

**The American Occupational Therapy Association
Advisory Opinion for the Ethics Commission**

Balancing Patient Rights and Practitioner Values

Introduction

Clinical reasoning in occupational therapy involves art, science, and ethics, according to Joan Rogers (1983). The relationship between rights and duties is one of the ethical issues that may arise in clinical practice. The art and science of care delivered by occupational therapy personnel relates directly to the correlation between rights and duties. The rights of a person who presents for intervention should be met with a trained practitioner's duty to provide care that benefits that individual. The following question is raised: "Do circumstances exist whereby occupational therapy personnel can ethically refrain from providing services?" Although there is an overarching professional duty to provide benefit to clients, there may be unsafe situations in which the practitioner may ethically refrain from providing service. On the other hand, the practitioner may feel unsafe due to a significant difference of personal values that impedes therapeutic interaction. Some argue that there are situations where the practitioner's moral duty or personal values will outweigh the patient's right to receive services. However, in a diverse society, ideas of right and wrong vary as much as the individuals themselves. It is increasingly difficult to identify what constitutes an ethical right of conscience in healthcare and the limits of decisions based on conscience(Stein, 2006). Although some may agree with the provider's right to refrain from care in scenarios in which the practitioner has a personal moral conflict with a patient, moral consensus as to the provider's rights versus responsibilities has not been reached. Therefore the practitioner must be prudent and diligent in differentiating between a conflict of values and a truly unsafe environment in order to obtain a balance with the rights of the patient.

Many OT personnel have experienced working with difficult patients who are either uncooperative, appear to lack motivation or are in some way repugnant. This may be manifested by harsh and inappropriate language spoken during the therapy session or complete unresponsiveness. A homebound patient unable to perform daily hygiene activities or who does not have anyone responsible for overseeing such basic needs as nutrition and cleansing may become offensive to the practitioner. In these situations it is important for occupational therapy personnel to separate their personal feelings of aversion from the treatment protocol, and deliver the prescribed care. Occupational therapy practitioners must acknowledge the dignity of patients regardless of their unpleasant nature or condition. Within the boundaries of the provider-patient relationship, the continuation of care is essential to upholding the ethical guidelines of patient autonomy and beneficence. In other words, patients have choices about personal behaviors and are entitled to receive the benefit of services and care. However, if environmental conditions exist that truly jeopardize the practitioner's safety, he or she has the right to refrain from providing services in that context.

Case Scenarios

Scenario I Conflict of Values

Keisha, a home care therapist, meets her new patient, Rafaella, who recently had a hip replacement as a result of longstanding rheumatoid arthritis. Rafaella is currently estranged from her husband who has been abusive in the past. On the second visit, the therapist notices a large bruise on her neck, which she attempted to cover up with a scarf. The therapist inquires as to how she got bruised and she says she fell out of bed but seems withdrawn and does not make eye contact while speaking. The therapist is concerned about the situation and suspects abuse. As Keisha continues to treat Rafaella, they establish a therapeutic relationship whereby Rafaella discloses that her husband continues to stop by when he is intoxicated and can become quite physically abusive. Keisha encourages Rafaella to file a police report and get a restraining order. Rafaella adamantly refuses this advice, stating that she still loves her husband and would not want to get him in trouble. The occupational therapist questions her ability to continue treating Rafaella because she does not feel that she can support Rafaella's choice to remain in an abusive relationship.

Scenario II Unsafe Environment

During the scenario above, while Keisha is treating Rafaella, her estranged husband arrives with alcohol on his breath, is verbally abusive, and is swaggering around. Keisha notices a gun in his waistband. The husband confronts Keisha and orders her to leave, yelling that he will shoot if she returns. Keisha feels that she cannot continue to treat Rafaella in her home because she fears for her own safety. Keisha also fears for Rafaella, but feels she has done all she can to encourage Rafaella to seek assistance from the police.

Discussion

Although both of these scenarios portray a situation where the provider, Keisha, questions her duty to continue treating Rafaella, her professional ethics may require her to act differently based on the circumstances at hand. The moral dilemma facing Keisha stems from conflicts between the client's and the professional's autonomy as well as beneficence. Respect for an individual's autonomy, or the right to make their own decisions (self-determination), has historically been a pervasive concept in the field of ethics. Respect for the client's autonomy requires the practitioner to acknowledge the individual as a moral agent as well as recognize the client's "right to hold views, to make choices, and to take actions based on personal values and beliefs" (Beauchamp & Childress, 2001, p. 63). The overriding question is how far does this right extend? Does respect for client autonomy require the practitioner to place him- or herself in a situation that places him or her in danger? Although patient autonomy plays a significant role in the ethical delineation of services, according to Fleming, "a successful and ethically grounded [provider]-patient relationship presumes respect for autonomy, bolstered by good communication and shared decision-making that requires careful balancing of the values and beliefs of both participants" (p. 263). Neither scenario supports abandonment of the patient; instead both scenarios call for communication and decision-making as described by Fleming.

Following this line of thinking, in scenario 1 Keisha, needs to work with Rafaella in order to facilitate a safe environment. However, if Rafaella does not ultimately agree to Keisha's involvement in changing her environment, according to Principle 3 of the *Occupational Therapy Code of Ethics (2005)*, occupational therapy personnel are required to assure the rights of service recipients. Moral objections to a person's life or lifestyle would not warrant discontinuation of services. Therefore, Keisha must respect Rafaella's autonomy and does not have an ethical right to refrain from providing services based on her moral objections regarding Rafaella's decision. However, note that if there is a law that requires a health care practitioner to report abuse (e.g., children or the elderly), then the occupational therapy practitioner must do so regardless of the autonomy principle.

Scenario 2 also calls for shared decision making between the client and the provider. However, Keisha can ethically remove herself from the immediate situation, which violates her own rights as a provider. Keisha is not ethically required to subject herself to danger in order to serve her clients. However, Keisha does have an extended responsibility to acknowledge their provider-patient relationship and thus work with Rafaella to find a safe place in which to continue therapy services. This extended responsibility of the provider is supported through Principle 1, Beneficence, of the *Occupational Therapy Code of Ethics (AOTA, 2005)*, which requires occupational therapy personnel to "demonstrate a concern for the safety and well-being of the recipients of their services" (pg. 639). In addition, Principle 1C requires the practitioner to "make every effort to advocate for recipients to obtain needed services through available means," (p. 639). Again, through shared-decision making and communication, Keisha should partner with Rafaella to ensure access to services in the safest environment available.

Summary and Conclusion

The actions on the part of a practitioner must benefit the health of the patient in addition to acknowledging the autonomy of the patient as established by his or her right to be informed, privacy, and confidentiality. The recipient of occupational therapy services has duties and the provider has rights that affect the therapeutic relationship. For example, the recipient has the duty to arrive on time for therapy, follow through with intervention plans, and pay for services rendered. Occupational therapy personnel have the right to work in safe environments and in clinical settings that support the ethical nature of their role with clients. Given these parameters, when questions arise regarding rights versus responsibilities of the provider, one must thoughtfully determine which justifiable course of action to take. Practitioners must be grounded by not only a moral conscience to do what is right, but also by the courage to proceed and ensure the best interests of the patient. This may require occupational therapy personnel to apply a framework of ethical decision-making. Such action highlights the specific details of the case, assessment of the patient's condition, and determination of realistic alternatives for intervention, if needed. Therapeutic interventions should be interrupted only after all potential avenues to continue care have been exhausted. Acknowledging these moral obligations within the provider-patient relationship clearly delineates the role of occupational therapy personnel.

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