A Friendly Reminder

Social media can be great for public relations, but they also present conundrums

F-r-i-e-n-d. Six letters that can mean a lot—or not so much. Consider the following scenario, in which a simple request is weighted with potential ramifications.

Facing a Choice

As the youngest and newest physical therapist (PT) at his clinic, Jeff is used to being the "go-to guy" for some of the older and less tech-savvy PTs on staff when it comes to issues related to Internet technology (IT) and social media. He has helped several PTs shape their personal Facebook pages, led a staff in-service on Twitter, and contributes to the private practice's website, in-house blog, Facebook page, and Twitter feed.

Jeff tries to keep his personal presence on social media separate from his professional one. While he is personal-page "Facebook friends" with some of his coworkers and even with a few former patients (with a caveat that will be discussed shortly), he makes it a rule never to discuss anything work-related in those interactions. He keeps up with the lives of selected work friends just as he would any other friend on Facebook. Jeff's personal policy is to turn down friend requests from former or current patients—thanking them for their interest but politely explaining that that he would prefer to keep the relationship strictly professional. (He knows, too, that former patients may well become future ones.)

There are a few exceptions that come with asterisks—former patients with whom Jeff has become both Facebook and full-fledged friends through shared interests in skiing and/or golf, Jeff's biggest recreational passions. A couple of his former patients are, like Jeff, members of the local ski club. Two other former patients are members of the golf club to which Jeff belongs. A fifth former patient belongs to both groups; Jeff now considers him to be a close friend.

One day, Jeff receives via Facebook a friend request from a recent patient named Michael, who had presented with several comorbidities and made great progress while he was under Jeff's care. Michael sometimes made Jeff uncomfortable, however, by, in Jeff's view, oversharing about his personal life. During one visit he told Jeff that he often feels insecure and defensive, that he has few friends, and that he gets depressed when he feels that his overtures of friendship have been rebuffed. On another occasion he told Jeff that he's "been told" he can be pushy and needy, but that he finds it difficult to back off.

Jeff doesn't know whether Michael ever has seen a mental health professional, but he suspects the possibility from some allusions Michael has made. Jeff never encouraged or sought to prolong these personal lines of conversation when Michael introduced them. He typically tried, rather, to refocus Jeff on his physical therapy and the movement issues on which Michael and he were working.

On this final visit for physical therapy, Michael pointed to a photo on Jeff's desk of the PT standing on a golf course with his clubs and remarked out of the blue, "I really like you. You should teach me to play sometime."

Jeff had responded lightly, "Golf will break your heart! Get out before you even start, my friend. That's my advice to you."

Jeff replays that conversation as he views the Facebook friend request on his computer screen. Could Michael have imbued Jeff's innocuous word choice with unintended meaning?

In this particular case, Jeff is reluctant to proceed as he typically does—explaining his reasoning and declining Michael's Facebook request. He doesn't really know *what* to do. So, at first he does nothing. He hopes the request has no outsized meaning for Michael. Maybe it's just 1 of many "friend" requests Michael has made, and Michael won't pursue it further.

The next day, however, Jeff returns to his office after lunch to find a voicemail message from Michael asking if he'd received the e-mail from Facebook. The PT realizes at that moment that he's probably going to have to engage Michael soon on the subject. But he isn't sure what exactly to say or write to Michael—recalling how deeply affected his former patient had seemed to be by the perceived rejections he'd recounted during his physical therapy visits. Jeff doesn't immediately respond to the phone message, either, unrealistically hoping—but hoping nonetheless—that Michael's inquiries will end there.

Unsurprisingly, however, when Jeff checks his email between patient visits the following morning, he finds that he's received a message from Jeff that reads, simply, "Left you a phone message. Please check." There's also an automated message from Facebook reminding Jeff that Michael had sent him a friend request the day before.

Jeff slumps down in his office chair. He doesn't want to further dent Michael's self-esteem, but neither does he wish to engage in this way with a former patient. He also worries about leading Jeff on, in a sense, as he has reason to believe that his former patient may equate Facebook friendship with a real, multidimensional relationship. How to let him down gently?

Or, should he let him down at all? Could a Facebook friendship with Michael "work"? Might his professional/personal rule of thumb toward social media, Jeff wonders, be a little too rigid?

His phone buzzes, alerting him that his next patient has arrived. As he exits his office, he eyes the copies of Physical Therapy on his bookshelf, which remind him that he can draw on APTA resources in considering his course of action. He resolves to explore the association's website at lunchtime to see what guidance the Code of Ethics for the Physical Therapist might offer him, and whether any other APTA documents shed additional light.

Use the 4 steps to decide the ***realm, individual process and situation***
Is it legal or ethical?
Is it an ethical dilemma or problem?
Which ethical principles apply?
Which Regulation from the NJ Practice Act applies?

An Education on Staff Behavior

What does "professional responsibility" ethically entail? It's a broad term that encompasses all aspects of professional behavior and the obligation to ensure that every patient and client receives safe and effective care. Consider the following scenario.

Not Onboard

Lance, a physical therapist (PT) with a total of 8 years of experience in a variety of practice settings, feels that he's secured his dream job when he's named director of physical therapy services at the Brunswick Comprehensive Care Community.

The one-time nursing home has been extensively remodeled and modernized in recent years under new ownership. It offers residents an array of living arrangements—independent and assisted living, nursing, and memory care—under a common roof. Lance leads a staff of 7 PTs and 3 physical therapist assistants (PTAs), a few of whom have been employed at Brunswick since its creation in 1985. Facilities include a 6-bed subacute unit, an outpatient clinic, a 30-bed skilled nursing unit, and a 10-bed memory care wing.

Lance's predecessor, Ray, had left under murky circumstances. He'd been cordial and helpful to Lance during the transition, and had told Lance that his family was relocating to live nearer to his aging in-laws. But Lance sensed from management that Ray, who'd been at Brunswick since 1998, had been slow to adapt to the expansion of services and was uneasy about plans to break ground on a new building adjacent to the existing one. Lance believes that the parting of ways was at best a mutual decision but that Ray probably was forced out.

It is precisely management's commitment to expanded services for seniors that has Lance so excited, however. He remembers very well how significantly his own grandmother's quality of life had deteriorated when she lived in a nursing home in her final years. Lance feels energized by the opportunity he's been given to play a key role in enhancing the lives of seniors at Brunswick by ensuring that they receive the physical therapist services they need to optimize their movement and stay as physically active as possible.

Lance has been mentored at each of his previous jobs by forward-looking PTs, has taken a multitude of professional development courses on the latest developments in geriatrics and practice management, and has been stockpiling ideas for a comprehensive professional development program that he plans to implement at Brunswick.

After spending his first month on the job getting to know staff, residents, and the facility itself, Lance is ready to share his plans. During the Monday-morning staff meeting, he delivers an impassioned speech about the importance of up-to-the-minute, evidence-based practice. Lance lays out plans for a weekly "journal club" in which staff will take turns talking about pertinent research, and a monthly in-service during which staff will share what they've learned in recent professional development courses. "We'll all learn together, and our residents will reap the benefits!" he exclaims.

While a few staff are visibly excited by these plans, overall the initial reaction is muted. Lance isn't discouraged, however. He knows that continuing education requirements are fairly minimal in their state, that his predecessor had not emphasized coursework, and that staff aren't used to commanding the floor and talking about research and developments within the profession.

Lance asks individual staff members to sign up for weekly journal club leadership, and to indicate which courses interest them from an array listed on a handout. This exercise opens up discussion, with some people volunteering that "I've really been wanting to get up to speed on this subject," and others recalling, "I read something about this study that I think would be perfect for our discussion." Before long, everyone has chimed in—and seemingly bought into—Lance's education program.

Everyone, that is, except Sid, a PT who remains silent and looks frankly bored by the discussion. Lance decides to let it pass, as Sid is one of the original Brunswick staffers and undoubtedly is a bit set in his ways. As Lance's program unfolds and an environment of collective learning is fostered, Sid likely will get into the spirit, Lance reasons.

But in the following month, such optimism is not borne out. In fact, not only does Sid remain detached during journal club and the in-service meeting, but his behavior causes Lance to look into and uncover some troubling aspects of Sid's work. He consistently has the highest number of no-show and cancelled appointments among staff, according to records, and, even more disturbing, he has a pattern of delivering more or less the same interventions, regardless of circumstances, and of insufficiently progressing his patients.

Lance asks Tammy—who, like Sid, had been one of Brunswick's very first PTs—for her assessment of her coworker's care provision and attitude. "All I'll say," she responds, "is that my philosophy is to never stop learning, while Sid's is ‘Never stop doing what you've always been doing.' Which, I have to say, tends to be as little as possible."

Lance is taken aback by Tammy's words. He's not sure what upsets him more—Sid's pattern of substandard patient care and lack of interest in growing professionally, or the suggestion that Sid's behaviors are widely acknowledged and tolerated by his coworkers. Clearly, Lance sees, it is his responsibility as director of physical therapy to address these issues.

For Reflection

Lance has correctly concluded that doing nothing is not an option. He could simply fire Sid. Or, if Sid is amenable to remediation, Lance could see that Sid gets the instruction and guidance he needs to change his behaviors and mindset in ways that ensure safe and effective patient care—with the understanding that failure to reform will mean termination. Lance also could articulate a zero-tolerance policy toward substandard performance and institute guidelines for confidential reporting.

What would you do, were you in Lance's shoes? Do you have alternatives to suggest?

Use the 4 steps to decide the ***realm, individual process and situation***

Is it legal or ethical?

Is it an ethical dilemma or problem?

Which ethical principles apply?

Which Regulation from the NJ Practice Act applies?

Assessing the Situation

In physical therapy as in real estate, it's all about location

We love what we do as physical therapists (PTs). We're understandably enthusiastic about our profession and the knowledge and skills we offer patients and clients. But we always must keep in mind where we are when we are encouraged to share with others our expertise. Consider the following scenario.

A Tempting Request

With the support and encouragement of the New England private practice for which she works, Leslie recently passed the exam to become an orthopedic clinical specialist (OCS). She's proud of her accomplishment and of the opportunity to share her expertise with patients and clients. She also is grateful to be employed by a nurturing clinic that embraces and emphasizes high professional and ethical standards, as she sometimes hears stories from physical therapists (PTs) at other facilities that give her pause.

Leslie decides to celebrate her achievement with a long-overdue trip to Oregon, where her brother Bill lives with his wife and their 2 young boys. After months of studying and balancing work with exam preparation, she's looking forward to relaxing with her family.

Three days into her stay in Portland, however, she's unexpectedly pressed to wear her professional hat. Bill has told his business partner, Jim, about Leslie's accomplishments. One afternoon, Jim "just happens" to show up with his 16-year-old daughter-ostensibly to meet Leslie but transparently to seek free professional advice. Jim's daughter, Meg, a member of her high school's track team, hurt herself in a meet the previous week. An emergency room physician ordered magnetic resonance imaging (MRI) and said the scan showed a possible tear in the left leg's anterior cruciate ligament (ACL). Jim dreads the consultation fees of orthopedic surgeons.

"Since you're not only a PT but an orthopedic specialist who's just passed what I understand is an extremely rigorous exam," he says to Leslie, laying on the flattery, "I wonder if you can give us your expert opinion before I go bringing other doctors into this."

Before Leslie even can respond, Jim has handed her the MRI. She quickly sees that it shows nothing obvious about Meg's ACL. The truth is, she does feel flattered by Jim's request-and confident in her own abilities. She's tempted to share her thoughts about the MRI, to thoroughly examine Meg, and share her findings. She knows she has the knowledge and skills to make a sound clinical assessment, and she's eager to show Jim what highly trained PTs can do.

"This MRI looks to me ...," she starts to respond-but then she catches herself.

Leslie pauses for a few seconds, then says, "You know, Jim, as much as I'd like to help you out here, I'm not licensed to practice physical therapy in Oregon-which is what I'd be doing were I to perform an assessment on Meg," Leslie says. "I'm really sorry."

Jim, seeing that his ploy to get free professional advice is being threatened, responds with a mild taunt. "Well, that's okay," he sighs. "I wasn't completely sure if PTs are qualified to assess situations like this, anyway."

Leslie is aware that Jim is trying to goad her into changing her mind. "Oh, we're certainly qualified," she calmly responds. "And I applaud your instinct to consult a PT. But my professional ethics dictate that I encourage you to seek out a PT who's licensed to practice in this state. Oregon has unrestricted direct access, which means you won't need a referral from a physician. In fact, if you'd like, I can do some checking for you to see which local PTs are orthopedic specialists."

Jim thanks Leslie half-heartedly. She notes, however, that Bill is beaming. This isn't the first time her brother has seen Jim seek a free consultation, and Bill clearly is impressed by her ability not only to act ethically but to promote her profession while doing so.

Considerations

Could Leslie have helped Jim without experiencing any legal repercussions? Most likely. But might not her ethical handling of the situation ultimately heighten Jim's-and perhaps Meg's-respect for both Leslie and her profession? Particularly if a visit to an Oregon-licensed PT proves fruitful?

For Reflection

Our enthusiasm and willingness to share our expertise and knowledge as PTs is an important part of our professional growth. We always must be mindful, however, that if we are not licensed in a jurisdiction we cannot practice physical therapy there-period. We can, however, refer patients to the "Find a PT" feature on APTA's consumer website, www.moveforwardpr.com, for a list of licensed PTs in their state.

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Is it an ethical dilemma or problem?

Which ethical principles apply?

Which Regulation from the NJ Practice Act applies?

Determining the Best Choice

When decision making is a family affair

It's the goal of every physical therapist (PT) to ensure that his or her patients receive the best possible care. But what if a prospective patient is the PT's spouse, and the PT is the best option among local PTs for his spouse's particular physical condition? Consider the following scenario.

Referred Pain?

Larry has focused his entire career as a PT on issues related to the cervical spine, as he long has been fascinated by the mechanical challenges of its role supporting the head. Accordingly, Larry is a board-certified orthopedic clinical specialist. In addition to serving this patient population in his solo private practice, he is a credentialed clinical instructor who offers at least 2 rotations a year to doctor of physical therapy students interested in taking a very manual approach to patient care.

Larry also is quite active in the community as a youth soccer coach, Boy Scout leader, Special Olympics volunteer, and accessibility consultant to the town planning board. In short, he's quite well known and respected in the community, and his practice is thriving. This mostly is good, except in a few cases in which people have infringed on the lines separating Larry's professional relationship with the individual from his personal one. Occasionally, a parent who Larry knows through youth soccer has become his patient, and has come by Larry's house in the evening to ask him to review aspects of his or her home-exercise program. A few times, his neighbors have sought Larry out on a weekend for a gratis "consultation" about their latest ache or pain. While Larry always is friendly, he typically asks such visitors to schedule an appointment and stop by his office if they need more than a simple clarification or a quick piece of advice.

One winter day, Larry's wife, Cheryl, is involved in a fender-bender on an icy road. At first she seems to be uninjured, but within 48 hours she is experiencing cervical pain, with an accompanying headache. Over-the-counter analgesics and ice aren't helping her, and Larry notes postural changes that are consistent with soft-tissue injury. At his urging, Cheryl gets a complete workup from the couple's primary care physician to rule out any other pathology. She then is cleared to begin physical therapy.

The question for Larry now is whether he should be the PT to treat Cheryl. On the one hand, issues of the cervical spine are his specialty, and he's certain that he is the best PT in the area to treat her particular condition. (Typically, after all, other PTs in the community refer to him their patients who have cervical problems.) On the other hand, however, this is his wife who Larry is considering taking on as a patient.

There's a clause in the couple's insurance policy advising him against taking on family members as patients without well-documented justification for the decision. While Larry is certain that he can justify treatment of Cheryl to the company's satisfaction, he

understands the reasoning. The insurance company is wary that familial relationships may lead to unnecessary and costlier care, due to the provider's abundance of care and caution for a loved one. Can he be completely objective in his treatment of Cheryl? Larry believes that he can, but still, something about taking on his wife as his patient doesn't feel quite right to him.

Sitting in his living room, he hears his wife wince in the kitchen, and knows that she needs the services of a physical therapist sooner rather than later. There are several excellent PTs in the community, albeit none who are as skilled as he in issues of the cervical spine. Should Larry entrust Cheryl's care to one of those other PTs, or treat her himself? He knows he must decide tonight.

For Reflection

Larry wishes his decision was black and white. If he and Cheryl lived in a rural area that was unserved by other PTs, he wouldn't hesitate to treat her himself. Conversely, had he a practice partner whose own background and experience matched his own in treating issues of the cervical spine, he most certainly would refer Cheryl's care to that individual. As it is, he firmly believes that he is the best PT to treat his wife's condition, but he's hesitant to do so.

If Larry reviews his ethical obligations as a PT, he'll find that, while there is no specific principle regarding treatment of family members, a number of principles have bearing on his situation and can collectively lead him to the optimal decision.

Use the 4 steps to decide the ***realm, individual process and situation***

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Is it an ethical dilemma or problem?

Which ethical principles apply?

Which Regulation from the NJ Practice Act applies?

Head in the Sand

The potential consequences of doing nothing

Failure to act on warning signs related to an employee's behavior not only is unwise but also is unethical, and it may have profound societal repercussions. Consider the following scenario.

Where There's Smoke, No Firing

Sarah is a longtime supervisor at Prime Time Therapy Services in upstate New York. Carol is in her third week at the practice. Late one morning, Carol steps into Sarah's office, holding a newspaper. She closes the door behind her and asks if Sarah has read or heard about the arrest of a physical therapist (PT) who has been charged with molesting a 13-year-old patient in the outpatient department of a local hospital.

"I can't imagine anyone in our profession violating the public's trust in such a horrible way," says a visibly shaken Carol.

"Unfortunately, there are predators in all walks of life," Sarah responds. "But you're right-if it's true, it's shocking."

Carol, a new graduate who recently earned her doctor of physical therapy degree from a university in California and moved East to join her fiancé, asks, "I'm curious, since you've been a PT in this area for a long time-have you ever run into this guy?" She reads from the newspaper a name Sarah doesn't recognize. There is no photo of the accused PT in the article.

"No, it doesn't ring a bell," Sarah answers.

A few hours later, however, something kicks in, and she realizes that not only has she crossed paths with the man she knew by an abbreviation of the middle name cited in the newspaper article, but that he actually worked at Prime Time briefly about 5 years ago. She can picture him in her head but can't immediately recall much about him or his tenure at the practice. At the end of the day she seeks out Tim, a veteran physical therapist assistant at Prime Time with whom she sometimes reminisces about "the old days."

Tim is surprised that Sarah's memory of their 1-time colleague seems fuzzy. "Don't you remember that time I told you I overheard him seeming to be coming on to a patient who couldn't have been more than 12?" he asks. "The guy denied it, of course, and said I'd misheard him and taken things out of context. I also told you about the time I suspected he'd taken a photo of a young girl while she was doing her exercises on a mat, because when I came into the room he stuffed his phone in his pocket and looked all nervous."

"Oh my gosh, yes!" Sarah now recalls. "You know, I'd talked to him about those incidents, and I wasn't completely satisfied with his answers. I'd never seen any suspect behavior myself, but you weren't the only person working here back then who shared suspicions with me. He was a smooth talker, but I was thinking of putting him on probation when he

told me he was leaving after only having been here for, what, 4 months? I just kind of thought, 'Good riddance.'

"In fact, when another clinic called me for a reference," she now recalls, "I certainly wasn't effusive, but I was factual about what I saw as being his strengths. I felt uncomfortable mentioning the other stuff because it was unproven. I don't know if he ultimately got that job, but obviously he found his way to the hospital at some point."

There's an uncomfortable silence as both Tim and Sarah simultaneously wonder if Sarah might somehow have altered the course of subsequent events. "What could I have done differently?" she asks herself, feeling guilty about her inaction. "What if I'd really tried to get to the bottom of people's suspicions? What if that had led to my firing the guy? What effect might that have had? Should I have reported him to law enforcement, even though all I had was 'smoke' but no 'fire'? What were my ethical obligations in that situation?"

Tim starts putting on his coat to go home. "Well, you never really know about people, or what they might do," he says, uneasily, in a way that tells Sarah he neither is absolving nor completely indicting her.

"No, I suppose you don't," she responds.

Considerations

Confrontation and follow-up with colleagues over workplace issues is uncomfortable but often is necessary. When an employee leaves a facility voluntarily, what and how much to share with other employers about his or her performance may be dictated by institutional policies regarding verbal and written references. But let's assume in this case that Sarah had no constraints that would have prevented her from sharing the totality of her thoughts about the departed employee.

For Reflection

The individual who has been charged with child molestation in this case has had at least 3 employers, and perhaps more. If other supervisors had been made aware of issues similar to those that were reported to Sarah, but if they, like her, took no definitive action, might such collective passivity have facilitated and emboldened the PT to have perpetrated the act with which he's been charged? This is why the ethical decision-making realm in this case can be deemed institutional and societal, as well as individual.

Use the 4 steps to decide the ***realm, individual process and situation***

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House Rules

Which care setting is best for a rehabbing patient?

Situations aren't always ethically clear-cut. In the following scenario, a physical therapist (PT) struggles to feel at home ”if you'll pardon the expression” with a decision regarding the next step in a patient's rehabilitation process.

Declaration of Independence

Matt has been a physical therapist (PT) for more than a decade and has worked exclusively in home care for the past 4 years. He considers it to be the ideal practice environment and doubts that he'll ever change settings. He enjoys the opportunities and challenges of treating patients literally where they live, and he likes the straightforwardness of home care. He describes it to his clinical rotation students as "old-school physical therapy. No expensive gadgets”just my head, heart, and hands."

Matt also relishes his role as mentor to PTs at his agency who are new to home care. One thing he always emphasizes with them is the importance of ensuring that home care is right for the individual at this particular point in his or her recovery, given that inpatient or outpatient care may be more appropriate. "Take everything into account," Matt counsels his colleagues. "The patient's wants and the patient's needs aren't always the same thing."

The size of Matt's caseload varies significantly, given the ebb and flow of referrals over the course of the year. While he never cuts corners on the time he spends with patients, or on the attention he devotes to meeting ever-increasing documentation requirements, his schedule can be packed, and his days typically are long during peak times for patients to undergo elective surgery. Conversely, December usually is a very slow month for Matt, with the holidays approaching and many people putting off planned surgeries until the new year.

The home care PT is pleased, then, when”on December 8, and with his schedule light”he receives a referral for Harry Scopes, a 72-year-old widower who 3 weeks earlier had bilateral knee replacements, subsequently spent time at a rehab facility, and recently was sent home with instructions to use a walker initially. Over the phone, Harry is upbeat and sounds eager to get started on physical therapy. He exhibits the same potential to be a model patient when Matt pays him his first visit.

Matt begins by doing a quick structural assessment of the home”a task he calls "casing the joint." Harry laughs and says he'll be happy to show the PT around the place. Matt already had noted, before entering the home, that the 3 front steps are in good shape, as are the handrails leading up to the front door. Harry himself, Matt notes, is quite fit-looking and probably could pass for a man 10 years younger.

The walker sits in the front hallway. Harry uses a cane as he leads Matt through his small 2-story home. "By this past weekend I felt like I was ready for the cane," Harry explains.

Matt notes that the home is very tidy, and well set up for an individual using an assistive device. All the safety features and even furniture configurations that Matt normally would recommend already are in place. As the PT follows Harry around the main floor of the house, he notes that Harry easily navigates the various rooms, with minimal assistance from his cane. In fact, when Harry is eager to point something out to Matt, he hooks the cane over his arm and walks at a faster pace to the spot in question.

To be sure, Harry's gait retains some mild deviations “consistent with an individual who is recovering nicely 3 weeks after surgery. But Harry has no particular difficulty climbing the stairs to the second floor. Matt assesses his balance as good, and the safety of the master bedroom's bathroom” with its shower bench and raised commode seat” as sufficient. Harry's strength, range of motion, and endurance are such that he can complete all his activities of daily living, Matt observes.

Later, the pair walk outside. Harry descends the front stairs without issue, negotiates the walkway to the street, and gets into and out of the passenger seat of his car with only minor assistance. This informs Matt's determination that Harry needs no more than minimal supervision to complete "instrumental" activities of daily living”tasks that support an independent lifestyle.

Back inside the house, Matt tells Harry, "You're doing great! You don't need me at all. You're ready for outpatient therapy. All you need from me is the phone number of the van that will be picking you up for your weekly appointments. And I've got that card right here."

Matt's about to hand the card to him when Harry, looking upset, exclaims, "Wait a minute here! I feel like I'm not getting all the services to which I'm entitled. First they tell me I'll be in rehab for 2 weeks, but it turns out to be only 10 days. Then I'm supposed to get 2 or 3 weeks of home care, so that I can drive myself to outpatient therapy at the end of that period. But now you're telling me that I won't get home care at all? And that I've got to ride to my therapy appointments in some van that's filled with a bunch of struggling old people? No thanks!"

Matt is surprised by this turn of events, to put it mildly. It's clear that Harry would much rather receive home care and then, after a few weeks, drive himself independently to his outpatient appointments.

That's not an entirely unreasonable request, Matt silently concedes. While Harry doesn't truly fit the requirements for home care therapy, it is what he fervently desires. Matt certainly could work with Harry and put him in position to drive himself to outpatient care in a few weeks' time. It's a slow month for the home care agency, so it isn't as if working with Harry will deprive another patient of Matt's services. And Matt knows that, because home care is the protocol prescribed by Harry's surgeon, Matt's employer will be fine with Matt taking on Harry as a home care patient.

Which course of action, however, is in Harry's best interest? Would Harry be better served by proceeding immediately to outpatient therapy? Also, Matt wonders, what is his

fiduciary responsibility in this instance, given that home therapy isn't really indicated? Can he come up with a valid justification for Harry to receive home care?

"So, you'll be seeing me here at home, right?" Harry”smiling now”asks hopefully. Matt doesn't know what to say. He'd like to stall for more time while deciding how to answer the question.

For Reflection

Matt's first consideration, ahead of payment issues, must be what is best for his patient. There is arguable validity to both courses of action ”providing home care or sending Harry directly to outpatient rehab. It's the very definition of a moral dilemma” a problem that demands a single resolution to 2 or more arguably appropriate options.

Use the 4 steps to decide the ***realm, individual process and situation***

Is it legal or ethical?

Is it an ethical dilemma or problem?

Which ethical principles apply?

Which Regulation from the NJ Practice Act applies?

Joined at the Hip

In most cases, physical therapists' (PTs) relationships with colleagues in other health care disciplines are excellent. Sometimes, however, situations arise that place us in the uncomfortable position of having to balance our fiduciary obligation and concern for our patient with our professional respect for other health care professionals who also are serving that patient. Consider the following scenario.

Pop Goes the Prosthetic

Jim has been a solo private practitioner for more than 20 years. He practices in a small town, but it is located within a large metropolitan area, so his patients and clients have many choices for physical therapy. Jim is proud that he has many longtime patrons from larger towns and cities in the area. He has established strong relationships with many area physicians, to whom he refers patients and who, likewise, refer patients to him.

Mitch is a 62-year-old construction worker and avid "weekend warrior" who has come to Jim for various physical issues over the years related to his strenuous job and hard-driving recreational pursuits. Mitch's hip has been wearing down for some time, and Jim has counseled the eventual need for replacement surgery. After resisting the idea for months, during physical therapy after a weekend of escalating pain Mitch concedes that he ought to have the medical procedure.

Jim typically gives his patients a few options among the physicians with whom he regularly works. He gives Mitch the names of 3 surgeons, all of whom he recommends. Noting that Mitch's company insurance covers "prehabilitation" in the weeks immediately preceding such surgery, Jim further recommends that he and Mitch work together to get him as strong as possible for the hip-replacement procedure and postsurgery physical therapy.

Mitch readily agrees to prehab. Jim is surprised, though, when Mitch selects for the surgery a physician who isn't among those Jim had recommended. "My buddy says this guy is really good," Mitch explains. Jim certainly respects Mitch's right to make his own decisions. Jim is unfamiliar with the physician, but he is determined, as always, to help his patient get into the best possible shape for surgery and postsurgery physical therapy.

Two weeks after surgery and a brief stint in inpatient rehab, Mitch returns to Jim's clinic. Although Mitch seems optimistic and is excited about getting back to work soon, Jim is concerned to note, during the course of his evaluation, that Mitch's surgical scar is significantly more extensive than those he has seen in recent years. Jim also is discomfited by the fact that the prosthesis had dislocated shortly after surgery and had to be refitted. Still, dislocations do happen on occasion, Jim knows. What's most important to Jim is that Mitch is well-versed in the precautions he's been instructed to observe to prevent another dislocation. "I'm going to be a good patient and get back to business," Mitch pledges.

Jim schedules Mitch's next appointment for later that week, but he is surprised first thing the next morning to find Doris, Mitch's wife, in the waiting room and looking frantic. She

reports that Mitch is outside in the car, is in a lot of pain, and that they believe the new hip popped again an hour earlier. Can Jim please take a look?

Jim walks out to the parking lot, where Mitch is reclined in the passenger's seat. "I swear, I did everything the doc said!" Mitch exclaims. "I just heard a pop when I stood up. So, is there something you can do to help me out?"

"I'm sorry, but you need to go to the emergency room," Jim responds. Mitch is disappointed, but he agrees.

It's another 2 weeks and a surgical repair procedure later before Jim sees Mitch again. "The doc says it must've been something I did or you did," Mitch reports. "I'm sure it wasn't you, so I'm thinking I must not have been careful enough." While Jim is gratified by Mitch's faith in him, he feels certain that his patient in no way contributed to his current circumstance.

"Now that you've had this second procedure, the worst should be behind you," Jim tells Mitch. "Still, you might want to get another medical opinion, given the difficulties you've had." He suggests that Jim contact 1 of the physicians whose name he'd given Mitch initially. While Jim doesn't want to give an impression of impugning the competence of Mitch's surgeon, rarely do any of Jim's patients experience any significant setbacks after joint replacement surgery, let alone 2 postsurgical incidents. Thus, Jim feels strongly that Mitch would benefit from the opinion of a second surgeon.

To Jim's dismay, however, Mitch replies, "I'm done with doctors and procedures! I'll see you bright and early Monday morning for physical therapy. It's high time for me to get back to work!"

But Mitch is a no-show Monday morning. Concerned by his absence, Jim calls Mitch's house but gets the answering machine. About an hour later, a distressed Doris calls from the hospital to report that Mitch is in the ER because the new hip again has dislocated. Jim expresses his concern and sympathy and asks Doris to keep him apprised of further developments.

After he puts the phone down, Jim sits at his desk and ponders the situation. Surely now Mitch will consult with another physician. But what if he doesn't? What if Mitch remains convinced that he's somehow to blame for the dislocations—or comes to believe, based on what his physician had said, that physical therapy has played a role in the setbacks? If Mitch declines to seek a second opinion, should Jim simply "cut bait" and terminate his relationship with Mitch, he wonders. Should he suggest that Mitch see a different PT?

For Reflection

Jim wants what is best for his patient, but if Mitch should decline to take his advice, there will be implications for Jim's practice, reputation, and, perhaps, his livelihood. Poor surgical outcomes certainly will affect Jim's ability to effectively progress Mitch, reflecting poorly on the perceived quality of Jim's care. Furthermore, the seeds of doubt the physician has sewn about Jim's work could leave Jim open to litigation.

Jim knows the frequent dislocations may have a nonsurgical cause, and he doesn't wish to give the appearance of questioning that aspect of the physician's work. Jim does feel, however, that Mitch would benefit from the opinion of a physician who's willing to explore other causes, rather than simply blaming the patient or the PT.

Use the 4 steps to decide the ***realm, individual process and situation***

Is it legal or ethical?

Is it an ethical dilemma or problem?

Which ethical principles apply?

Which Regulation from the NJ Practice Act applies?

Matter of Vital Concern

Off the Cuff

Ed has been working at Metro University Hospital since his graduation 10 months ago from the state university's Doctor of Physical Therapy (DPT) program. He's pleased with how much he's learning as a staff PT, and he feels confident enough to serve in his spare time on the Public Relations Committee of the state APTA chapter.

One of Ed's colleagues on that committee is Sherry, who owns Star Physical Therapy, a private practice located near the hospital. The two PTs often carpool to chapter meetings, and on the way home from one Sherry says she needs a PT to work one or two evenings a week at her clinic because the caseload is steadily increasing. She asks Ed if he's interested.

The inquiry intrigues him for several seasons. He'd like some exposure to outpatient private practice to see if he might someday care to move into that setting. He knows from their past conversations that quality of care is very important to Sherry, so he feels he and she are compatible in placing great value on maintenance of high professional standards. And frankly, some extra cash would help Ed in his battle against the mountain of debt he incurred while paying for his PT education.

Given that he's been a PT for less than a year, Ed also feels tremendously complimented by Sherry's faith in him. The following week he accepts the job. He agrees to work one night a week at the outset, with the possibility of adding a second night in a few months if both parties like the way things are going.

On Ed's first night at Star, he starts out by shadowing Sherry and Denise, another PT. After familiarizing himself with their caseload, he steps in and treats a few patients himself. He isn't concerned when he can't locate certain equipment, as he doesn't yet know where everything is kept. Rather than query his new colleagues, he simply grabs his physical therapy kit from the trunk of his car and uses its blood pressure cuff, stethoscope, and some other items. On his way home that night, Ed makes a mental note to ask somebody next week where those items are kept.

When he arrives the following week, Sherry is off and Denise is busy with a patient in a private treatment room. Ed again has brought in his kit from the car, just in case, and sure enough, a cursory search of the drawers and cabinets to which he has ready access yields no sphygmomanometer or stethoscope. Ed uses his own equipment throughout the evening. As he and Denise are completing their paperwork at closing, he asks her where he can find certain forms, supplies, and, of course, the tools for taking vital signs. Ed is more than a bit surprised and concerned by her answer.

Denise says she's "never needed" a blood pressure cuff or stethoscope, so she isn't sure where those items are kept. She does point Ed toward where he can find most of the other materials he's seeking. Ed tells Denise that he'll ask Sherry where the vital signs tools are kept later that week, when he and Sherry are to drive together to a continuing education seminar.

In the car a few days later, with Ed driving and Sherry beside him in the passenger seat, the two PTs have a great discussion about a gamut of professional issues, including APTA's Vision 2020, direct access, the PT as practitioner of choice, and physical therapy as a doctoring profession. But Ed realizes later, during the seminar, that he forgot to ask Sherry about the equipment, so shortly into the drive home he brings it up, asking Sherry where such supplies as blood pressure cuffs and stethoscopes are kept.

Sherry softly chuckles and tells Ed his "acute care focus is showing." She says she thinks there's a blood pressure cuff on the premises somewhere, but that it might be broken. She usually keeps a stethoscope

on hand, she adds, but she may have loaned it to a friend who needed one as part of a costume for a play. Sherry promises to check on both items the next day, and tells Ed he's certainly welcome to take patients' and clients' vital signs if he so chooses.

Ed is silently shocked by her virtual dismissal of procedures he considers essential to each evaluation and all subsequent interventions. When he returns to the clinic the next week, Sherry mentions nothing about the equipment. Several more weeks pass without any blood pressure cuffs, sphygmomanometers, or stethoscopes appearing. Ed continues to use his own equipment. He has noticed, too, that the clinic's treatment forms have no designated spaces for documenting vital signs. He's been adding those measurements to his narratives.

Ed doesn't mind bringing his own equipment to the practice, but he's concerned that none of the other PTs seem to miss these items or seem inclined to take and record vital signs of either established or new patients and clients, some of whom have come to the clinic via direct access. Even patients with known pathologies, Ed observes, are not being monitored for vital signs prior to, during, or after exercise.

He's perplexed. Ed's colleagues at Star seem to be caring, competent, and in most ways extremely professional. But how can such valuable assessment tools go unused-and worse, be absent entirely from the premises? If such a well-respected clinic doesn't monitor patients' and clients' vital signs, he wonders, what do other outpatient practices do?

He wonders what to do. Should he say something to Sherry? Should he, rather, be content in the knowledge that he personally is doing what he deems to be the "right thing" and appropriate standard of care, and hope his example rubs off on his colleagues?

Considerations

Use the 4 steps to decide the ***realm, individual process and situation***
Is it legal or ethical?
Is it an ethical dilemma or problem?
Which ethical principles apply?
Which Regulation from the NJ Practice Act applies?

Do you agree that PTs are ethically obliged to help their colleagues recognize the importance of these basic procedures as ways of better ensuring patient safety and minimizing risk?