CA Physical Therapy: Ethical Decisions (334)

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Course Summary

Ethical behaviors in the physical therapy setting are grounded in the principle of professional autonomy and demonstrated here through a case that presents a true ethical dilemma. Includes the RIPS decision-making model as a tool for resolving such situations.

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Course Objectives

When you finish this course you will be able to:

1. Explain what is unique about healthcare ethics.
2. Describe the relationship of professionalism and ethics.
3. Name the six principles that undergird the language of bioethics.
4. Describe the concepts of moral threshold and moral potency.
5. Differentiate between ethics and the law.
6. Explain how to apply an ethical decision-making model in a clinical situation.

Healthcare Ethics

Reports of ethics violations in government, industry, and the financial world have captured the attention of the public in recent times. The omnipresent nature of today's news media contributes to the revelation of misdoings in a way never seen before. In every sector of the economy, ethical violations make news. In medicine, the topic of ethics evolved slowly from the 2500-year-old Oath of Hippocrates over many centuries to the biomedical ethics of today (Sugarman, 2000; Edelstein, 1967). The body of knowledge around ethical theory is evolving rapidly now, fed by challenges that the healthcare delivery system places on practitioners as well as significant changes in healthcare that present new challenges for providers (eg, the use of digital healthcare data) (Aicardi, 2016; Means, 2015; Pasztor, 2015; Wells, 2015).

Healthcare has always demanded impeccable behavior from its practitioners, and currently there is increased awareness when ethical breeches occur, as well as renewed expectation of a high level of ethical behavior (Tenery, 2016). Physical therapists often find themselves faced with the need for ethical decision-making. Because it is not possible to behave ethically without a thorough understanding of the standards of practice for one's own healthcare field, this course spells out the guidelines for making good ethical decisions in physical therapy (Marques, 2012; Quigley, 2015).

Professionalism

Healthcare providers recognize they have a special relationship with their patients that is based on trust; indeed, trust is one of the pillars of the professionalism on which the healthcare relationship rests. When patients have an injury or disability, their increased vulnerability creates special challenges within the general population and within the healthcare system.

All physical therapy providers are faced with the challenges of a swiftly changing medical environment that includes redefining of roles, advances in education, and increases in the scope and nature of practice—factors that challenge professional behaviors and demand ethical decision-making skills. Yet, even though physical therapists understand the need to make ethics-based clinical decisions, they may have had no training for doing so. Education and training to manage ethical decision-making should always be integral to clinical preparation (Miles, 2016; Brody, 2014; Murrell, 2014).

Physical therapists (PTs) are generally independent professionals delivering services directly to patients. In addition, PTs are increasingly completing clinical doctorates; all the CAPTE-accredited schools require that Doctor of Physical Therapy be the entry-level degree (CAPTE, 2016). This raises public expectations of the level of practice. The public's demand for transparency and the growing visibility of other healthcare providers have increased the pressure on allied health providers and other non-physicians to be more accountable for their actions.

Pellegrino (1999) refers to physical therapy as a "relatively new" profession, one in which "ethical maturity has not yet completely evolved." That statement of almost twenty years ago is in some respects still true as PTs struggle with ethical decision-making in many clinical situations (Hightower, 2012).

Dove (1995) speaks of the loss of trust the public has in professionals in the helping fields and how the loss of trust can be prevented with appropriate education in professional ethics (Sokol, 2015; Sutherland-Smith, 2011). This requires that knowledge of ethical behavior by clinicians be disseminated to the public to help maintain and, if necessary, restore trust. It is critical that this begins in the entry-level education program, where breeches of ethical behavior should not be tolerated (deOliveira, 2015; Rawson, 2013; Nijhof, 2012; Pantic, 2012).

Scott (1998) reasoned that loyalty to the patient can be very difficult to reconcile with the organizational priorities and financial pressures associated with care today. In addition, it should be noted that physical therapists have a **fiduciary** (financial) obligation toward their patients.

Physical therapists and physical therapist assistants are today confronted with ethical situations in which it has become increasingly difficult to deliver care effectively. For example, in a 2003 study of more than 450 practicing physical therapists, 64% of the respondents felt that the number of ethical issues confronting PTs in the past ten years had increased, and 97% felt they either stayed the same or increased. Less than 2% of the respondent's felt the number of issues decreased (see table) (Kirsch, 2003). These findings are consistent with those in other health fields (Kaldjian, 2013; Hightower, 2012).

Change in Number of Ethical Issues Facing Physical Therapists (2003 Study)		
	Frequency	Percent
No response	3	0.70
Decreased	8	1.80
Increased	291	64.20
Same	151	33.30

Source: Kirsch, 2003.

The responsibility of a profession to manage its own ethical "house" was identified more than thirty years ago. Andrew Guccione (1980) stated: "The need to identify and clarify ethical issues within physical therapy increases as the profession assumes responsibility for those areas of direct care in its domain."

Susan Sisola (2013) further identified the responsibility of practitioners, stating: "The privilege and influence that accompany professional practice obligate healthcare providers to look beyond literal or superficial interpretations of their ethical code, and to consider the complexities of the ethical issues evident in the current practice environment" (Knapp, 2013; Avey, 2009; Avolio, 2009; Hannah, 2008; Sisola, 2003).

Healthcare ethics are unique. Often patients cannot choose who they want as a healthcare provider. They are vulnerable to variations in care and to potential exploitation, and the result of poor behavior on the part of the practitioner can have dire consequences (Caldicott, 2014; Mansbach, 2012; Hren, 2011, Barnett, 2005,).

The Language of Bioethics

The language of biomedical ethics is applied across all practice settings, and four basic principles are commonly accepted by bioethicists. These principles include (1) autonomy, (2) beneficence, (3) nonmaleficence, and (4) justice. In physical therapy, and other health fields, veracity and fidelity are also spoken of as ethical principals but they are not part of the foundational ethical principles identified by bioethicists.

The Principle of Autonomy

Autonomy is an American value. We espouse great respect for individual rights and equate freedom with autonomy. Our system of law supports autonomy and, as a corollary, upholds the right of individuals to make decisions about their own healthcare.

Respect for autonomy requires that patients be told the truth about their condition and informed about the risk and benefits of treatment. Under the law, they are permitted to refuse treatment even if the best and most reliable information indicates that treatment would be beneficial, unless their action may have a negative impact on the well-being of another individual. These conflicts set the stage for ethical dilemmas.

The concept of autonomy has evolved, from paternalistic physicians who held ethical decision-making authority, to patients empowered to participate in making decisions about their own care, to patients heavily armed with Internet resources who seek to prevail in any decision-making. This transition of authority has been slower to evolve in the geriatric population but, as the baby boomers age they will assert this evolving standard of independence. Autonomy, however, does not negate responsibility. Healthcare is at its foundation a partnership between the provider and the recipient of care. Each owes the other responsibility and respect (Veatch, 2016).

The Principle of Beneficence

The beneficent practitioner provides care that is in the best interest of the patient. **Beneficence** is the act of being kind. The actions of the healthcare provider are designed to bring about a positive good. Beneficence always raises the question of subjective and objective determinations of benefit versus harm. A beneficent decision can only be objective if the same decision was made regardless of who was making it.

Traditionally the ethical decision making process and the ultimate decision were the purview of the physician. This is no longer the case; the patient and other healthcare providers, according to their specific expertise, are central to the decision-making process (Valente, 2000). For example, physical and occupational therapists have expertise in quality-of-life issues, and in this capacity can offer much to the discussions of lifestyle and life-challenging choices, particularly when dealing with terminal diseases and end-of-life dilemmas (Leeuwenburgh-Pronk, 2015).

The Principle of Nonmaleficence

Nonmaleficence means doing no harm. Providers must ask themselves whether their actions may harm the patient either by omission or commission. The guiding principle of *primum non nocere,* "first of all, do no harm," is based in the Hippocratic Oath. Actions or practices of a healthcare provider are "right" as long as they are in the interest of the patient and avoid negative consequences.

Patients with terminal illnesses are often concerned that technology will maintain their life beyond their wishes; thus, healthcare providers are challenged to improve care during this end stage of life. Patients may even choose to hasten death if options are available (Phipps et al., 2003). The right of the individual to choose to "die with dignity" is the ultimate manifestation of autonomy, but it is difficult for healthcare providers to accept death when there may still be viable options. Here we see the principle of nonmaleficence conflicting with the principle of autonomy as the healthcare providers desire to be beneficent or, at the least, cause no harm. The active choice to hasten death versus the seemingly passive choice of allowing death to occur requires that we provide patients with all the information necessary to make an informed choice about courses of action available to them.

A complicating factor in end-of-life decisions is patients' concern that, even if they make their wishes clear (eg, through an advance directive), their family members or surrogates will not be able to carry out their desires and permit death to occur (Phipps et al., 2003). Treating against the wishes of the patient can potentially result in mental anguish and subsequent harm.

The Principle of Justice

Justice speaks to equity and fairness in treatment. Hippocrates related ethical principles to the individual relationship between the physician and the patient. Ethical theory today must extend beyond individuals to the institutional and societal realms (Gabard & Martin, 2003).

Justice may be seen as having two types: distributive and comparative. **Distributive justice** addresses the degree to which healthcare services are distributed equitably throughout society. Within the logic of distributive justice, we should treat similar cases similarly—but how can we determine if cases are indeed similar? Beauchamp and Childress (2001) identify six material principles that must be considered, while recognizing that there is little likelihood all six principles could be satisfied at the same time (see box).

Looking at the principles of justice as they relate to the delivery of care, it is apparent that they do conflict in many circumstances; for example, a real-life system that attempts to provide an equal share to each person is distributing resources that are not without limit. When good patient care demands more than the system has allocated, there may be a need for adjustments within the marketplace.

Principles of Justice

- To each person an equal share
- To each person according to need
- To each person according to effort
- To each person according to contribution
- To each person according to merit
- To each person according to free market exchanges

Comparative justice determines how healthcare is delivered at the individual level. It looks at disparate treatment of patients on the basis of age, disability, gender, race, ethnicity, and religion. Of particular interest currently are the disparities that occur because of age. In 1975, Singer related bias as a result of age to gender and race discrimination and referred to the practice as **ageism** (Gabard & Martin, 2003). In a society where equal access to healthcare does not exist, there is a continuing concern about the distribution of resources, particularly as the population ages and the demand for services increases.

Finally, the variations in healthcare tend toward greater spending on seniors in selected years between 1987 and 2004; although this is no surprise, it is important to note that the relative gap in spending between children, working adults, and seniors has not changed. The only exception is those age 85 and older because the number of individuals in that cohort continues to increase (Hartman et al., 2008). Equitable allocation of resources is an ever-increasing challenge as technology improves and lives are extended through natural and mechanical means.

Political trends and changes also impact the principle of justice in healthcare decisions. Democratic President Barack Obama introduced the first government sanctioned healthcare aimed at covering all Americans (PPACA, 2010). Republicans have tried for years to undo that legislation, and may succeed in doing so under President Donald Trump.

All of these factors place greater stress on an already inefficient and overburdened healthcare system and results in more difficult ethical decisions about workforce allocation and equitable distribution of financial resources.

The Principle of Veracity

Veracity (truthfulness) is not a foundational bioethical principle and is granted just a passing mention in most ethics texts. It is at its core an element of respect for persons (Gabard, 2003). Veracity is antithetical to the concept of medical paternalism, which assumes patients need to know only what their physicians choose to reveal. Obviously there has been a dramatic change in attitudes toward veracity because it forms the basis for the autonomy expected by patients today. Informed consent, for example, is the ability to exercise autonomy with knowledge.

Decisions about withholding information involve a conflict between veracity and deception. There are times when the legal system and professional ethics agree that deception is legitimate and legal. **Therapeutic privilege** is invoked when the healthcare team makes the decision to withhold information believed to be detrimental to the patient. Such privilege is by its nature subject to challenge.

The Principle of Fidelity

Fidelity is loyalty. It speaks to the special relationship developed between patients and their physical therapists. Each owes the other loyalty; although the greater burden is on the medical provider, increasingly the patient must assume some of the responsibility (Beauchamp & Childress, 2001). Fidelity often results in a dilemma, because a commitment made to a patient may not result in the best outcome for that patient (Veatch, 2016). At the root of fidelity is the importance of keeping a promise, or being true to your word. Individuals see this differently. Some are able to justify the importance of the promise at almost any cost, and others are able to set aside the promise if an action could be detrimental to the patient.

The Moral Threshold and Moral Potency

Professional ethics are incumbent only on those individuals who occupy a professional role. Beyond that, each of us has a **moral threshold**, a bar below which we will not compromise. To compromise below your moral threshold is to compromise your personal integrity (Janoff-Bulman, 2009).

A national study conducted in 2007 found that 77% of the participants either agreed or strongly agreed that there was a lack of confidence in America's leaders (Rosenthal, 2007). The corporate scandals of the past decade and the response to them are relevant to the non-for-profit healthcare environment as well (Xu & Ma, 2016, Welsh & Ordonez, 2014). Hannah and Avolio (2010) proposed that there is a key element missing from ethical leadership, which they refer to as *moral potency*. The basis of their work stems from the question: Why do leaders who know what the right ethical decision is fail to take action, even when action is clearly necessary? (Schaubroeck, 2010).

Ethical behavior is not as strongly influenced by judgment as it is by *acting on* a moral judgment. Hannah, Avolio, and May (2011) define **moral potency** as "the capacity to generate responsibility, and motivation to take moral action in the face of adversity and to persevere through challenges."

Moral potency is built on (1) **moral ownership,** a sense of responsibility to take ethical action when faced with ethical issues; (2) **moral efficacy,** the beliefs of individuals that they can organize and mobilize to carry out an ethical action; and (3) **moral courage,** the courage to face threats and overcome fears to act. (Hannah, Avolio, & Walumbwa, 2011; Hannah et al., 2009; Goud, 2005).

The Relationship of Ethics and the Law

There is an ongoing debate about the relationship of ethics and the law. In 1958 the *Harvard Law Review* published the famous Hart Fuller Debate, which addressed the relationship of law and ethics (Harvard Law Review, 1958). Hart stated morality and law are separate, and Fuller opined that morality is the source of laws' binding power. Ethics and law both address similar issues (see box).

It has been said that the relationship of ethics and law considers that conscience is the guardian in the individual (ethics) for the rules which the community has evolved for its own preservation (law). There are limits to the law. The law cannot make people honest, caring, or fair. For example lying, or betraying a confidence, is not illegal but it is unethical. While not every physical therapy practice act requires adherence to a code of ethics, all do require adherence to the law.

Issues Addressed by Both Ethics and Law

- Access to medical care
- Informed consent
- Confidentiality
- Exceptions to confidentiality
- Mandatory reporting
- Privileged communication with healthcare providers
- Advance directives
- Abortion
- Physician-assisted suicide

Applying Ethics to Clinical Practice

The bioethical principles presented in Module 3 establish the framework for ethical decision making and undergird the case study in the next section. A grasp of the basic principles provides the template for sound decision making. The way in which clinicians actually arrive at ethical decisions continues to be studied and refined. Clearly ethical and *clinical* decision making models must overlap significantly to derive a satisfactory outcome (Dale, 2016; Drumwright, 2015; Kearney & Penque, 2012; Sujdak & Birgitta, 2016).

The Ethical Decision Making Process

Ethical decision making is a challenge to physical therapy professionals, who face both an increase in the number of issues and situations that are increasingly complicated. Ethical decision making skills can be enhanced by your studying cases and developing a strategy for facing ethical issues. Practitioners don't always have complete control over the situations that confront them. When the welfare of the patient is compromised, the healthcare provider is challenged to manage the situation in the patient's best interest (Airth-Kindree & Kirkhorn, 2016; O'Fallan & Butterfield, 2005; Osswald, 2009; Rate, 2007).

Making decisions is part of everyday living, whether it is deciding to turn off the stove or how to find your way to work. For the most part, these decisions are part of an automatic, and therefore unconscious, process. But there are other decisions, particularly those related to professional practice, that are not automatic. We are often confronted with two equally appropriate choices. Kidder calls this a **right vs. right dilemma.** When evaluating the alternatives, both courses of action have positive and negative elements. Right vs. right is an ethical dilemma, whereas right vs. wrong is identified as a moral temptation (the individual knows the right thing to do, but chooses the action that is wrong) (Kidder, 1996).

All healthcare providers struggle to establish ethical decision making standards that provide guidance in a challenging practice environment, and the challenge is not unique to physical therapists. One threat to ethical practice arises from *within* each profession as a result of materialistic self-interest and from the *outside* in terms of profit motivation. Another kind of challenge to ethics comes as the result of scientific advances such as mapping of the human genome, which made possible some procedures that raise ethical issues as to whether certain things should be done just because they are possible (eg, cloning animals—or people).

A wealth of literature exists on the subject of ethical decision making. A search of this literature reveals that professionals are inconsistent in ethical decision making (Smith, 1991; Tymchuk et al., 1982). The literature speaks of the "science" of decision making but cautions that human limitations result in the inconsistencies that professionals acknowledge in their decision making skills.

Decision making is described by Brecke and Garcia (1995) as a course of action that ends uncertainty. The theory they developed requires that the uncertainty associated with the decision must be brought to a level where the decision can be made with confidence. They also place considerable importance on the time that it takes to make a decision. The time line for decision making can range from a few seconds to several years.

Brecke and Garcia (1995) developed a decision making process that consisted of four points related to a decision making time line. Decisions are made at different points on the time line, but at any point where action is not taken the decision will ultimately be made by default. Initially, practitioners recognize that there is an opportunity to make a decision. The nature of the decision becomes clearer, and they determine what they will do and then commit to a course of action.

The final point on this continuum is the default point where no intervention on the part of the practitioner will result in a course of action on which they had limited or no input (Brecke & Garcia, 1995). Choosing the default option, or, stated more appropriately, permitting the default option to occur, can be potentially harmful to patients because failure to make a decision carries its own set of ethical concerns. Healthcare providers have a responsibility to protect their patients from harm, and failure to make a decision may place the patient in a potentially harmful situation.

Ethical decision making is the level that is expected and demanded of professionals. Pellegrino (1993) identifies ethical decision making as the integration of ethical principles with practical wisdom, enabling healthcare providers to make ethical choices. Healthcare providers have specific standards and codes that guide practice; these are in the form of codes of ethics and professional practice standards (Newkrug, 1996). Codes of ethics are generally broadly written. They help to identify issues, but they are not meant to serve as a methodology for ethical decision making. To recognize an action and carry out that action requires both knowledge and skill in the art of ethical decision making.

Patients have the right to expect that their healthcare providers are involving themselves in thoughtful deliberation of ethical issues, with a commitment to take reasonable and rational action. These steps warrant the trust of the patient and society. Unethical, self-serving behaviors result in a loss of trust by patients and their families. According to Dove (1995), the loss of trust could be prevented with training programs that include the application of professional ethics to actual situations.

End-of-life issues, caregiver challenges, and right-to-choose plans of care often become intertwined with ethical issues, and the medical team, patients, and families find that they are confronted by complex ethical decisions. This is made more challenging when the issues involve one or more generations, who may have the same interests at heart but prefer different expressions of those interests.

The Ethical Decision Making Model

There are many models for ethical decision making that help to organize the thoughts of the individual. Some are quite simplistic. The tilt factor model looks at the choices confronting the individual, with pros and cons defined and with the factors that would change the decision indicated as "tilt factors." This simple model does not truly guide the practitioners' actions but it does help to frame the question.

Among the many models available is one offered by Kornblau and Starling (2000). This template provides the practitioner with guidance for collecting information about the problem, the facts of the situation, the identification of interested parties, and the nature of their interest: is it professional, personal, business, economic, intellectual, or societal? The practitioner is then encouraged to determine if an ethical question is involved and if there is a violation of the code of ethics of the profession, or if there is a potential affront to personal moral, social, or religious values. This model also demands that any potential legal issue such as malpractice, or a practice-act infringement, be identified. The practitioner is encouraged to gather more information if it is needed to make an appropriate decision. This is the point where the healthcare provider is encouraged to brainstorm potential actions and then analyze the course of the chosen action.

Another method of ethical decision making that is becoming increasingly popular with physical therapists is the Realm, Individual Process, Situation (RIPS) model (Swisher, 2005). The steps of the RIPS model bring forward many of the aspects of a problem confronting the interdisciplinary team. This method essentially involves four steps (Nordrum, 2009). To better illustrate the ethical decision making process, we will work through a case that involves issues of utilization. You will see that the three primary components of the RIPS model are implemented in the case.

Too Much of a Good Thing

[This case is adapted from Kirsch, 2009.]

Mr. Markham is 82 years old and he has been in relatively good health. He does have high blood pressure, and eight years ago he had bypass surgery. He lives with his 79-year-old wife in the two-story home they have owned for more than forty years. He is retired from an executive position at a large manufacturing company. His primary insurance is Medicare.

Two weeks ago he awakened disoriented in the middle of the night and fell as he tried to get out of bed to use the bathroom. His wife called 911 and he was taken to the hospital, where it was determined he had sustained a right CVA with a resulting left hemiplegia. His course in the hospital was complicated by an unexplained fever. When he had been fever-free for 48 hours it was determined that he could be discharged to a subacute facility to begin rehabilitation.

Mr. Markham looks forward to starting rehab but is very tired and finds it difficult to tolerate the 30 minutes of therapy he is receiving in the hospital. He has only been out of bed for 20 minutes at a time and was exhausted afterward. He and his family are assured by staff that he will continue to get stronger each day.

At the subacute facility he is evaluated by physical therapy (PT), occupational therapy (OT), and speech therapy. He is found to have no speech deficits and no cognitive deficits other than mild confusion, which is steadily clearing. His entire program will thus consist of physical therapy and occupational therapy. Following evaluation he is placed on Tim's caseload for PT and Casey's caseload for OT.

Mr. Markham is assigned a very high level RUG rehab (Resource Utilization Group, under Medicare Part A) and Tim and Casey plan his program around the required 500 minutes of therapy in seven days required for this RUG level. He is to receive over an hour of service per day, seven days a week.

The first day Tim sees Mr. Markham, the patient is begging to return to his room after 15 minutes. His blood pressure has dropped and he had tachycardia. He is diaphoretic and becoming increasingly lethargic. Tim returns Mr. Markham to his room, recognizing that he will have to make up the time in the afternoon. Casey sees Mr. Markham after lunch and, though he wants to cooperate, Mr. Markham cannot do more than 20 minutes before he is having difficulty keeping his head up.

When Tim arrives to take Mr. Markham to PT in the afternoon he finds him asleep and difficult to rouse. Tim and Casey confer at the end of the day and find that between them they saw Mr. Markham for 35 minutes. They report the situation to the rehab supervisor, who reminds them of the importance of achieving the full 500 minutes and tells them to be sure to include the missed time over the rest of the week. He reminds them that if Mr. Markham cannot participate in therapy he may have to be discharged from the subacute facility to a nursing home.

Tim and Casey wonder if Mr. Markham should be at the assigned RUG level, the second highest level of therapy. They are concerned that, if they push him to achieve the level in which he has been placed, they could compromise his fragile medical condition. On the other hand, if he cannot do the program they have designed for him and he is sent to a nursing home, there is little chance of his doing well enough to ever return home. Tim and Casey are very uncomfortable with the situation in which they find themselves.

The following day they rearrange their schedules, switching a few patients to afford Mr. Markham more advantageous times of the day. He does a bit better but still cannot achieve even 45 minutes of combined time. Tim and Casey approach their supervisor again and ask for a decrease in the RUG level for Mr. Markham. Once again they are told to make it work. The lower rehab category does not have sufficient time to justify a subacute stay for this patient.

From experience Tim and Casey recognize that "make it work" means they need to provide the minutes of treatment but they cannot rationalize placing this patient at risk to meet the minutes. They believe their supervisors do not share their concern and feel that their professional values could easily be compromised as they balance their desire to act with nonmaleficence (not harming the patient) while maintaining veracity (being truthful regarding the treatment rendered).

Applying a Modified RIPS Model to the Case

Through "Tim" and "Casey" we will work through this situation using a multi-faceted ethical decision making model that combines the work of Kornblau and Starling (2000) and Kidder (1996), and the RIPS model developed by Swisher and colleagues (2005). The following template, developed by John Nordrum (2009), helps to establish a logical sequence for integrating the RIPS model with the work of Kornblau, Starling, and Kidder.

Template for Ethical Decision Making Using the RIPS Model

Step 1: Recognize and define the ethical issues	Realm	Individual process	Situation
	Individual	Moral sensitivity	Issue or problem
	Organizational/ institutional	Moral judgment	Dilemma
		Moral motivation	Distress
	Societal	Moral courage	Temptation
		Moral failure	Silence

Step 2: Reflect

1. What are the relevant facts and contextual information?
2. Who are the major stakeholders?
3. What are the possible consequences (intended and unintended)?
4. What are the relevant laws, duties, obligations, and ethical principles?
5. What professional resources speak to this situation?
6. Are any of the five tests for right vs. wrong situation-positive (legal test, stench test, front-page test, Mom test, professional ethics test)?

Step 3: Decide the right thing to do

Approaches to resolve the issue:
Rule-based: follow the rules, duties, obligations, or ethical principles already in place
Ends-based: determine the consequences or outcomes of alternative actions and the good or harm that will result for all of the stakeholders
Care-based: resolve dilemmas according relationships and concern for others

Step 4: Implement, evaluate, reassess

- What did you as a professional learn from this situation?
- What are your strengths and weaknesses in terms of the four individual processes?
- Is there a need to plan professional activities to grow in moral sensitivity, judgment, motivation, or courage?

Source: Nordrum, 2009.

Step 1: Recognize and Define the Ethical Issue

Realm

Into which realm does this case fall—individual, organizational/ institutional, or societal?

This situation falls into the institutional realm. The care of the patient is being dictated by institutional policy. There is also a societal component here, because of the policies dictated by a third-party payer (Medicare), care is determined largely on payment parameters; but a professional must weigh treatment outcomes vs. treatment options. In this case it appears that reimbursement is driving practice, not practice driving reimbursement.

Individual Process

What does the situation require of Tim and Casey? What individual process is most appropriate? There are four components to the individual process. To manage an ethical issue all four components of the process must come into play at some point, although there is no particular order in which the components are handled. The four components are defined as follows.

Moral sensitivity. This involves recognizing that there is an issue and being aware of its impact. Tim and Casey recognize that this is an ethical issue. They cannot rationalize treating Mr. Markham at a level that he cannot tolerate; not only will it not be beneficial but it also has a high probability of being detrimental to him.

Moral judgment. The individual considers possible actions and what the effect will be on all parties. Tim and Casey recognize that, while they are right to insist that their patient not be forced into therapy he cannot tolerate, if Mr. Markham cannot participate fully in the program at the level it has been set, he risks being discharged to a lower level of care or to home without the benefit of the rehab program he needs. Tim and Casey are torn because they believe that Mr. Markham just needs some time to build up his endurance, but they cannot document treatment not rendered. Will their honesty result in his loss of services?

Moral motivation. This is the force that compels the individual to consider possible courses of action. Casey and Tim are not willing to compromise their integrity or their loyalty to their patient. They want him to get the services to which he is entitled but they also want to protect him. Their supervisors appear to see only the financial ramifications of Mr. Markham’s lack of treatment. Tim and Casey are faced with falsifying minutes to protect his treatment program, treating him at a level that he cannot tolerate, or risking early discharge by treating him to his tolerance and documenting appropriately. While they support each other in their ethical decision making, they do not feel they are getting much support from their superiors.

Moral courage. This is a measure of ego strength, the strength to take action to correct a wrong. It is interchangeable with moral character. Tim and Casey feel strongly that Mr. Markham should be given a lower RUG level—realistically, a rehab high-level—until he can tolerate more therapy. Administration does not support this view but Tim and Casey are very emphatic. They cite the literature supporting this more moderate approach and attempt to get their supervisor to understand their discomfort with the treatment protocol. The treatment plan put in place by administration compromises the autonomy to which they are obligated by the practice acts for each of their disciplines.

Moral failure. This is deficiency in any of the four components, the failure to recognize that an issue exists, the inability to plan a course of action, the lack of motivation to take action, and the inability to follow through on the action. The supervisors and administration in the facility are subject to moral failure with deficiencies in multiple areas.

Moral Potency. This is the element that, when absent, results in action not being taken. As a relative newcomer, moral potency is a concept we have to grow into (Schaubroeck et al., 2010).

Situation

What type of an ethical situation is this: a problem, a distress, a dilemma, a temptation, or a silence?

An ethical problem. The practitioner is confronted with challenges or threats to their own moral duties and values. This results in a need to reflect on a course of action.

An ethical distress. The focus is on the practitioner. The practitioner knows what action should be taken but there is a barrier in the way of doing what is right. The individuals experience some discomfort because they are prevented from being the kinds of persons they want to be or doing what they know is right.

An ethical dilemma. This type of problem involves two or more morally correct courses of action where only one can be followed. In choosing one course of action over another the practitioner is doing something right and wrong at the same time.

An ethical temptation. This involves two or more courses of action, one that is morally correct and one that is morally incorrect but, for reasons determined by the practitioner, they consciously choose the incorrect course of action.

Silence. The practitioner chooses to ignore the problem, and takes no action**.**

So, from the above we see that Tim and Casey are faced with an ethical distress. They know the correct action they wish to take but they are unable to take that action because of institutional constraints.

Step 2: Reflect

This is the opportunity to gather the additional information necessary to make a decision.

What else do we need to know about the situation, the patient, and the family? Who are the stakeholders in addition to Mr. Markham, the patient, and the healthcare practitioners, Tim and Casey. The following people are also stakeholders, or potential stakeholders:

- The patient's wife
- The institution, and the supervisor
- Other healthcare providers
- The insurance company
- The licensing board charged with protecting the public
- The professional association and its code of ethics

What are the consequences of action?

Determining a plan of care is based on the assessment of the patient and available resources for treatment. In this situation, the assessment indicates the need for care and the resources are available to the patient but the rehab professionals have their plan of care dictated by the institution/third-party reimbursement. The professionals find the care to be unreasonable and potentially harmful; however, if they refuse to carry out the care as it is proposed, they may endanger the patient's access to care in their facility.

What are the consequences of inaction?

The members of the rehab team understand that failure to question the plan of care and, instead, attempting to impose the RUG parameters on this patient may place the patient in danger. Mr. Markham is not medically stable enough to manage care at the level they are being forced to deliver it. In many cases this is a time-sensitive issue because the patient may be able in the future to benefit from the care, but the current level of recovery is insufficient to tolerate it. Rehabilitation professionals often find themselves caught between what they have determined is appropriate for the patient and external pressures regarding the delivery of care.

The last step of the reflection phase is associated with a proposal by Rushworth Kidder in *How Good People Make Tough Choices* (Kidder, 1996). Kidder initially proposed a four-standard test. Later, a fifth standard was added because the **Kidder Test** was being applied to professional ethics. A code of ethics/professional guidance check was incorporated into the test.

Kidder Test Adapted to Mr. Markham

1. The Legal Test

- Are any laws potentially broken?
- What does the state practice act say about providing inappropriate care?
- What does the practice act demand of licensed professionals as to their autonomy and their individual responsibility to make decisions that are not dictated or controlled by other sources?
- Does the potential exist that the rehab professionals are culpable if they cannot achieve the minutes required, and the care is being billed at the RUG level?
- How close do they come to billing in a potentially fraudulent manner?

2. The Stench Test

Does the situation feel right or does it stink? The uncomfortable feeling of a professional when integrity is challenged produces a positive response to the stench test. The individual knows that "it stinks." In good conscious, professionals cannot pretend the situation does not exist or is beyond their control.

3. The Front Page Test

Is the potential publicity something you would not like to have on the front page? Healthcare providers generally take pride in the work they do. Positive publicity is welcomed by most professionals, but negative publicity reflects badly on all practitioners and is poorly received by the healthcare community. Negative publicity does considerable harm because it diminishes the public trust. Imagine the headline in our case: "Patient welfare compromised in a revenue enhancement scheme."

4. The Mom Test

The Kidder Test looks at the background of the individual, recognizing that much of our ethical decision making has strong foundations in our upbringing, reflecting the value system of those who influenced us along the way. Kidder calls this the "mom" test, but it is broader than the values instilled by your mother. It incorporates not just parental guidance but also those mentors, teachers, and colleagues who have influenced your values as a professional. The mom test integrates personal integrity with the professional values that every healthcare professional brings to the situation.

If the action you are contemplating would not be acceptable to those who helped you develop your value system, you must consider other actions more consistent with the values that you hold to be important. If this requires a change in behavior, then you are faced with an ethical challenge to develop a course of action that is different and would be acceptable. In this case, continuing to treat this patient despite Tim's and Casey's concerns about Mr. Markham's well-being would not pass the mom test.

5. The Professional Values Test

This is the element that was added to the Kidder test, which was originally devised for society in general and not for professionals. What guidance do we get from professional standards? The physical therapist involved with the care of this patient has access to guidance from the APTA Code of Ethics (2010). Codes and other professional documents help individuals determine what their responsibility is to the patient. The APTA Code of Ethics and Standards of Ethical Conduct for the Physical Therapist Assistant were completely revised effective July 1, 2010.

Consider the following guidance from the Code of Ethics:

- **3A**. Physical therapists shall demonstrate independent and objective professional judgment in the patient/client's best interest in all practice settings.
- **7A**. Physical therapists shall promote practice environments that support autonomous and accountable professional judgments.

The case made by the therapists on behalf of the patient contained current evidence and was substantiated by the literature. This is consistent with Principle **3B**: Physical therapists shall demonstrate professional judgment informed by professional standards, evidenced by practitioner experience and patient/client values (including current literature and established best practice) (APTA, 2010).

If the situation does not pass the Kidder test, there is no need to go any further. The only question remaining is whether the healthcare professional has the moral courage to follow through and take appropriate action. Action in this case must be taken in order to preserve professional integrity (Kirsch, 2006). For Tim and Casey, taking action to place their patient's needs above those of the institution is more consistent with their professional values.

Step 3: Decide the Right Thing to Do

Step 3 presumes that all the factual material has been investigated and the individual is now ready to make a decision. The adaptation of Kidder tests the factual information against the five standards of law: legal, stench, front page, parent/mentor, and professional guidance.

If any of the Kidder tests are positive, action must be taken. Even if the situation passes the Kidder Test there may still be an ethical issue to consider. At that point the information you have gathered must be considered in view of three classical approaches to ethical decision making: rule-based, ends-based, or care-based.

Rule-Based Approach

People who take the rule-based approach follow that which they think everybody else should follow. These are the rules, duties, and obligations already in place (Gabard, 2003). The procedures, techniques, and methods are what would be considered the "standard of care." It is not hard to conceive of an approach that would apply selected parameters to care rendered and clearly define certain limits. In addition, objective measurements are available to provide guidance about the ethical dilemma of overtreating a medically fragile patient in order to qualify for care from which he cannot yet benefit. Standardized assessments—such as those for blood pressure, heart rate, oxygen absorption, reaction to exercise—provide objective measurements that are easily applied and interpreted.

Applying a rules-based approach to our patient situation would ensure that care not be rendered to the patient if he could not tolerate it. Note that this approach does not protect the patient against the situation where care is no longer available because he cannot meet the standard.

Ends-Based Approach

Those using the ends-based approach do whatever produces the greatest good for the most people. The analysis of the action and the resulting outcomes looks at the good and harm for all of the stakeholders, not just the patient (Sugarman, 2000). An ends-based approach looks more at the general good of society and less at the individual's needs. This would be the least likely application in our case.

Care-Based Approach

Those using the care-based approach follow the Golden Rule ("Do unto others as you would have them do unto you") (Gabard, 2003). Situations are resolved according to relationships and concern for others. It is difficult for healthcare providers to remove themselves from the situation completely, but they can recall a personal experience or another patient-care situation that reminds them how important it is to integrate the ethic of care into the entire patient-care situation.

Step 3 encourages the rehabilitation professional to implement the decision made. There is reasonable evidence that this will resolve the issue. But implementing a plan does not conclude the ethical decision making process. Each situation provides an opportunity to learn more and to develop a workable plan for managing future situations.

Step 4: Implement, Evaluate, and Reassess

It is the responsibility of the professional to reflect on the chosen course of action and consider any steps needed to avoid this type of ethical situation in the future. The responsibility to modify behavior lies not only with the individual but also with the institution.

The situation confronting Tim and Casey points to the difficulty of implementing plans of care that are not at the discretion of the treating practitioner. The patient's entire team needs to make the treatment a collaborative effort. To effect the most positive outcome, this includes the patient and family. For the team to work as a cohesive unit there must be mutual understanding and respect for the unique contribution of each team member and the way in which that contribution can benefit the approach to the patient (Badawi, 2016; McCarthy 2015; Keehan et al., 2008).

Initially the professional must do some reflection and answer the following questions:

- What was learned from the case involving Mr. Markham and his plan of care? For Tim and Casey they confirmed their professional responsibility to be autonomous practitioners. They also recognized the constraints they have working in a setting that does not necessarily respect that responsibility.

- What are the strengths and weaknesses of the practitioner with regard to the individual processes? Does the individual exhibit moral sensitivity, judgment, motivation, and courage? Tim and Casey exhibited moral sensitivity, judgment, and motivation. We don't know the outcome of this scenario. We do know that moral courage would require overt action on their part to protect their patient.
- Is the profession mature enough to have developed the ability to move ahead in recognizing the necessity for moral potency? (Schaubroeck, 2010; Tenbrunsel & Messick, 2008; Tenbrunsel & Smith-Crowe, 2008).
- If the provider needs to develop one or all of these skills, what type of professional activities would help to accomplish this? Ethical reasoning can be taught (Handelsman, 1986). The best method for teaching ethical decision making skills is through case studies (Reuben, 2004). Teaching ethics does diminish the uncertainty that is inherent in ethical decision making. Seeking the opportunity to further develop these skills is critical to sound ethical decision making.
- Was the outcome what was expected? Was there any collateral damage? When confronted with an ethical situation we may carry some preconceived concepts about what may result. It is important to look back at the outcome and compare it to what we anticipated. This is particularly important when collateral damage may be worse than the initial situation. Preventing collateral damage is always preferable to trying to ameliorate them after the fact. A thorough review of collateral damage—similar to a risk/benefit ratio—may be enough to suggest mechanisms to prevent them in the future. Elger and Harding (2002) suggest that if collateral damages cannot be prevented there has to be an assessment to determine if the damage is worse than what would occur as a result of the ethical breech.

* * *

The previous case was analyzed extensively. We will look at the following case with a more clinically friendly approach.

Stepping Over the Line?

[adapted from Kirsch, 2017.]

Jim makes it a point to take at least one student physical therapist a year as their clinical instructor (CI). While it takes a lot of time, he feels strongly that it is a professional responsibility. He gratefully remembers his CIs while he was in school and wants to "pay it forward" by providing a quality experience for a student. The other therapists in the large rehabilitation hospital where he works also consider the student program a significant way in which to be engaged with the profession. Tom, his new third-year student, is starting his final clinical rotation.

Jim and Tom hit it off immediately and Jim begins to orient Tom to the patients and the routine at the hospital; this is generally a rather steep learning curve in this very busy clinical environment where every patient is complex. It is not unusual for students assigned to this facility to have difficulty as it is known to be quite challenging. While the days are busy, the two men find a few minutes to discuss the sports headlines and the prospects for the upcoming season. Unfortunately, Jim is becoming aware that Tom is not prepared for the neurological case load that Jim carries.

Jim is willing to help Tom, and both men come in early and stay late, but Tom is still struggling. Jim remains in contact with the school, and the director of clinical education visits the facility to work with the two men. Together, they determine that a learning contract should be made to clarify what is expected for Tom to complete this clinical rotation successfully. Despite Tom's difficulty and the fact that Jim was still unable to give him the caseload he should be carrying, they nevertheless had a very good working relationship.

During lunch break on Friday Jim shares with Tom that he and his wife are moving from their apartment to a new house and a friend who was going to help with the move is sick. Jim suddenly looks at Tom, and seemingly without stopping to think, says "Hey, I've taught you everything you need to know about body mechanics, can you give me a hand?"

Tom did have weekend plans with friends but he is pretty sure they will understand the importance of helping his CI; at first he sees it as an opportunity to repay Jim, who has been so good to him. Yet, upon reflection, he wonders if it might look as if he's trying to "butter up" his CI. It doesn't feel right but he thinks he hasn't much choice, so Tom agrees to help out, spending both Saturday and Sunday as Jim's right hand man.

Monday morning Tom chats with the other students about their weekend activities. When he tells them that he helped Jim all weekend they exchange a knowing glance, and one says "That should ensure a passing grade" before going off to start the day.

While on the surface this may appear not too much of an ethical breech, there are some rather significant boundary crossings that occur and are easily extrapolated to other situations when you consider the many potential ramifications.

Recognize and Define the Ethical Issues

In which realm does this occur? This is occurring in the **individual realm** as it is a situation occurring between the two men—Jim, the CI, and Tom, his eager but struggling student.

The individual process for Jim is **moral sensitivity**: he fails to recognize that he is placing his student in a difficult situation. Tom is faced with a **moral judgment**: How will his willingness to help appear? And, if he declines, how will that appear?

This situation is a **moral problem** for Jim but it is a potential **distress** for Tom as he attempts to determine if the decision he is making is appropriate.

It could also be considered a **moral temptation** for Tom, because he is stepping into a situation that goes beyond the therapist-student relationship. He does stand to benefit from it, and he needs all the help he can get.

Reflect (Step 2)

Not every step of the reflection must be completed in a short ethical analysis; the practitioner chooses those aspects of the analysis that will provide the information needed.

1. Who are the **stakeholders**? Defining the stakeholders helps the therapist reflect on the broader nature of the case. It is not just Jim and Tom who are involved—it impacts other patients both currently and in the future. If Tom is not competent to treat, this will impact both the individual patient and the credibility of the profession. It also impacts the school. They are aware of the difficulty Tom is having. Can they continue to rely on the objectivity of the CI, Jim. The school relies on the objectivity of their clinical instructors in determining if students are prepared for clinical practice.
2. What are the **possible consequences** (intended and unintended)? A possible consequence is that the relationship Jim created could result in his using a different standard to evaluate Tom than he would use for other students.
3. What are the **relevant laws, duties, and obligations**? Jim has an obligation to be fair and he did exert some undue pressure on Tom, which is explained in the Code of Ethics, Principle **4B***: Physical therapists shall not exploit persons over whom they have supervisory, evaluative, or other authority.*

Conclusion

Physical therapists may no longer defer ethical decision making to other healthcare providers with whom they share patient responsibility. They must recognize their responsibility as autonomous practitioners to work on ethical quandaries in order to find a reasonable solution that is in the best interest of the patient. To accomplish this professional mandate, physical therapists must know ethical principles and be able to apply the principles effectively to ethical situations and then to analyze the outcomes.

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Post Test (CA PT Ethics 334)

Use the answer sheet following the test to record your answers.

1. Ethical decision making has become more complex because:

    a. The Hippocratic Oath has long been outdated.
    b. Society today is steeped in immorality.
    c. Organizational priorities and financial pressures affect everyday decisions.
    d. There are just so many more rules today than in earlier times.

2. At the center of the patient therapist relationship is:

    a. Loyalty.
    b. Affection.
    c. Sincerity.
    d. Trust.

3. Healthcare ethics are unique because:

    a. Patients are vulnerable.
    b. A lot of money is involved.
    c. Healthcare workers care about people.
    d. Patients have complete autonomy.

4. Beneficence means:

    a. Being kind.
    b. Doing little harm.
    c. Ensuring services for all.
    d. Encouraging independence.

5. Nonmaleficence means:

    a. First of all, assess your patient.
    b. Not being malicious.
    c. Doing no harm.
    d. Avoiding malpractice.

6. Veracity means:

a. Paternalism.

b. Therapeutic privilege.

c. Legitimacy.

d. Truthfulness founded on a respect for persons.

7. When you lower your moral threshold, you:

a. Compromise your integrity.

b. Open your mind to new ideas.

c. Increase your awareness of complex issues.

d. Recognize the reality of healthcare.

8. Moral potency is:

a. Repeating an action until you get the results you want.

b. The capacity to take moral action responsibly in the face of adversity.

c. Being willing to express your religious beliefs across all settings.

d. Doing the right thing.

9. A hospital is about to break ground for a new wing. People chain themselves to a number of old trees that will be lost if the building goes forward. These people are behaving:

a. Legally but unethically.

b. Legally and ethically.

c. Unethically and illegally.

d. Ethically but illegally.

10. Right vs. wrong may be a moral temptation, but right vs. right is:

a. The best of both worlds.

b. An ethical dilemma.

c. A chance for correct action.

d. A political brawl.

11. The model of ethical decision making called RIPS means:

a. React intuitively to present solutions.

b. Respect institutional protocols selectively.

c. Rest in peace serenely.

d. Realm, individual process, and situation.

12. When PTs act to correct a situation, they are exhibiting:

    a. Moral sensitivity.

    b. Moral judgment.

    c. Moral motivation.

    d. Moral courage.

13. When PTs decide on a line of action, they are exhibiting:

    a. Moral sensitivity.

    b. Moral judgment.

    c. Moral motivation.

    d. Moral courage.

14. When PTs recognize an ethical problem but take no action, it is called:

    a. An ethical distress.

    b. An ethical dilemma.

    c. An ethical temptation.

    d. An ethical silence.

15. When action is taken based on the standard of care, it is:

    a. Care-based.

    b. Rule-based.

    c. Ends-based.

    d. Ethics-based.

16. When action is taken based on achieving the greatest good, it is:

    a. Care-based.

    b. Rule-based.

    c. Ends-based.

    d. Ethics-based.

17. The final step of a professional in ethical decision making is:

a. Implement, evaluate, and reassess.

b. Recognize and reflect.

c. Decide and implement.

d. File a report.

Answer Sheet (334)

CA: Ethical Decisions in Physical Therapy

Name (Please print your name): _____

Date: _____

Passing score is 80%

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____

Course Evaluation (CA PT Ethics 334)

Please use this scale for your course evaluation. Items with asterisks * are required.

- 1 = Strongly agree
- 2 = Agree
- 3 = Neutral
- 4 = Disagree
- 5 = Strongly disagree

* Upon completion of the course, I was able to:

a. Explain what is unique about healthcare ethics.

○1 ○2 ○3 ○4 ○5

b. Describe the relationship of professionalism and ethics.

○1 ○2 ○3 ○4 ○5

c. Name the six principles that undergird the language of bioethics.

○1 ○2 ○3 ○4 ○5

d. Describe the concepts of moral threshold and moral potency.

○1 ○2 ○3 ○4 ○5

e. Differentiate between ethics and the law.

○1 ○2 ○3 ○4 ○5

f. Explain how to apply an ethical decision-making model in a clinical situation.

○1 ○2 ○3 ○4 ○5

* The author(s) are knowledgeable about the subject matter.

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

* The author(s) cited evidence that supported the material presented.

○1 ○2 ○3 ○4 ○5

* This course contained no discriminatory or prejudicial language.

Yes No

* The course was free of commercial bias and product promotion.

Yes No

* As a result of what you have learned, do you intend to make any changes in your practice?

Yes No

If you answered Yes above, what changes do you intend to make? If you answered No, please explain why.

* Do you intend to return to ATrain for your ongoing CE needs?

- Yes, within the next 30 days.
- Yes, during my next renewal cycle.
- Maybe, not sure.
- No, I only needed this one course.

* Would you recommend ATrain Education to a friend, co-worker, or colleague?

- Yes, definitely.
- Possibly.
- No, not at this time.

* What is your overall satisfaction with this learning activity?

1 2 3 4 5

* Navigating the ATrain Education website was:

- Easy.
- Somewhat easy.

- ○ Not at all easy.

* How long did it take you to complete this course, posttest, and course evaluation?

- ○ 60 minutes (or more) per contact hour
- ○ 50-59 minutes per contact hour
- ○ 40-49 minutes per contact hour
- ○ 30-39 minutes per contact hour
- ○ Less than 30 minutes per contact hour

I heard about ATrain Education from:

- ○ Government or Department of Health website.
- ○ State board or professional association.
- ○ Searching the Internet.
- ○ A friend.
- ○ An advertisement.
- ○ I am a returning customer.
- ○ My employer.
- ○ Other
- ○ Social Media (FB, Twitter, LinkedIn, etc)

Please let us know your age group to help us meet your professional needs.

- ○ 18 to 30
- ○ 31 to 45
- ○ 46+

I completed this course on:

- ○ My own or a friend's computer.
- ○ A computer at work.
- ○ A library computer.
- ○ A tablet.
- ○ A cellphone.
- ○ A paper copy of the course.

Please enter your comments or suggestions here: _____

_____

_____

_____

Registration Form (CA PT Ethics 334)

Please print and answer all of the following questions (* required).

* Name: _____

* Email: _____

* Address: _____

* City: _____ * State: _____ * Zip: _____

* Country: _____

* Phone: _____

* Professional Credentials/Designations:

_____

* License Number and State: _____

* Please email my certificate:

○ Yes ○ No

(If you request an email certificate we will not send a copy of the certificate by US Mail.)

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You may pay by credit card or by check.
Fill out this section only if you are **paying by credit card.**
2 contact hours: $29

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Address (if different from above): _____

* City: _____ * State: _____ * Zip: _____

* Card type:

○ Visa ○ Master Card ○ American Express ○ Discover

* Card number: _____

* CVS#: _____

* Expiration date: _____