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Physical Therapists as Consultants to Elder Law Attorneys and Clients

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Physical Therapists as Consultants to Elder Law Attorneys and Clients

Physical therapists can act as valuable consultants to attorneys practicing elder law and their clients. Here is an overview of this profession, including areas of practice, certification, ethics code, and information on contacting physical therapists.

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Physical therapists are primary healthcare professionals who may serve elder law attorneys and their clients in a wide range of consultative capacities. There are approximately 120,000 physical therapists in the United States[1] who are licensed, like physicians, pharmacists, and registered nurses, in all fifty states. Their principal domains of practice include clinical healthcare delivery to patients across the life spectrum; basic science and clinical research; education, health policy, and patient advocacy; and global consultative services. Physical therapists are aided by physical therapist assistants, who are licensed in many, but not all, states, and by other healthcare extenders, including exercise physiologists, rehabilitation aides, and others.

Physical therapist education is conducted exclusively at the post-baccalaureate level. While 169 of 196 accredited professional (entry-level) education programs are at the masters-degree level, the trend is toward entry-level professional doctoral education, similar to the Juris Doctorate. The emerging entry-level degree is the Doctor of Physical Therapy, or D.P.T., degree.

Physical therapist education program curricula are similar to those of medical schools, with substantial foundational science instruction (including human anatomy dissection), clinical course work, social sciences and humanities, including professional ethics and legal issues courses. Student physical therapists typically undertake one-half calendar year or more of clinical internships. Progressive curricula also include courses or material in differential diagnosis, pharmacology, and radiology.

The Federation of State Boards of Physical Therapy, a private association responsible for developing and administering the physical therapist licensure examination, has developed a Model

Practice Act, in which physical therapy is defined as:

1. Examining, evaluating, and testing individuals with mechanical, physiological, and developmental impairments, functional limitations, and disability or other health and movement-related conditions in order to determine a diagnosis, prognosis, plan of therapeutic intervention, and to assess the ongoing effects of intervention.
2. Alleviating impairments and functional limitations by designing, implementing, and modifying therapeutic interventions that include, but are not limited to, therapeutic exercise; functional training in self-care and in the home; community or work reintegration; manual therapy, including soft tissue and joint mobilization and manipulation; therapeutic massage; assistive and adaptive orthotic, prosthetic, protective, and supportive devices and equipment; airway-clearance techniques; debridement and wound care; physical agents or modalities; mechanical and electrotherapeutic modalities; and patient-related instruction.
3. Reducing the risk of injury, impairment, functional limitation, and disability, including the promotion and maintenance of fitness, health, and quality of life in all age populations.
4. Engaging in administration, consultation, education, and research.[2]

The five domains of physical therapy clinical practice, according to the definitive *Guide for Physical Therapist Practice, 2nd ed.* are patient/client:

- Examination (history-taking and physical examination),
- Evaluation (of pertinent clinical and historical findings),
- Diagnosis (by functional impairment vs. medical diagnosis),
- Prognosis, and
- Intervention (treatment, education, referral).[3]

As part of initial and ongoing patient/client care activities, clinical physical therapists also formulate goals or outcomes, which are the expected results of patient/client care. Prospective sections of the *Guide* are expected to delineate minimum data sets and recommended interventions for practice pattern diagnoses for the musculoskeletal, neuromuscular, cardiovascular, pulmonary, and integumentary body systems. These additions will make the *Guide* particularly useful to attorneys as a comprehensive and definitive set of clinical practice guidelines for physical therapy.

Physical therapists may apply for clinical specialization certification by the American Board of Physical Therapy Specialties in seven specialty areas, including cardiovascular and pulmonary, clinical electrophysiology, geriatrics, neurologic, orthopaedics, pediatrics, and sports physical therapy. Board-certified clinical specialists include the designator "C.S." (clinical specialist) with their other professional credentials.

Legal and Professional Ethical Standards

Physical therapists receive in-depth education about pertinent legal issues in virtually every entry-level education program in the United States.[4] In fact, comprehensive legal instruction is mandated as part of professional curricula by the Commission on Accreditation in Physical Therapy Education.[5]

The physical therapy profession has published exhaustive legal and ethical topic compendia.[6] The profession also has a well-developed Code of Ethics[7] (and is implementing a *Guide for Professional Conduct*[8]), which, along with the aforementioned Model Practice Act, forms the basis for many substantive provisions within individual state governing practice acts.

The informed consent provision within the physical therapy ethics code is perhaps the most comprehensive, concise, and expressly protective of patient/client rights of any of the healthcare disciplines. It reads:

> Physical therapists shall obtain informed consent before treatment, to include disclosure of: (i) the nature of the proposed intervention, (ii) material risks of harm or complications, (iii) reasonable alternatives to the proposed intervention, and (iv) goals of treatment.[9]

Case law involving physical therapy malpractice is also well developed. At least thirty-one reported cases involving alleged physical therapy malpractice appear in the legal literature since 1972.[10]

In addition to the practice-defining *Guide to Physical Therapist Practice*,[11] highly detailed patient/

client care documentation standards are promulgated for the profession in the *Guidelines for Physical Therapy Documentation*,[12] which may be used by counsel to establish the physical therapy standard of care in legal malpractice proceedings.

Physical Therapist Consultative Roles

Physical therapists serve a wide range of consultative roles in support of patients, clients, attorneys, and others. Many of these have been described in reported case law, while other roles have developed with new legislation and administrative regulations at state and federal levels.

Physical therapists can testify as percipient witnesses to clinical events that they observe and as expert witnesses on a variety of issues. As experts, physical therapists offer salient insight into patients' rehabilitative progress and potential, placement and care needs, as well as functional and work capacity. Physical therapists can also provide insight into the propriety of physical restraints,[13] decubitus ulcer amelioration[14] and general integumentary integrity, among a myriad of other practice areas and areas of expertise. These areas might include health records review,[15] identification of possible patient/client abuse,[16] ergonomic workplace evaluations, quality and risk-management assessments, and disabled patient/client advocacy (and/or industrial consultation[17]) pursuant to the Americans with Disabilities Act (ADA).[18]

Identification of, and communication with, appropriate potential physical therapist consultants may be obtained through the American Board of Physical Therapy Specialties' Directory of Clinical Specialists (800-999-2782, x8520, www.apta.org/education/specialist), among other professional association and commercial resources.

Endnotes

1. Interview with Sarah Miller, Department of Research, American Physical Therapy Association, Alexandria, VA (Apr. 17, 2001).
2. *See generally* MODEL PRACTICE ACT FOR PHYSICAL THERAPY, §2D1-4 (1997).
3. *See generally* GUIDE FOR PHYSICAL THERAPIST PRACTICE, SECOND ED., *reprinted in* 81 PHYSICAL THERAPY 9, (2001).
4. *See generally* Ron W. Scott, *Instruction on Healthcare Malpractice Issues in Entry-Level Physical Therapy Curricula,* 19 J. ALLIED HEALTH 211, (1990).
5. *See* COMM'N ON ACCREDITATION IN PHYSICAL THERAPY EDUC., Evaluative Criteria, Criterion 3.8.3.4, (1998).
6. *See generally* AM. PHYSICAL THERAPY ASS'N., Law & Liability, Parts I & II (1999); *see also* AM. PHYSICAL THERAPY ASS'N, Ethics in Physical Therapy, Parts I & II (1998).
7. *See generally* AM. PHYSICAL THERAPY ASS'N., Code of Ethics (2001).
8. *See generally* AM. PHYSICAL THERAPY ASS'N., Guide for Professional Conduct (2001).
9. *Id.*
10. *See* Ron W. Scott, *Physical Therapy Malpractice Update III*, 8 PT MAG. PHYSICAL THERAPY 50, (2000).
11. *Supra,* note 4.
12. *See generally* AM. PHYSICAL THERAPY ASS'N., Guidelines for Physical Therapy Documentation (2000).
13. *See* Julie A. Braun & Jane M. R. Mulcahy, *Nursing Home Litigation: An Overview*, 2 ELDER'S ADVISOR 1 (2000).
14. *See* Jeffrey M. Levine, *The Pressure Sore Case: A Medical Perspective*, 2 ELDER'S ADVISOR 44 (2000).
15. See Deborah D. D'Andrea, *The Role of the Legal Nurse Consultant in Gathering and Analyzing the Nursing Home Record,* 2 ELDER'S ADVISOR 32 (2000).
16. *See generally* AM. PHYSICAL THERAPY ASS'N., Guidelines to Physical Abuse Identification (1997).
17. *See* Ron W. Scott, *The ADA and You*, 12 CLINICAL MGMT. 18 (1992).
18. *See generally* Americans with Disabilities Act, 42 U.S.C. §§ 12101-12117.