009 was unique in several ways. First, it was unique in the number of people who were involved in the dialogue about ethical matters...
through presentations and discussions at APTA Combined Sections Meetings and Annual Conferences, chapter delegate discussions, HOD bulletin board discussions, the online surveys, presentations and forums at section meetings, and the HOD meeting. To our knowledge, it is the first time that proposed revisions were placed before the physical therapy communities of interest in this format and with this level of involvement. The process also was unique in that the revisions were based on ethical issues generated by practitioners, educators, administrators, students, and researchers, making it to some extent reflective of real-world situations across the range of physical therapist education and practice settings. Although the online survey was not a scientific sample, it nevertheless constituted another source of data as to whether the revised documents were representative of current practice. In Frankel’s words, it was a “process of self-criticism, codification, and consciousness-raising” and one that did indeed prove to be “an important learning and maturing experience for both individual members and the profession.”12(p113) Although it is impossible to characterize the experience of more than 400 delegates, it did appear that many of the delegates matured in their ethical understanding throughout the debate. Although a good deal of the early concern of the pre-HOD and early HOD discussion focused on format and process, it seemed to us that the delegates increasingly “owned” the responsibility of the HOD to adopt ethical documents that would set a high standard for member conduct.

Some scholars of professional ethics have discussed the meaning of community and moral community. Hester47 described community as “intelligent working together and not merely the believing or being together that marks/makes community. Community, then, is not shared values but shared valuing and shared evaluation. Though communities do have shared values, those values are the result of processes which are themselves already instances of community(ifying). . . .”47(p1452) Engelhardt defined a community as “a body of men and women bound together by common moral traditions and/or practices around a shared vision of the good life, which allows them to collaborate as moral friends.”48(p7) Responding to Engelhardt, Laabs49 stated that “moral family” may be a better term. On the other hand, Webster and Baylis defined a moral community as “a community where there is coherence between what healthcare institutions publicly profess to be . . . and what employees, patients, and others both witness and participate in.”50(p228) It is possible that what the delegates were experiencing through debate and adoption of these revisions was a sense of moral community.

The revised Code of Ethics and Standards of Ethical Conduct for the Physical Therapist Assistant also may have regulatory significance in states that have provisions requiring adherence to APTA’s ethical documents or the “standards of ethics of the profession” within state practice acts. In light of the fact that most states allow either partial or completely unrestricted direct access to physical therapists, the educational and political evolution of autonomous physical therapist practice supports higher and more specific standards of ethical behavior. Although it is not possible to predict whether this will cause more physical therapists or physical therapist assistants to be cited for violations of their practice act, it is true that the revised documents set an elevated and more detailed standard of ethical conduct and perhaps provide a clearer basis for state regulatory agencies to evaluate whether someone might have engaged in unethical conduct. Simi-
Revised APTA Code of Ethics and Standards of Ethical Conduct for the Physical Therapist Assistant

Both authors provided concept/idea/project design, writing, data analysis, project management, and consultation (including review of manuscript before submission).

The authors thank the members of the Task Force to Revise the Core Ethics Documents; the members and Chair Nancy R. Kirsch, PT, DPT, PhD, of the Ethics and Judicial Committee during the revision process; staff members Jennifer Baker, MSW, CAE; John J. Bennett, JD; Lauren Dockter, JD; Angela K. Boyd; Mary Jane Harris, PT, MS; BOD liaison Sharon L. Dunn, PT, PhD, OCS; House of Delegates officers Shawnie E. Soper, PT, DPT, MBA, EdD; Laurita M. Hack, PT, DPT, MBA, PhD, FAPTA, and Babette Sanders, PT, MS; Marc Goldstein, EdD; and Sarah C. Miller from APTA’s Department of Research; respondents to the online survey; and the delegates to the 2009 APTA House of Delegates for their commitment to and efforts in support of the process to revise APTA’s core ethics documents. Special thanks to Project Manager Joseph P.H. Black, MDiv, PhD (Project Manager); and Melissa H. Chemical, PT, MS (APTA General Counsel); Joseph P.H. Black, MDiv, PhD, who was instrumental to the revision process. The authors also thank Gina Maria Musolino, PT, MS Ed, EdD, for her thoughtful review of and suggested edits to the manuscript.

Task Force to Revise the Core Ethics Documents: Debra Kay Bornmann, PT, PAA; Kathryn L. Bossen, PT, DPT; Ann Griffin, PT, MS; Meredith Hinds Harris, PT, DPT, EdD; Peggy L. Miller, PT, Gail M. Jensen, PT, PhD, FAPTA; Milagros Jorge, PT, EdD; Nancy R. Kirsch, PT, DPT, PhD; Lee Nelson, PT, DPT, MS; Charlene Portee, PT, PhD; Jeffrey M. Rosa, MPP; Babette Sanders, PT, MS; Neil Shiosaki, PT; Susan W. Sisola, PT, PhD; Laura Lee (Dolly) Swisher, PT, MDiv, PhD; Herman Trienzenberg, PT, PhD; John J. Bennett, JD (APTA General Counsel); Joseph P.H. Black, MDiv, PhD (Project Manager); and Michael S. Pritchard, PhD (Consultant).

Some of the content in this article was presented at APTA Combined Sections Meetings and Annual Conferences during the last several years.

This article was received November 12, 2009, and was accepted January 18, 2010.


References


4 Wilensky HL. The professionalization of everyone? AJS. 1964;70:137–158.


Appendix 1.

Code of Ethics

EFFECTIVE JULY 1, 2010. For more information, go to www.apta.org/ethics.

CODE OF ETHICS HOD S06-09-07-12 [Amended HOD S06-06-12-23; HOD 06-91-05-05; HOD 06-87-11-17; HOD 06-81-06-18; HOD 06-78-06-08; HOD 06-78-06-07; HOD 06-77-18-30; HOD 06-77-17-27; Initial HOD 06-73-13-24] [Standard]

Preamble

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

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

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

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

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

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

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

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

**Principles:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6B. Physical therapists shall take responsibility for their professional development based on critical self-assessment and reflection on changes in physical therapist practice, education, health care delivery, and technology.

(Continued)
Appendix 1.
Continued

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

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

**Principle #7:** Physical therapists shall promote organizational behaviors and business practices that benefit patients/clients and society.

*(Core Values: Integrity, Accountability)*

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

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

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

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

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

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

**Principle #8:** Physical therapists shall participate in efforts to meet the health needs of people locally, nationally, or globally.

*(Core Values: Social Responsibility)*

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

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

8C. Physical therapists shall be responsible stewards of health care resources and shall avoid over-utilization or under-utilization of physical therapy services.

8D. Physical therapists shall educate members of the public about the benefits of physical therapy and the unique role of the physical therapist.

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

*(General Counsel, ext.3253)*
Appendix 2.
Standards of Ethical Conduct for the Physical Therapist Assistant

EFFECTIVE JULY 1, 2010. For more information, go to www.apta.org/ethics

STANDARDS OF ETHICAL CONDUCT FOR THE PHYSICAL THERAPIST ASSISTANT HOD S06-09-20-18
[Amended HOD S06-00-13-24; HOD 06-91-06-07; Initial HOD 06-82-04-08] [Standard]

Preamble

The Standards of Ethical Conduct for the Physical Therapist Assistant (Standards of Ethical Conduct) delineate the ethical obligations of all physical therapist assistants as determined by the House of Delegates of the American Physical Therapy Association (APTA). The Standards of Ethical Conduct provide a foundation for conduct to which all physical therapist assistants shall adhere. Fundamental to the Standards of Ethical Conduct is the special obligation of physical therapist assistants to enable patients/clients to achieve greater independence, health and wellness, and enhanced quality of life.

No document that delineates ethical standards can address every situation. Physical therapist assistants are encouraged to seek additional advice or consultation in instances where the guidance of the Standards of Ethical Conduct may not be definitive.

Standards:

Standard #1: Physical therapist assistants shall respect the inherent dignity, and rights, of all individuals.

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

1B. Physical therapist assistants shall recognize their personal biases and shall not discriminate against others in the provision of physical therapy services.

Standard #2: Physical therapist assistants shall be trustworthy and compassionate in addressing the rights and needs of patients/clients.

2A. Physical therapist assistants shall act in the best interests of patients/clients over the interests of the physical therapist assistant.

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

2C. Physical therapist assistants shall provide patients/clients with information regarding the interventions they provide.

2D. Physical therapist assistants shall protect confidential patient/client information and, in collaboration with the physical therapist, may disclose confidential information to appropriate authorities only when allowed or as required by law.

Standard #3: Physical therapist assistants shall make sound decisions in collaboration with the physical therapist and within the boundaries established by laws and regulations.

3A. Physical therapist assistants shall make objective decisions in the patient’s/client’s best interest in all practice settings.

3B. Physical therapist assistants shall be guided by information about best practice regarding physical therapy interventions.

(Continued)
Appendix 2.
Continued

3C. Physical therapist assistants shall make decisions based upon their level of competence and consistent with patient/client values.

3D. Physical therapist assistants shall not engage in conflicts of interest that interfere with making sound decisions.

3E. Physical therapist assistants shall provide physical therapy services under the direction and supervision of a physical therapist and shall communicate with the physical therapist when patient/client status requires modifications to the established plan of care.

**Standard #4:** Physical therapist assistants shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, other health care providers, employers, payers, and the public.

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

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

4C. Physical therapist assistants shall discourage misconduct by health care professionals and report illegal or unethical acts to the relevant authority, when appropriate.

4D. Physical therapist assistants shall report suspected cases of abuse involving children or vulnerable adults to the supervising physical therapist and the appropriate authority, subject to law.

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

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

**Standard #5:** Physical therapist assistants shall fulfill their legal and ethical obligations.

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

5B. Physical therapist assistants shall support the supervisory role of the physical therapist to ensure quality care and promote patient/client safety.

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

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

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

(Continued)
Appendix 2.
Continued

**Standard #6:** Physical therapist assistants shall enhance their competence through the lifelong acquisition and refinement of knowledge, skills, and abilities.

6A. Physical therapist assistants shall achieve and maintain clinical competence.

6B. Physical therapist assistants shall engage in lifelong learning consistent with changes in their roles and responsibilities and advances in the practice of physical therapy.

6C. Physical therapist assistants shall support practice environments that support career development and lifelong learning.

**Standard #7:** Physical therapist assistants shall support organizational behaviors and business practices that benefit patients/clients and society.

7A. Physical therapist assistants shall promote work environments that support ethical and accountable decision-making.

7B. Physical therapist assistants shall not accept gifts or other considerations that influence or give an appearance of influencing their decisions.

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

7D. Physical therapist assistants shall ensure that documentation for their interventions accurately reflects the nature and extent of the services provided.

7E. Physical therapist assistants shall refrain from employment arrangements, or other arrangements, that prevent physical therapist assistants from fulfilling ethical obligations to patients/clients.

**Standard #8:** Physical therapist assistants shall participate in efforts to meet the health needs of people locally, nationally, or globally.

8A. Physical therapist assistants shall support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.

8B. Physical therapist assistants shall advocate for people with impairments, activity limitations, participation restrictions, and disabilities in order to promote their participation in community and society.

8C. Physical therapist assistants shall be responsible stewards of health care resources by collaborating with physical therapists in order to avoid over-utilization or under-utilization of physical therapy services.

8D. Physical therapist assistants shall educate members of the public about the benefits of physical therapy.

**Proviso:** The *Standards of Ethical Conduct for the Physical Therapist Assistant* as substituted will take effect July 1, 2010, to allow for education of APTA members and non-members.

(General Counsel, ext.3253)