Physical Therapist Student Experiences With Ethical and Legal Violations During Clinical Rotations: Reporting and Barriers to Reporting
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Background and Purpose. The specific aims of this research were to: (1) gather insight on students’ ability to identify, address, and report ethical and legal violations encountered in the clinic; (2) gain insight into barriers that prevent students from reporting these violations; and (3) collect student suggestions for the curriculum and clinical supervision that might assist them in identifying and reporting ethical and legal violations.

Subjects and Methods. A survey was developed, based on an extensive review of the literature, to assess 6 potential areas for ethical and legal violations: resource utilization, supervision, sexual harassment, truth telling, respect, and blatant wrongdoing. After survey administration, students were invited to participate in a voluntary group discussion in which they gave feedback on the survey and their answers. Sixty-nine surveys were completed.

Results. The survey response rate was 98.5% (69/70). The length of participant clinical experience ranged from 16 to 24 weeks. Seventy-one percent of the participants were female. In all areas investigated, students reported violations, often accurately and appropriately but also at times failing to respond. The reason chosen for failure to respond from most often to least often was: (1) “low position of hierarchy,” (2) “fear of not being a team player,” (3) “did not recognize as an issue,” and (4) “personal consequences.”

Discussion and Conclusion. In many cases students did recognize ethical and legal wrongdoing in the clinical environment and responded appropriately. Among those who recognized the problems but did not report, the most common barrier was “low position of hierarchy.” The second most common barrier reported was “did not recognize as an issue.” Results from the discussion groups indicated that the survey reflected topics covered in didactic coursework; however, students felt they would have benefited from having courses covering these violations earlier in their curriculum and incorporating ethical and legal issues into the more clinically based didactic coursework. Although all the students had been exposed to the legal and ethical issues covered in the survey, there was a marked inability to set aside self-interest and responsibly report violations in the clinic. In response to claims that they were unaware of legal requirements for practice, we offer the suggestion of a mandatory competency test on the state practice act prior to clinical affiliations. For other barriers, we recommend optimal course construction and placement to foster moral reasoning and courage, policy changes to recognize clinical time prior to reporting if replacement is required and education policies modeled after state licensure laws that punish observers of wrongdoing who fail to respond or report.

Key Words: Clinical education, Ethical issues, Ethics and morality, Legal issues, Professional Issues.

BACKGROUND AND PURPOSE
As the physical therapy profession moves toward increased professional autonomy, it is in the best interest of the public and the profession for physical therapists to continually develop the skills required to uphold legal and ethical standards in the workplace. With increased clinical autonomy, physical therapists (PTs) will need to navigate more complex ethical dilemmas. The foundation for developing clinical skills related to ethical decision making should occur in didactic coursework. Physical therapist education must teach students to make ethical and legal clinical judgments in order to meet the challenges of clinical practice.

The specific aims of this research were to: (1) gain insight on students’ ability to identify, address, and report legal issues, ethical issues, and dilemmas; (2) gather insight into barriers that prevent students from reporting these violations encountered in the clinic; and (3) collect student suggestions for the curriculum and clinical supervision that might assist students in identifying and reporting ethical and legal violations.

Previous research has shown that many ethical conflicts arise from inappropriate use of resources, improper supervision, sexual harassment, lack of truth telling, respect, and blatant wrongdoing. In a fast-paced practice environment, it can be challenging to recognize ethical dilemmas and determine the appropriate course of action. Students in many health care professions are encountering an increased number of ethical dilemmas and conflicts when practicing in the clinical setting. The Code of Ethics for the Physical Therapist serves as a resource for physical therapists and physical therapist students to aid in recognition and resolution of ethical and legal dilemmas. Recent literature has provided some explanation and insight into the health care practitioner’s ability to identify and resolve certain ethical and legal issues.
study, legal issues are defined as those explicit behaviors which violate the state practice act, state laws, or any of the federal laws governing the health care workforce, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and Occupational Safety and Health Administration (OSHA) or Medicare and Medicaid rules and regulations. Ethical issues are those areas such as respect for autonomy or beneficence that are essential to professional conduct but may not be required by law. Ethical dilemmas are defined as "situations in which moral reasons come into conflict, and it is not immediately obvious what should be done." In most cases we are concerned with both ethical issues and dilemmas. The following are domains of concern that appeared repeatedly in the literature relevant to clinical behaviors witnessed or performed by health care students in various health professions.

**Inappropriate Use of Resources**

The Ethics and Judicial Committee of the American Physical Therapy Association (APTA) has identified the following as examples of improper use of resources: overutilization of services, billing fraud, improper use of personnel, false advertising, endorsement of products, and inappropriate fees. The literature supports that these issues are among the most common current ethical issues facing physical therapists.

**Improper Supervision**

State practice acts, as well as payers such as the Centers for Medicare and Medicaid Services, establish specific requirements for PTs regarding supervision of students, physical therapist assistants (PTAs), and physical therapy aides involved in patient care. Supervision also includes proper use of clinical time. In spite of these laws and regulations, improper supervision is a frequent theme experienced by students in many health professions, including medicine, nursing, occupational therapy, and physical therapy.

**Sexual Harassment**

Sexual harassment is defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature. This is an important issue in health care due to the close human contact between patients and practitioner and the necessity for patients to disclose personal information. Examples of sexual harassment include sexual remarks and comments of a sexual nature, requests for sexual favors, leering, nudity, display of offensive visual materials, and deliberate, unwanted physical contact. Sexual harassment in physical therapy is frequent and is linked to the close physical contact required for safe and effective application of practice techniques. A study by McComas et al reported that almost one-half of physical therapists and one-third of physical therapist students reported experiencing severe inappropriate sexual behavior, yet only 20% perceived that they had been sexually harassed. Demayo focused on "sexually related patient behaviors" and both studies confirm the lack of training for sexual harassment in the workplace and in physical therapy curriculums.

**Lack of Trust Telling**

Honesty relates to moral character and signifies positive qualities such as truthfulness and integrity. Open, honest communication among practitioners, patients, and families is critical for effective, efficient delivery of care. Unfortunately, lack of truth telling is recognized as one of the most common acts reported by students in health care fields.

**Respect**

Principle One of the Code of Ethics for the Physical Therapist states: "Physical therapists shall respect the inherent dignity and rights of all individuals." Trizenenberg identified ethical issues in physical therapy practice involving disrespectful behavior that involved informed consent, confidentiality, social characteristics, and adherence to ethical guidelines. A questionnaire completed by medical students regarding confrontation with ethical dilemmas indicated 98% of students heard physicians refer to patients in a derogatory way. Physical therapists have also observed unprofessional and disrespectful behavior by other medical team members, including verbal abuse by staff towards elderly and mentally ill patients.

**Blatant Wrongdoing**

Blatant wrongdoing, an obvious disregard of the law, is a serious issue in the medical profession. Violating patient confidentiality has been found to be commonly observed by medical, nursing, occupational and physical therapy students, and other health care professionals. Medical billing fraud costs the United States billions of dollars annually. Among 379 health care fraud cases between 1996 and 2005, $9.3 billion was recovered, with more than $1 billion paid to whistleblowers. In 2012, the federal government recovered $4.2 billion dollars for fraudulent billing, and the Justice Department convicted 826 people for health care fraud. Common types of physical therapy fraud include: billing for physical therapy services performed by unqualified personnel, billing for physical therapy services that were never performed or only partially performed, billing for unskilled or maintenance physical therapy services, billing for physical therapy services performed under a deficient plan of care, and billing under individual therapy codes for group therapy services.

**METHODS**

A literature review was performed to assess the ethical and legal violations that students and young professionals face in the medical, nursing, occupational therapy, and physical therapy fields. The common themes on the barriers to report such situations were also explored. Based on the reoccurring themes of ethical and legal violations and barriers to reporting, a survey was created that encompassed what was found in the literature review as it might pertain to the physical therapy setting. The questions were based on 6 legal and ethical themes: resources, supervision, sexual harassment, truth telling, respect, and blatant wrongdoing.

The survey was presented to a focus group consisting of 5 new physical therapist graduates. The focus group provided feedback on the clarity and face validity of the questions as related to the research purpose. Responses from the group were used to modify the survey questions. The test-retest reliability of the survey was determined by administering the survey to a group of 10 new graduates of a Doctor of Physical Therapy (DPT) program via SurveyMonkey. Each individual's answers were analyzed for consistency between test and retest. Portions of the survey with multiple choice responses had to be identical to qualify as consistent, and qualitative statements had to be judged by 2 independent researchers as the same response between tests. In total, 2 questions were omitted and no other changes to the survey were imposed. The remaining 33 questions were assigned a number and their order randomized using a computer-generated randomized number chart. None of the questions were identified as "ethical" or "legal" but rather as random discrete questions.

A letter requesting participation from students was sent to the directors of clinical education of 6 DPT programs in California. Two schools agreed to participate. Both programs are private and located geographically close to each other. Students often feel proud and protective of their respective schools. To avoid underreporting, it was agreed that data would be summated and no comparisons between the 2 schools would be offered. This assertion was made in the Institutional Review Board request at each institution and this assurance was given to each group of students.
prior to the administration of the survey. A second group of students administered the survey in person to other currently enrolled in these 2 programs. To make certain that students were familiar with the most common ethical and legal topics, respondents only included DPT students who had completed at least one 6-week, full-time, clinical experience and had covered content within the curriculum including, but not limited to, issues concerning sexual harassment, Medicare fraud, improper use of resources, patient advocacy, improper supervision, and blatant wrongdoing. Participants responded to questions about either witnessing or participating in ethical or legal violations in the clinical setting. If an individual’s answer was affirmative, further clarification was requested, including whether the incident was reported. A negative response to reporting led to an additional inquiry to identify the perceived barriers.

After survey administration, respondents were invited to participate in a small, voluntary focus group in order to: (1) gather more insight on what the survey meant to them, (2) allow them to further explain some of the reasons they may have not reported ethical or legal violations, (3) give them a chance to provide suggestions for curricular changes, and (4) offer insight to clinical supervisors that might aid in identifying and reporting ethical and legal violations. The discussion was led by student researchers and included open-ended questions such as: “How did you interpret this survey?”, “What did ‘did not recognize as an issue’ mean to you?”, and “What suggestions do you have for clinical instructors or curricular changes to better help you understand the material?”

RESULTS

The survey was completed by 69 out of 70 participants. The response rate was 98.5%. One survey was omitted from the analysis due to incompletion. Length of clinical experience ranged from 16 to 24 weeks. Forty percent (n = 28) of participants had completed 16 weeks of clinical experience and 59.5% (n = 41) of participants had completed 24 weeks of clinical experience. Seventy-one percent of the participants were female.

Inappropriate Use of Resources

There were 7 survey questions related to improper use of resources. All 7 questions had “yes” responses for having participated in or witnessed such events (Table 1). The number of “yes” responses to each question ranged from 10 to 24 participants. Of all students who responded “yes” to any of these 7 questions, 13 reported the event. For those who did not report, the most common barrier was “low position of hierarchy,” followed by “fear of not being a team player.”

Improper Supervision

Five questions on the survey related to supervision. All 5 questions within this theme had “yes” responses that improper supervision had been observed. The number of “yes” responses ranged from 11 to 46 students (Table 2). Survey question number 5 had the greatest “yes” response rate in the survey (n = 46). This question pertained to witnessing physical therapists utilizing clinical time for nonclinical or personal business. Of the 46 respondents who witnessed or participated in such an event, none reported it.

Sexual Harassment

Eight questions on the survey were related to observing or experiencing sexual harassment. The number of “yes” responses to each question ranged from 2 to 31 participants (Table 3). Of the students who observed or experienced sexual harassment, 20 reported the situation. Within the theme of sexual harassment, the most common reason for not reporting an incident was “low position of hierarchy” followed by “did not recognize as an issue.” Survey question 11 yielded the most responses in this category and dealt with a staff member or patient telling sexually suggestive stories or offensive jokes. Twenty-five out of 31 students did not report the incident.

Lack of Truth Telling

There were 4 questions in the survey related to truth telling. All 4 of the questions had “yes” responses to observation or participation in lack of truth telling. The number of “yes” responses to each question ranged from 1 to 24 students (Table 4). Of those individuals, 6 participants reported the event. The most common barrier to reporting was “did not recognize as an issue” followed by “low position of hierarchy.” Survey question 8 had the most “yes” responses for this category. This question pertained to witnessing or participating in post-dating documentation in the medical record. Of the 24 students who responded “yes,” 4 reported the event.

Respect

Four questions on the survey were related to respect. The number of respondents who identified disrespectful behavior ranged from 17 to 27 students (Table 5). Of those individuals, 7 students reported the situation. Within the theme of respect, the most common reason for not reporting an incident was “low position of hierarchy” followed by “personal consequences.” Survey question 4 had the highest response rate for this category. Twenty-five out of 27 witnesses did not report an occurrence regarding universal precautions or infection control guidelines.

Blatant Wrongdoing

Five questions on the survey were related to blatant wrongdoing. Four of the questions had “yes” responses for students having witnessed or participated in such events (Table 6). The number of “yes” responses for each question ranged from 3 students to 36 students. Of those who witnessed or participated in one of the occurrences, only 5 students reported the situation. Survey question 17 had the most responses in this category; 35 out of 36 individuals did not report the event of witnessing a physical therapist cosigning an intervention that he or she did not supervise.

Barriers to Reporting

Throughout the survey the most common barrier to reporting events was “low position of hierarchy,” chosen a total of 141 times (Figure 1). This barrier led in 4 of the 6 categories: sexual harassment, inappropriate use of resources, lack of respect, and blatant wrongdoing. “Did not recognize as an issue” (n = 126) was the second most common barrier reported and led in 2 out of 6 categories: supervision and truth telling. “Fear of not being a team player” and “personal consequences” were tied for the third most common barrier, with 81 responses each.

Results of the Focus Groups

Focus groups were held after each cohort completed the surveys. Three students from each program participated. Three leading questions were asked to guide conversation:

1. Did the survey reflect topics you learned in your curriculum?
2. If you answered “did not recognize as an issue” as a barrier, why?
3. Do you have any suggested curriculum changes?

The students agreed that the survey reflected topics covered in didactic coursework prior to their clinical experiences. One participant reported that he or she had chosen “did not recognize as an issue” because he or she did not understand the issue at the time. One student elaborated on witnessing a particular incident involving respect. It was discussed that there was a fine line between a clinical instructor belittling the student and providing constructive feedback. Individual students may interpret situations differently. Though the participants agreed that the survey covered topics reviewed in their curriculum, most of the students felt that it would have been beneficial if courses covering the
topics and occurrences mentioned in the survey were earlier in the curriculum (eg, before embarking on the first or second long-term clinical affiliation). Another student thought that incorporating ethical and legal issues into more clinically based didactic coursework would help to identify violations and aid in application of ethical reasoning prior to clinical rotations. For example, in orthopedic classes, after demonstrating a technique, having a short discussion on the use of correct billing codes for that specific technique or similar techniques would be helpful. The student felt this would help make ethical and legal reasoning applicable. In addition, the students might feel more confident upon beginning a clinical experience.

**DISCUSSION AND CONCLUSION**

**Reporting of Ethical and Legal Concerns**

In all the domains investigated, students frequently observed violations of legal or ethical principles of practice, similar to students in other health professions. Overwhelmingly, students who observed these breaches did not report the violations. The students had the choice to report the situation to anyone or to do nothing. Reporting is understood at both institutions to include not only the director of clinical education (DCE), but any faculty member. Had students chosen to engage with a faculty member, there would have been a dialogue about the situation and a decision on a course of action.
### Table 2. Supervision Responses

<table>
<thead>
<tr>
<th>Survey Question</th>
<th>Witnessed/Participated</th>
<th>Reported</th>
<th>Barrier</th>
<th>Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. At your clinical site, have you ever witnessed a patient with Medicare being treated by unlicensed personnel (ie, PT aide)?</td>
<td>No-34&lt;br&gt;Yes-35 or 50.7%</td>
<td>No-33&lt;br&gt;94.3%</td>
<td>Low position of hierarchy-13&lt;br&gt;Fear of not being a team player-7&lt;br&gt;Did not recognize as an issue-15&lt;br&gt;Personal consequences-7&lt;br&gt;Other-5</td>
<td>Outpatient Hospital Based-5&lt;br&gt;Inpatient-3&lt;br&gt;Skilled Nursing Facility-2&lt;br&gt;Private Practice&lt;br&gt;Outpatient-24&lt;br&gt;Other-1</td>
</tr>
<tr>
<td>5. At your clinical site, have you witnessed a physical therapist utilizing clinical time for non-clinical or personal business?</td>
<td>No-23&lt;br&gt;Yes-46 or 66.7%</td>
<td>No-46&lt;br&gt;100%</td>
<td>Low position of hierarchy-21&lt;br&gt;Fear of not being a team player-10&lt;br&gt;Did not recognize as an issue-14&lt;br&gt;Personal consequences-8&lt;br&gt;Other-4</td>
<td>Outpatient Hospital Based-11&lt;br&gt;Inpatient-13&lt;br&gt;Skilled Nursing Facility-2&lt;br&gt;Private Practice&lt;br&gt;Outpatient-31&lt;br&gt;Other-2</td>
</tr>
<tr>
<td>7. At your clinical site, was there a time that you were unable to locate your supervising therapist while you were treating patients?</td>
<td>No-45&lt;br&gt;Yes-24 or 34.8%</td>
<td>No-21&lt;br&gt;87.5%</td>
<td>Low position of hierarchy-6&lt;br&gt;Fear of not being a team player-5&lt;br&gt;Did not recognize as an issue-7&lt;br&gt;Personal consequences-3&lt;br&gt;Other-3</td>
<td>Outpatient Hospital Based-6&lt;br&gt;Inpatient-9&lt;br&gt;Skilled Nursing Facility-0&lt;br&gt;Private Practice&lt;br&gt;Outpatient-8&lt;br&gt;Other-1</td>
</tr>
<tr>
<td>15. At your clinical site, have you ever treated a patient without a supervising physical therapist on site?</td>
<td>No-58&lt;br&gt;Yes-11 or 15.9%</td>
<td>No-6&lt;br&gt;54.5%</td>
<td>Low position of hierarchy-2&lt;br&gt;Fear of not being a team player-1&lt;br&gt;Did not recognize as an issue-2&lt;br&gt;Personal consequences-1&lt;br&gt;Other-0</td>
<td>Outpatient Hospital Based-2&lt;br&gt;Inpatient-0&lt;br&gt;Skilled Nursing Facility-0&lt;br&gt;Private Practice&lt;br&gt;Outpatient-4&lt;br&gt;Other-1</td>
</tr>
<tr>
<td>26. At your clinical site, have you ever witnessed or directed a physical therapy aide to apply traction on a patient with no supervision during the setup?</td>
<td>No-53&lt;br&gt;Yes-16 or 23.2%</td>
<td>No-16&lt;br&gt;100%</td>
<td>Low position of hierarchy-5&lt;br&gt;Fear of not being a team player-2&lt;br&gt;Did not recognize as an issue-10&lt;br&gt;Personal consequences-3&lt;br&gt;Other-1</td>
<td>Outpatient Hospital Based-2&lt;br&gt;Inpatient-0&lt;br&gt;Skilled Nursing Facility-0&lt;br&gt;Private Practice&lt;br&gt;Outpatient-14&lt;br&gt;Other-0</td>
</tr>
</tbody>
</table>

### Barriers to Reporting

**Low position of hierarchy.** "Low position of hierarchy" was the most commonly reported barrier (Figure 1). It led as the response on 50% of the themes, including: sexual harassment, lack of respect, and inappropriate use of resources. It received the second highest percentage of responses in the themes of truth telling and improper supervision. Previous studies have found that students fail to speak up on ethical and legal matters primarily because of their subordinate position.3,10,25,27,29 Students may feel insecure about their obligations to speak up and therefore stay silent in the world of just being a student.29

When it comes to resources, students have difficulty reporting inappropriate billing and advocating for patients, including advocating for additional treatment. In 1986, the Court of Appeal in California ruled in Wickline v. California that if a physician (health care provider) did not make an effort to negotiate limitations in coverage that would have adverse effects on the patient, the provider became accountable, at least in part, for unfavorable outcomes.31,32 Fraud is a serious offense that can lead to suspension of licensure, monetary fines and imprisonment. Therefore, it may be intimidating for a student to report fraudulent acts. When it comes to advocating for patients, decision making about endpoints in physical therapy treatment in a rehabilitative setting can be difficult, because a patient can often make gains with additional physical therapy intervention.15 An appropriate endpoint for treatment may not be clear, especially if one is a novice in the profession. Though students are able to recognize an ethical dilemma, it is difficult for students to challenge preceptors and practitioners in the clinic.

For instances of sexual harassment, students failed to report the issue due to having a "low position of hierarchy," closely followed by "did not recognizing as an issue." More than half of the respondents experienced a patient or staff member make sexually crude remarks, tell suggestive stories, or tell offensive jokes. Many of the students that did witness these occurrences perceived them in a joking manner from all parties involved. Because the participants "did not believe it was a serious remark” or “it was not a big enough deal,” they may not have reported the issue.
### Table 3. Sexual Harassment Responses

<table>
<thead>
<tr>
<th>Survey Question</th>
<th>Witnessed/ Participated</th>
<th>Reported</th>
<th>Barrier</th>
<th>Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. At your clinical site, have you witnessed or experienced a staff member or patient making crudely sexual remarks?</td>
<td>No-43</td>
<td>No-20</td>
<td>Low position of hierarchy-9 Fear of not being a team player-3 Did not recognize as an issue-6 Personal consequences-5 Other-4</td>
<td>Outpatient Hospital Based-3 Inpatient-6 Skilled Nursing Facility-1 Private Practice Outpatient-16 Other-0</td>
</tr>
<tr>
<td></td>
<td>Yes-26 or 33.3%</td>
<td>76.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. At your clinical site, have you witnessed or experienced a staff member or patient telling sexually suggestive stories or offensive jokes?</td>
<td>No-38</td>
<td>No-25</td>
<td>Low position of hierarchy-10 Fear of not being a team player-4 Did not recognize as an issue-10 Personal consequences-3 Other-3</td>
<td>Outpatient Hospital Based-6 Inpatient-8 Skilled Nursing Facility-1 Private Practice Outpatient-18 Other-0</td>
</tr>
<tr>
<td></td>
<td>Yes-31 or 44.9%</td>
<td>80.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. At your clinical site, have you witnessed or experienced a staff member or patient intentionally staring at someone so that they felt uncomfortable?</td>
<td>No-67</td>
<td>No-1</td>
<td>Low position of hierarchy-1 Fear of not being a team player-0 Did not recognize as an issue-0 Personal consequences-0 Other-0</td>
<td>Outpatient Hospital Based-1 Inpatient-0 Skilled Nursing Facility-0 Private Practice Outpatient-0 Other-0</td>
</tr>
<tr>
<td></td>
<td>Yes-2 or 2.9%</td>
<td>50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. At your clinical site, have you witnessed or experienced a staff member or patient give an inappropriate romantic/ sexual gift?</td>
<td>No-67</td>
<td>No-2</td>
<td>Low position of hierarchy-0 Fear of not being a team player-0 Did not recognize as an issue-1 Personal consequences-0 Other-1</td>
<td>Outpatient Hospital Based-1 Inpatient-1 Skilled Nursing Facility-0 Private Practice Outpatient-0 Other-0</td>
</tr>
<tr>
<td></td>
<td>Yes-2 or 2.9%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. At your clinical site, have you witnessed or experienced a staff member or patient touch someone else in an uncomfortable manner?</td>
<td>No-66</td>
<td>No-2</td>
<td>Low position of hierarchy-2 Fear of not being a team player-0 Did not recognize as an issue-0 Personal consequences-2 Other-2</td>
<td>Outpatient Hospital Based-0 Inpatient-1 Skilled Nursing Facility-0 Private Practice Outpatient-1 Other-0</td>
</tr>
<tr>
<td></td>
<td>Yes-3 or 4.3%</td>
<td>66.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. At your clinical site, have you witnessed or experienced a staff member or patient request intimate physical contact?</td>
<td>No-67</td>
<td>No-1</td>
<td>Low position of hierarchy-0 Fear of not being a team player-1 Did not recognize as an issue-0 Personal consequences-0 Other-0</td>
<td>Outpatient Hospital Based-0 Inpatient-0 Skilled Nursing Facility-0 Private Practice Outpatient-1 Other-0</td>
</tr>
<tr>
<td></td>
<td>Yes-2 or 2.9%</td>
<td>50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. At your clinical site, have you witnessed or experienced a staff member or patient make attempts to draw someone into a conversation about their sexual affairs?</td>
<td>No-63</td>
<td>No-4</td>
<td>Low position of hierarchy-2 Fear of not being a team player-1 Did not recognize as an issue-0 Personal consequences-1 Other-1</td>
<td>Outpatient Hospital Based-0 Inpatient-0 Skilled Nursing Facility-0 Private Practice Outpatient-4 Other-0</td>
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<tr>
<td></td>
<td>Yes-6 or 8.7%</td>
<td>66.7%</td>
<td></td>
<td></td>
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<tr>
<td>27. At your clinical site, have you witnessed or experienced a staff member or patient asking for a date?</td>
<td>No-64</td>
<td>No-2</td>
<td>Low position of hierarchy-0 Fear of not being a team player-0 Did not recognize as an issue-2 Personal consequences-1 Other-0</td>
<td>Outpatient Hospital Based-0 Inpatient-1 Skilled Nursing Facility-0 Private Practice Outpatient-2 Other-0</td>
</tr>
<tr>
<td></td>
<td>Yes-5 or 7.2%</td>
<td>40%</td>
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</table>
### Table 4. Truth Telling Responses

<table>
<thead>
<tr>
<th>Survey Question</th>
<th>Witnessed/ Participated</th>
<th>Reported</th>
<th>Barrier</th>
<th>Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. At your clinical site, have you witnessed or participated in post-dating</td>
<td>No-45</td>
<td>No-20 83.3%</td>
<td>Low position of hierarchy-5 Fear of not being a team player-2 Did</td>
<td>Outpatient Hospital Based-8 Inpatient-3 Skilled Nursing Facility-1</td>
</tr>
<tr>
<td>documentation in the medical record?</td>
<td></td>
<td></td>
<td>not recognize as an issue-12 Personal consequences-1 Other-2</td>
<td>Private Practice Outpatient-13 Other-0</td>
</tr>
<tr>
<td>25. At your clinical site, have you witnessed or participated in using clinical</td>
<td>No-53</td>
<td>No-15 93.8%</td>
<td>Low position of hierarchy-4 Fear of not being a team player-1 Did</td>
<td>Outpatient Hospital Based-5 Inpatient-2 Skilled Nursing Facility-1</td>
</tr>
<tr>
<td>resources or property for purposes that were not clinical or patient related?</td>
<td></td>
<td></td>
<td>not recognize as an issue-7 Personal consequences-4 Other-2</td>
<td>Private Practice Outpatient-9 Other-0</td>
</tr>
<tr>
<td>29. At your clinical site, have you ever failed to report suspected child</td>
<td>No-68</td>
<td>No-0 0%</td>
<td>Low position of hierarchy-0 Fear of not being a team player-0 Did</td>
<td>Outpatient Hospital Based-0 Inpatient-0 Skilled Nursing Facility-0</td>
</tr>
<tr>
<td>abuse?</td>
<td></td>
<td></td>
<td>not recognize as an issue-0 Personal consequences-0 Other-0</td>
<td>Private Practice Outpatient-0 Other-0</td>
</tr>
<tr>
<td>33. At your clinical site, have you ever witnessed a physical therapist</td>
<td>No-61</td>
<td>No-8 100%</td>
<td>Low position of hierarchy-3 Fear of not being a team player-1 Did</td>
<td>Outpatient Hospital Based-2 Inpatient-1 Skilled Nursing Facility-0</td>
</tr>
<tr>
<td>introducing themselves as “Doctor” without mentioning “of Physical Therapy”?</td>
<td></td>
<td></td>
<td>not recognize as an issue-4 Personal consequences-1 Other-1</td>
<td>Private Practice Outpatient-7 Other-0</td>
</tr>
</tbody>
</table>

### Table 5. Respect Responses

<table>
<thead>
<tr>
<th>Survey Question</th>
<th>Witnessed/ Participated</th>
<th>Reported</th>
<th>Barrier</th>
<th>Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. At your clinical site, have you witnessed or participated in the failure to</td>
<td>No-42</td>
<td>No-25 92.6%</td>
<td>Low position of hierarchy-10 Fear of not being a team player-4 Did</td>
<td>Outpatient Hospital Based-5 Inpatient-13 Skilled Nursing Facility-2</td>
</tr>
<tr>
<td>follow “Universal Precautions” or infection control guidelines with patient care?</td>
<td></td>
<td></td>
<td>not recognize as an issue-6 Personal consequences-7 Other-4</td>
<td>Private Practice Outpatient-6 Other-2</td>
</tr>
<tr>
<td>6. At your clinical site, has your treatment or plan of care ever been influenced</td>
<td>No-52</td>
<td>No-16 94.1%</td>
<td>Low position of hierarchy-9 Fear of not being a team player-2 Did</td>
<td>Outpatient Hospital Based-1 Inpatient-4 Skilled Nursing Facility-0</td>
</tr>
<tr>
<td>by stereotyping the patient?</td>
<td></td>
<td></td>
<td>not recognize as an issue-5 Personal consequences-3 Other-1</td>
<td>Private Practice Outpatient-12 Other-1</td>
</tr>
<tr>
<td>31. At your clinical site, have you witnessed or participated in disrespectful</td>
<td>No-47</td>
<td>No-21 95.5%</td>
<td>Low position of hierarchy-13 Fear of not being a team player-6 Did</td>
<td>Outpatient Hospital Based-8 Inpatient-9 Skilled Nursing Facility-1</td>
</tr>
<tr>
<td>communications regarding other healthcare professionals?</td>
<td></td>
<td></td>
<td>not recognize as an issue-3 Personal consequences-5 Other-1</td>
<td>Private Practice Outpatient-9 Other-2</td>
</tr>
<tr>
<td>32. At your clinical site, have you been belittled or witnessed another student</td>
<td>No-48</td>
<td>No-17 81.0%</td>
<td>Low position of hierarchy-9 Fear of not being a team player-3 Did</td>
<td>Outpatient Hospital Based-4 Inpatient-7 Skilled Nursing Facility-1</td>
</tr>
<tr>
<td>being belittled?</td>
<td></td>
<td></td>
<td>not recognize as an issue-0 Personal consequences-9 Other-1</td>
<td>Private Practice Outpatient-7 Other-0</td>
</tr>
</tbody>
</table>
As one of the most litigated areas of employment, students, faculty, and clinicians alike need to understand the seriousness of these violations and the possible ramifications to organizations.

For issues of respect, having a “low position of hierarchy” appears to be the barrier that prevents students from taking action. Most participants witnessed or participated in the failure to follow “Universal Precautions,” but did not report the issue because a medical professional was involved. Survey question 4 yielded responses such as: “PT was a skilled practitioner, did not want to get him in trouble” and “PT has been there for 3 years and other people at the facility didn’t say anything.” Students did not want to question the actions of the clinician. When it came to belittlement of fellow students or disrespectful communication, students felt uncomfortable and angry, but did not report the incident due to “fear of failing clinical.” Belittling is a form of harassment, and though students were able to recognize this they did not report the issue because they were fearful of the consequences. This demonstrates the need to educate students about the resources and systems set in place to encourage and foster a positive learning environment.

**Did not recognize as an issue.** “Did not recognize as an issue” was the second most common barrier reported among the 6 themes. It received the most responses in 2 of the 6 themes: improper supervision and truth telling. Under the theme of supervision, it appears that some students are not clear what proper supervision entails as defined by the California Physical Therapy Practice Act.13 Questions 7 and 15 pertained to the supervision that is required by the California Physical Therapy Practice Act. One respondent commented, “[I] just didn’t know I couldn’t do that. CI was late so I started treating the patient before the CI got there.” According to the California Physical Therapy Practice Act, appropriate supervision of a student requires that “the supervising physical therapist shall provide onsite supervision of the assigned patient care rendered by the physical therapist student.”13 Regarding treatment of Medicare patients, a participant commented, “[I] wasn’t aware at the time that aides could not work with Medicare patients.” The responses show that, even though students who participated in this survey had completed coursework in laws and regulations mandated by the California Physical Therapy Practice Act and other material related to physical therapy laws and regulations, uncertainty still exists. Or, it may be that the culture and practices of the clinic simply override information given in the formal curriculum.

Many of the respondents failed to report an occurrence mentioned within the truth telling theme as they did not recognize the issue. One example from the participants who responded “yes” to encountering an incident within the truth telling theme was witnessing post-dating documentation in the medical record.

**Fear of not being a team player.** "Fear of
not being a team player” was the third most common barrier reported across all themes (Figure 1). It is possible that, in regard to inappropriate behavior and issues with resources, students recognize the ethical dilemma and can identify the proper ethical course, but feel that their position as a student prevents them from taking appropriate action.\(^{30,34}\) Once again, students feel their subordinate position was a hindrance to reporting as they wanted to establish a good reputation with their clinical instructor and fellow members of the clinical environment. Many decisions not to report unethical incidents were based on not wanting to make my supervisor look bad.\(^{33}\) The number of responses for this barrier supports the theory that students might not understand the support systems that are available when reporting an unethical or unlawful situation. An alternative explanation is that students hope that by supporting their supervisor, the support will be reciprocated.

**Personal consequences.** "Personal consequences" tied with "fear of not being a team player" as the third most common barrier. The 2 are closely related because not being perceived as a team player could have personal consequences, such as an unfavorable clinical review. This result indicates that students consider the potential consequences of their actions for their personal good. It was second to “low position of hierarchy” in the category of respect. Many of the participants made comments such as "fear of repeating internship" and "fear of failing clinical." In addition to the fear of not passing their clinical education courses, students were concerned with how they were viewed by clinicians and staff. Students were concerned for their reputations. Callister et al\(^{30}\) found that students make decisions based on concerns regarding evaluations or grades. During clinical experiences students not only seek out learning opportunities but also look out for their own interests, articulating concern about what would happen to their evaluations, grades, and reputations.\(^{34}\) Students can be so preoccupied with obtaining passing marks and positive evaluations that they may ignore the patient’s best interest for that of their own.

Of the 4 most frequent barriers, 3 ("low position of hierarchy," “fear of not being a team player,” and “personal consequences”) are linked to the student's perception of self-interest. On a Kohlberg scale\(^{35}\) or its revisions by James Rest,\(^{36}\) that would translate to decision making at stage 2 (obeying rules as long as there is personal gain). Professional organizations depend on decision making at level 4 (obeying rules to maintain order and duties to others) to ensure proper patient care.\(^{37}\) It would be naïve to propose that student fears are unjustified, especially given their perceived vulnerability. Nor should we dismiss their inaction for this perception. The clinical settings are monitored and the DCE can intervene in cases like the ones given in the survey. It is in the best interest of the profession that the educational unit either report or sever its ties with a clinical setting that engages in illegal or unethical procedures. Even under the best of circumstances, at both institutions when a student is removed from a facility, they start over at another. This in turn means a delay in their educational progress and an increase in expenditures.

Both programs in this study utilize an evidence-based pedagogy for teaching ethical and legal issues. Evidence regarding components essential for effective ethics education indicates the following elements should be included. Ethics courses should be named stand-alone courses\(^{38,39}\) sufficient in length (2-3 semester units),\(^{40,41}\) use small groups\(^{42,43}\) and case studies,\(^{44}\) and be focused on critical thinking and problem solving.\(^{44}\) They should also appear early in the curriculum and the content should be threaded throughout the curriculum, appearing in nearly every course as an expected component in decision making.\(^{45,46}\) Instruction that is not named and only threaded through the curriculum takes on the appearance of something not nearly as important as the named domains.\(^{47}\) Content that is only relegated to everyone often suffers from lack of consistency and depth. Courses that appear at the end of the curriculum are perceived as non-core add-ons and their position in the curriculum denotes their importance.

The majority of the research supports the notion that formal ethics training is effective in yielding superior results on objective measures,\(^{39,40,44}\) and, when implemented early, it endures throughout the curriculum.\(^{46}\) Evidence that the benefits of ethics training continues beyond the academic environment is based on studies about standardized measures, such as the Defining Issues Test\(^{48}\) and the Jefferson Scale of Empathy,\(^{49}\) and malpractice claims.\(^{49,50}\) Other outcomes have not been researched thus far.

In both institutions in this study, students had received instruction on legal issues that would have given them adequate knowledge to know the appropriate response. They were instructed about a process for decision making that approximated the following recommended steps. These steps are not a formula for making a specific decision, but they outline a desired process.

1. **Facts:** Identify the relevant factual information—relevant in terms of the moral reasons applicable in the situation. This includes the applicable laws and policies. Identify the relevant stakeholders; that is, people and groups directly affected by how the dilemma is resolved.
2. **Moral Reasons:** Identify the conflicting moral reasons that comprise the ethical dilemma. Moral reasons take many forms. They include responsibilities (obligations, duties), rights (both general human rights and specific rights created by contracts), good and bad consequences, valuable relationships, ideals, and virtues (good features of character).
3. **Options and Outcomes:** Identify the realistic options in resolving the dilemma and their likely outcomes.
4. Deliberation and Decision: Make a reasonable decision by deliberating to discover that option which most reasonably balances and integrates the moral reasons. (Occasionally more than one option can provide a reasonable solution.)

5. Action: Take action; implement one's decision.

6. Review: Reflectively review your process and assess the outcomes. Look for ways to improve the process by identifying procedural hurdles or barriers and assess if procedural changes are needed for the future.8(9)

Throughout this process, with some notable exceptions, such as when the observer is a mandated reporter, an integral part of each step communication with peers and colleagues where that consultation will not itself create a dilemma. But we must also recognize that ultimately we bear responsibility for our actions or lack of action.

The ethics curriculum, however, occurs after the first set of clinical rotations. Thus students are reporting a mixture of ethical responses to experiences, some of which they should have been prepared to meet and others for which they might not have been prepared. Ethics instruction using case studies provides an opportunity to practice ethical decision making and can foster self-confidence to promote more frequent reporting (regardless of whether the offense was legal or ethical).

There is an additional component to the clinical instructional side of the equation that is best expressed through the hidden curriculum, defined by Hafferty25 as the transference of the culture of medicine which can be antithetical to the goals and values of the formal academic curriculum. The tacit learning that occurs in the clinic often stresses objectivity, detachment, and distrust of patients, administrators, and others. This in turn fosters the development of 3 characteristics: detachment, entitlement, and nonreflective professionalism that embraces clinical attitudes often at variance with academic proclaimed values.52 The practices and culture of the clinic can reinforce or sabotage the best efforts in the academic environment.47,50 Students look to clinicians as role models because their goal is to be like them. Based on fraud statistics26,27,28 and California Board of Physical Therapy judgments,8 it is not the academic environment that is the problem. The culture of the clinic can radically transform most people, especially those like our students, who are fearful of not being a team player and feel powerless because of the position in the clinic hierarchy.

Students are engaged in both the clinic and the academic environment. A common tactic for students to avoid responsibility for content knowledge is to claim they have never heard the content before. Rest16 describes moral (and presumably legal) action as something that is derived from adequate sensitivity that a problem exists, motivation to do something about it, reasoning ability to develop a response, and the courage to act on those decisions. While some of the responses in this study may have been because students had forgotten material, or were never given the material, the prevalent barriers suggest another reason. Fear for consequences, not being a team player, and a low position in the hierarchy point to a probable lack of courage or a primary concern for personal well-being for some students.

This study provides information regarding ethical and legal issues physical therapist students encounter in clinical affiliations, the frequency with which they happen, and possible reasons for inaction. In the academic setting, this can be used to shape the curriculum to enhance the ability of students to act according to legal and ethical requirements of practice. In the clinical setting, this can be used to educate clinicians regarding the significant role clinic environment plays in shaping the attitudes and actions of future clinicians. Faculty, students, and clinicians are all responsible for upholding legal and ethical requirements of practice and we must hold each other accountable.

Limitations of the Study

This is a simple descriptive study, exploratory in its intent. We do not know if these students on average report more or less than students with different curricular designs, nor can we provide the breakdown between pre- and post-ethics instruction. The findings are confined to one geographical location and both schools were private institutions. There may well be geographic differences that this study could not define. Had this study taken place at the end of all clinical rotations, we might have a better assessment of prevalence. In addition, a larger sample size would have allowed us to identify the prevalence of these ethical, legal, and moral issues and barriers to reporting in specific clinical settings. Unfortunately only 2 out of the 6 programs contacted agreed to participate.

CONCLUSION

From the perspective of students who recognize legal and ethical problems in the clinical setting but fail to report them, the survey provided a better understanding of barriers that possibly hinder students’ ability to identify and report legal and ethical violations during clinical rotations. It is clear that many of these violations happen frequently in any setting. The survey identified that students most often failed to report due to a fear of not being perceived as a team player or other issues of self-interest coupled with the claim that they did not recognize the issues. Students felt especially insecure in reporting violations pertaining to resources such as billing fraud and patient advocacy. Yet, participation in fraud can result in loss of eligibility for licensure, loss of respect from the community, and provision of substandard care.

From the perspective of students who recognized and reported legal and ethical problems, the barriers identified by those who would not report were not substantial enough to prevent them from responding. James Rest16 identifies 4 psychological processes for organizing a review of an ethical problem and choosing a response: moral sensitivity, moral reasoning, moral motivation, and moral courage. If any process is missing, it is highly unlikely any action can or will be taken. He identifies 2 groups, issue and dilemma-responders and issue and dilemma-non-responders to describe response to these processes. Both groups in this study may have had the moral sensitivity to recognize the problem, most had the reasoning to know what should be done, and we can probably assume they had adequate motivation to act in an ethical and legal manner. What we cannot assume based on the reasons they gave for not reporting is moral courage. That would appear to be 1 major difference between the issue and dilemma-responders and issue and dilemma-non-responders. An informed curriculum can teach moral sensitivity, judgment, and motivation, but moral courage is often assumed by educators to be present (or not) long before graduate education begins.

Students can matriculate through undergraduate education in the sciences without challenging the status quo, secure in the mistaken belief that science is morally neutral. There are tremendous social rewards for conformity, especially in young adulthood. It is little wonder that courage to question a clinical supervisor or future colleague would be in short supply. Educational professional programs have to start shaping a sense of duty to the profession and patients as a duty that supersedes loyalty to peers or administrators. This needs to be made explicit in orientation and then reinforced through the curriculum. Perhaps a good place to start is with an introduction to the state practice acts and review of board rulings where failure to report or respond to wrongdoing has resulted in disciplinary action that stays a part of the professional profile for as long as the professional
is practicing. Departmental policies on cheating and other unprofessional conduct should be expanded to include penalties for failure to respond or report if those behaviors were witnessed by a student. Educators must make clear that we are a duty-to-patient-welfare profession regardless of whether that professional role occurs in clinical practice, administration, education, or any of the other areas affecting patient care.

Although there are many unanswered questions, we must follow with more intensity the steps we know and those identified by the students. First, we must familiarize students with the Code of Ethics for the Physical Therapist and the various state physical therapy practice acts early in the curriculum and incorporate these documents over the span of the program. For example, classes focused on developing skills and teaching techniques could incorporate ethical and legal vignettes into group discussions and labs. Ethics curricula can familiarize students with the professional ethical standards and use available resources to identify the practical dilemmas they are likely to see in daily clinical practice. Moral knowledge is embedded in the fabric of everyday physical therapy decision making and is a dimension of clinical expertise; therefore, blending ethical and legal practice into the curriculum would be highly beneficial following an introduction to ethical theory and problem solving.

Further, we can revise academic institution policies that do not give credit for partial clinical experiences when they are cut short because a student expresses the moral courage to respond to an illegal or unethical situation. We must also make sure that documentation is done in such a manner that future employers would not know of interruptions in the clinical experiences under these circumstances.

The clinical environment is also responsible for upholding ethical and legal standards. The coursework in ethics, laws, and regulations required in most states for license renewal may help clinicians stay current. But in addition to staying current, clinics need to create an environment in which students are able to discuss the perceived and actual breaches of ethical and legal standards with supervisors without fear of reprisal. Our suggestion for connecting the academic and clinical environments in the endeavor to properly educate students to recognize and act on violations of ethical and legal standards is for academic programs to administer an exam prior to clinical internships on ethical and legal standards for practice. Each student must pass this exam with a 100% accuracy to indicate they understand these requirements prior to beginning the clinical experience. The completed exam should be shared with the clinical site as proof of the student’s competence and as the program standard for student behaviors in these categories that programs expect the clinicians to support. The exam can be multiple-choice and administered online. At a minimum, the exam must cover information from the individual state practice act, the American Physical Therapy Association’s Code of Ethics for the Physical Therapist, and current information on the American Physical Therapy Association website concerning Medicare and Medicaid regulations, HIPAA, OSHA, and sexual harassment. Students should be given links to these documents and encouraged to form study groups to do a thorough review before the test where course sequencing does not expose them in depth to these requirements prior to the first clinical experience. This will create an additional opportunity for students to review and learn these requirements and by placing it immediately before clinical experiences may increase their ability to recognize these issues and dilemmas and act appropriately.

In addition, we must organize curricula so that students have adequate knowledge in both legal and ethical domains to conduct themselves in ways that are consistent with professional values. This may mean either delaying entry into the clinical setting or displacing some other content to a later position in the curriculum. But if we truly value ethical decision making and legal conduct, then we have to give it the same recognition and placement as any other foundational course.

In an effort to enhance moral courage, we should reward participation in class discussions of ethical dilemmas and professional responsibilities in abetting wrongdoing. This could occur in each class, as part of a professional development portfolio, or both. Academic institutional polices should be revised to mirror state licensure requirements that penalize providers who know of wrongdoing and fail to respond. In the state of California, failing to remediate, including reporting wrongdoing, is to be guilty of an offense similar to aiding and abetting or being a co-conspirator by silence. Supervisors are in most cases jointly guilty for transgressions of their subordinates under the doctrine that if they did not know of wrongdoing, they should have known as a part of the supervision responsibility.

Finally, local collaborations could be created between clinical instructors and academic faculty to develop a shared statement on how students in the profession should respond to suspected wrongdoing or questionable ethical conduct in the clinic. It is even possible that clinicians would challenge students to routinely engage in a discussion on perceived strengths and weaknesses of the institution’s compliance with legal and ethical standards within the department. This exchange could benefit both the facility and the student in their professional development.

This research uncovers more questions than it answers, not unlike most research. Future research should confirm levels of illegal or unethical behavior and barriers to taking action that students confront while in clinical affiliations throughout the US. With the inevitable emergence of needed cost-saving strategies, such as limited time per appointment and fewer visits, students may experience even more challenges than in the past. Academic strategies that enhance clinical behaviors that comply with accepted legal and ethical conduct should be shared across curricula. So far we have no sense for how clinical instructors view the ethical and legal knowledge of students under their supervision. We also do not know how they manage ethical and legal concerns within their own units. It is quite possible they are as hesitant to confront unethical or legal problems as our students.

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REFERENCES

Appendix 1. Survey Questions by Event Category

**Supervision (5)**
01. At your clinical site, have you ever witnessed a patient with Medicare being treated by unlicensed personnel (ie, PT aide)?
05. At your clinical site, have you witnessed a physical therapist utilizing clinical time for non-clinical or personal business?
07. At your clinical site, was there a time that you were unable to locate your supervising therapist while you were treating patients?
15. At your clinical site, have you ever treated a patient without a supervising physical therapist on site?
26. At your clinical site, have you ever witnessed or directed a physical therapy aide to apply traction on a patient with no supervision during the setup?

**Respect (4)**
04. At your clinical site, have you witnessed or participated in the failure to follow “Universal Precautions” or infection control guidelines with patient care?
06. At your clinical site, has your treatment or plan of care ever been influenced by stereotyping the patient?
31. At your clinical site, have you witnessed or participated in disrespectful communications regarding other healthcare professionals?
32. At your clinical site, have you been belittled or witnessed another student being belittled?

**Sexual Harassment (8)**
10. At your clinical site, have you witnessed or experienced a staff member or patient making crude sexual remarks?
11. At your clinical site, have you witnessed or experienced a staff member or patient telling sexually suggestive stories or offensive jokes?
14. At your clinical site, have you witnessed or experienced a staff member or patient intentionally staring at someone so that they felt uncomfortable?
16. At your clinical site, have you witnessed or experienced a staff member or patient give an inappropriate romantic/sexual gift?
18. At your clinical site, have you witnessed or experienced a staff member or patient touch someone else in an uncomfortable manner?
20. At your clinical site, have you witnessed or experienced a staff member or patient request intimate physical contact?
22. At your clinical site, have you witnessed or experienced a staff member or patient make attempts to draw someone into a conversation about their sexual affairs?
27. At your clinical site, have you witnessed or experienced a staff member or patient asking for a date?

**Blatant Wrong Doing (5)**
03. At your clinical site, have you ever witnessed or billed for a patient's treatment session that never took place?
12. At your clinical site, have you ever witnessed or participated in breaching patient confidentiality within the clinic or hospital setting?
17. At your clinical site, has the physical therapist ever co-signed a treatment that he or she did not supervise?
24. At your clinical site, have you ever witnessed or participated in breaching patient confidentiality outside the clinic in a social setting?
28. At your clinical site, have you witnessed or participated in the use of any drug or alcohol that compromises clinical judgment or job performance?

**Resources (7)**
02. At your clinical site, have you ever failed to advocate for a patient when additional treatment is required?
09. At your clinical site, have you ever witnessed, participated, or been encouraged to intentionally incorrectly bill an insurance company or payer?
13. At your clinical site, have you ever witnessed or participated in providing a treatment for an individual that has not demonstrated to be beneficial for their diagnosis?
19. At your clinical site, have you witnessed or participated in failing to discharge a patient when it was clinically appropriate?
21. At your clinical site, have you ever witnessed or been encouraged by a physical therapist to endorse equipment or products in which he/she had a personal financial interest?
23. At your clinical site, have you ever witnessed, participated, or been encouraged to bill for treatments using higher paying reimbursable codes than the service provided?
30. At your clinical site, have you ever witnessed or participated in documenting a billing code for which you spent insufficient amount of time?

**Truth Telling (4)**
08. At your clinical site, have you witnessed or participated in post-dating documentation in the medical record?
25. At your clinical site, have you witnessed or participated in using clinical resources or property for purposes that were not clinical or patient related?
29. At your clinical site, have you ever failed to report suspected child abuse?
33. At your clinical site, have you ever witnessed a physical therapist introducing themselves as “Doctor” without mentioning “of Physical Therapy?”
### Appendix 2. Sample Question

1. At your clinical site, have you ever witnessed a patient with Medicare being treated by unlicensed personnel (i.e. PT aide)?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

- Did you report the situation? **YES**
- NO

   If **YES** please go on to next question.

   If **NO**, why not?

   - Low position of hierarchy
   - Fear of not being a team player
   - Did not recognize as an issue
   - Personal consequences
   - Other (please specify below)

- What setting were you in?

   - Outpatient Hospital Based
   - Inpatient
   - Skilled Nursing Facility
   - Private Practice Outpatient
   - Other:_______________________

- How did the experience make you feel?

   - Felt like an accomplice
   - Felt bad or guilty
   - Re-thought personal ethical principles
   - Some personal ethical principles eroded or lost
   - Not pleased with personal ethical decision making
   - Other (please specify below)