The American Occupational Therapy Association
Advisory Opinion for the Ethics Commission

Patient Abandonment

According to Dictionary.com (2011), *abandon* is defined as “to leave completely and finally.” A legal definition clarifies what *abandonment* means in the health care setting: “withdrawal from treatment of a patient without giving reasonable notice or providing a competent replacement” (USLegal.com, n.d.).

One should note that according to this second definition, a health care professional can indeed “abandon” a patient appropriately, as long as some notice has been given. Tangential to withdrawing from a case in which treatment has already begun is the refusal to initiate treatment, which many patients also take as an act of abandonment. This “right” (as it is sometimes called) of health care professionals to withdraw from the treatment of a patient or to refuse to initiate treatment is supported by the American Medical Association’s (2001) *Principles of Medical Ethics*, Principle VI: “A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.” Similarly, the *Comprehensive Accreditation Manual for Hospitals* (Joint Commission on the Accreditation of Healthcare Organizations, [JCAHO], 1998) calls for the development of policies and procedures in health care facilities to govern “how staff may request to be excused from participating in an aspect of patient care on grounds of conflicting cultural values, ethics, or religious beliefs” (p. HR-21).

Belief in this “right” of health care professionals to refuse to treat can be found throughout the health care system in this country, because it flows out of the strong value Americans place on freedom of choice. As biomedical ethicist Albert R. Jonsen (1995) explained,

> There has long been, in the United States, a reluctance to force one person to pro- vide services to another against his or her will. . . . The right to refuse to care for a particular patient, either by not accepting that person as a patient or by discharging oneself from responsibility in a
recognized way, is deeply embedded in the ethos of American medicine. (p. 100)

The issue of patient abandonment versus the health care professional’s rights is one of several problems that contribute to the growing tension between patients and medical personnel. Finding and maintaining a balance between patient needs and the personal rights of those involved with health care delivery on this issue of abandonment would go far toward easing such tensions as we move into the next millennium.

CLARIFYING PATIENT ABANDONMENT

We must recognize that there are legitimate reasons across all fields of health care to cease providing treatment to a patient. Some of these are clear-cut. First, when treatment needs exceed the ability and expertise of a health care professional, the patient is best served by having care transferred to a more qualified practitioner. Because the goal of health care is the well-being of the patient, withdrawing from a case when one’s skill can no longer be of benefit is justified, even though claims of abandonment may be raised by the patient. However, the manner in which one presents the need for a transfer of care and the degree to which the patient is made aware of this need and involved in the choice of a new practitioner are important factors in lessening the patient’s perception of abandonment.

Second, it is commonly agreed that a health care practitioner may withdraw from the care of a patient who acts inappropriately in the health care setting. The most common situation discussed is when a patient becomes violent or acts in ways that endanger the practitioner, other patients, or staff. However, this also includes inappropriate sexual advances from a patient (or possibly from a patient’s guardian, spouse, parent, etc.). In such cases, a practitioner may, if necessary, withdraw from the treatment of the patient without abandoning the patient, because the health care relationship has already been severed and the bond of trust damaged.

A third area, but one that involves more difficulty, arises from issues regarding the cultural and religious values of health care practitioners. As noted in the Comprehensive Accreditation Manual for Hospitals (JCAHO, 1998), the delivery of health care should include respect for a health care practitioner’s “cultural values, ethics, and religious beliefs and the impact these may have on patient care” (p. HR-21). The Accreditation Manual emphasizes that to respect all staff members, a health
care institution (or practice) should establish policies for how staff members can make requests to discontinue care for ethical, religious, and cultural reasons as well as policies for ensuring that patient care will not be negatively affected. It is further noted that addressing such issues in advance, even at the time of hiring or contracting, is the most helpful for maintaining an appropriate level of patient care.

What makes these issues difficult is the subjective nature of “personal values.” Who is to say what represents a cultural value? What if one’s culture is in the minority—do minority values still have weight? Religious values might also be difficult to determine, because not all members of the same religion hold the same values. Should those making the decisions recognize only mainstream values of the staff member’s religion? And, of course, ethical values flow from the individual’s own conscience. How should a manager or a supervisor regard a staff member’s ethical claims? Should all expressed values carry the same weight, simply because someone claims they are important? The Accreditation Manual goes on to note that if an appropriate (in the judgment of the manager or supervisor) request has been made, accommodations should be made when possible and cites the following “Examples of Implementation” to support Standard HR.6:

There will be an understanding that if events prevent the accommodation at a specific point because of an emergency situation, the employee will be expected to perform assigned duties so he or she does not negatively affect the delivery of care or services.

If an employee does not agree to render appropriate care or services in an emergency situation because of personal beliefs, the employee will be placed on a leave of absence from his or her current position and the incident will be reviewed. (JCAHO, 1998, p. HR-21)

Such cases will surely be difficult for all involved, especially if they have not been addressed prior to the emergent situation. The issue here is further complicated by the fact that even though health care is becoming more diverse, when we work with each other we are not always aware of each other’s diverse beliefs, nor are we always open and understanding about such differences. Supervisors and employers need to become more aware of their staff’s values, and staff need to continue to keep patient care at the focus of their work during times of personal
conflict.

Beyond the above reasons for discontinuing patient care, disagreement begins to arise. What about refusing to treat a noncompliant patient? What if that patient is extremely non-compliant, rather than only occasionally non-compliant? In another vein, what about the patient who does not pay his or her bills? Is refusing to treat such a patient justifiable? What if the patient is unable to pay the bills? Would this make a difference? Alternatively, one might consider an especially demanding patient. If a patient takes time away from the care of others and continually calls the practitioner beyond normal care hours, is withdrawal from his or her care acceptable? Yet another problematic case might involve a patient whose appearance or manners disgust a practitioner. If a practitioner is so put off by a patient that it impedes his or her ability to be an effective therapist, would withdrawing from the case be an act of abandonment or patient benefit?

THE DUTY TO TREAT

Although there is disagreement about the issue of abandonment and the duty of health care professionals to treat patients, even in the face of personal inconvenience or risk, some helpful insights can be gained from the thoughts of bioethicist Edmund D. Pellegrino (1991). In his chapter “Altruism, Self-Interest, and Medical Ethics,” Pellegrino (1991) addressed the particular case of physicians and the treatment of persons with AIDS. To begin, the author questioned the notion that “medicine is an occupation like any other, and the physician has the same ‘rights’ as the businessman or the craftsman” (p. 114). As a counter to this notion, Pellegrino drew out three factors specific to the nature of medicine that he argued establish a duty of physicians to treat the sick, even in the face of personal risk. He first pointed out the uniqueness of the medical relationship, in that it involves a vulnerable and dependent person who is at risk of exploitation and who must trust another to be restored to health. As Pellegrino explained, “Physicians invite that trust when offering to put knowledge at the service of the sick. A medical need in itself constitutes a moral claim on those equipped to help.” Next, the author pointed out that, in short, medical education is a privilege. Societies make special allowances for people to study medicine for the good of the society, thereby establishing a covenant with future health care professionals. On the basis of this, Pellegrino concluded, “The physician’s knowledge, therefore, is not individually owned and ought not to be used primarily for personal gain, prestige, or power. Rather, the profession holds this knowledge in trust for the good of the sick” (p. 114.) Finally, Pellegrino
pointed to the oath that physicians take before practicing medicine: “That oath—whichever one is taken—is a public promise that the new physician understands the gravity of this calling and promises to be competent and to use that competence in the interests of the sick” (p. 114). Although the debate continues, several theorists have asserted that Pellegrino made a strong case for the duty to treat (Arras, 1991; Jonsen, 1995). Although Pellegrino’s comments were directed toward physicians, his reasoning cuts across all fields of medical practice.

THE DUTY TO TREAT, PATIENT ABANDONMENT, AND OCCUPATIONAL THERAPY

The points presented by Pellegrino (1991) have direct bearing on the profession of occupational therapy. The Preamble to the Occupational Therapy Code of Ethics (2015) (referred to as the “Code”; American Occupational Therapy Association, 2015) recognizes the vulnerability of the people who seek occupational therapists’ services and the trust that is required in the healing relationship. Even though the recipient of treatment depends on the occupational therapist, the Core Value of Equality “refers to treating all people impartially and free of bias.” (AOTA, 2015, p. 2). The Core Value of Dignity emphasizes treating the client “with respect in all interactions” (p. 2).

The need to respect the vulnerability of patients and build trust is also expressed in the Code in Principle 1, which states, “Occupational therapy personnel shall demonstrate a concern for the well-being and safety of the recipients of their services” (p. 2). Principle 2 adds, “Occupational therapy personnel shall refrain from actions that cause harm” (p. 3). Principle 2I also explicitly states that “occupational therapy personnel shall avoid exploiting any relationship established as an occupational therapy clinician, educator, or researcher to further one’s own physical, emotional, financial, political, or business interests at the expense of recipients of services” (p. 4). Principle 3 further demonstrates the concern of occupational therapists for building trust between practitioners and the persons in their care: “Occupational therapy personnel shall respect the right of the individual to self-determination, privacy, confidentiality, and consent” (p. 4). This principle recognizes the importance of collaborating with, gaining informed consent from, and respecting the confidentiality of service recipients.

As to the second point raised by Pellegrino (1991), occupational therapists do indeed recognize the importance of their training and education. This is emphasized in Principle 1G of the Code:
“Occupational therapy personnel shall maintain competency by ongoing participation in education relevant to one’s practice area” (AOTA, 2015, p. 3). To uphold this principle, occupational therapists must go beyond just receiving specialized training; they must seek to maintain their competence by participating in professional development and educational activities. Principle 1D also directs occupational therapists to protect service recipients in the discharge of their knowledge and skill by ensuring that “duties delegated to other occupational therapy personnel are congruent with credentials, qualifications, experience, competency, and scope of practice with respect to service delivery, supervision, fieldwork education, and research” (p. 3). Through these actions, occupational therapists can truly demonstrate that they do not acquire their knowledge for “personal gain, prestige, or power. Rather, the profession holds this knowledge in trust for the good of the sick” (Pellegrino, 1991, p. 114).

Finally, occupational therapists also make a public pledge to promote the well-being of others through the Code. The Preamble to the Code states, “AOTA members are committed to promoting inclusion, participation, safety, and well-being for all recipients in various stages of life, health, and illness and to empowering all beneficiaries of service to meet their occupational needs” (AOTA, 2015, p. 1). Principle 1 of the Code further supports this pledge for the well-being of the recipients of occupational therapy. Finally, the dedication of occupational therapists to the well-being of those they treat is echoed in the Core Value of Altruism: “demonstrating concern for the welfare of others” (p. 1).

This understanding of the duty of health care professionals to treat patients, as drawn from the perspective of occupational therapy, can provide some guidance for practitioners facing the initial concern of patient abandonment. There is, indeed, a strong claim here to treat all patients to the fullest of one’s ability as an occupational therapist. The two limiting factors to this claim are when a more competent therapist is needed and when the patient’s actions make further treatment imprudent. But aside from such cases, the Code challenges occupational therapists to act from a higher level of responsibility than the general norms of society. Thus, even though it may be standard practice to refuse to serve customers and clients at one’s discretion in business, occupational therapists have a higher standard to follow. They need to make prudential decisions about initiating or ceasing treatment when such actions are valid and necessary. However, to avoid the genuine abandonment of patients, occupational therapists must act according to both the letter and the spirit of the Code. Kyler (1995) summed up these points well when she wrote,
As ethical health care practitioners, we are guided by the fundamental belief in the worth of our clients. This belief is based on our social responsibility, as stated in the AOTA Code of Ethics and in the Standards of Practice. An ethical practitioner treats clients and delivers services not simply because of a contractual agreement, but because of a social responsibility to do so. (p. 176)

CONCLUSION: ABIDE, NOT ABANDON
As Doherty and Purtilo (2016) noted, the actual physical abandonment of patients by health care professionals is no longer as prevalent as it once was. However, she added that “psychological abandonment often replaces what used to be experienced as the more obvious bodily abandonment of the patient” (p. 156). Psychological abandonment still involves treating a patient, but in such a manner “that the patient becomes a total non-person to the health professional” (p. 156). One of the dangers here is that physical abandonment is rather obvious and can be empirically validated. Psychological abandonment is far more subtle and may even occur without the practitioner’s conscious knowledge—for example, as a type of defense mechanism in a difficult case. Nonetheless, even this form of abandonment must be guarded against. But how?

Doherty and Purtilo (2016) offered a simple but thought-provoking suggestion. She explained that the “opposite of abandonment is to stay with or abide with the patient” (p. 156). Learning to abide with those in need, those who are difficult, those whose actions seem immoral to us, and those whom we fear because of their specific health problems will certainly not be easy. However, as Doherty and Purtilo noted, health care professionals “can overcome their tendency to flee (physically or psychologically) only when the attitude of compassion is combined with an understanding of how much harm is induced by abandonment” (p. 157). Learning to abide with the recipients of occupational therapy may be one of the most important ways to safeguard against patient abandonment.

REFERENCES


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This chapter was previously published in the 2010 edition of this guide. It has been revised to reflect updated AOTA Official Documents and websites, AOTA style, and additional resources.

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