The American Occupational Therapy Association  
Advisory Opinion for the Ethics Commission  

Balancing Patient Rights and Practitioner Values  

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 relate 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, in unsafe situations, the practitioner may ethically refrain from providing service. In addition, the practitioner may feel unsafe because of a significant difference of personal values that impedes therapeutic interaction. Some professionals have argued that in certain situations, the practitioner’s moral duty or personal values 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 health care and the limits of decisions based on conscience (Stein, 2006). Although some may agree with the provider’s right to refrain from care when he or she 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 to obtain a balance with the rights of the patient.

Many occupational therapy practitioners have worked with difficult patients who are uncooperative, seem to lack motivation, or are in some way repugnant. They may use harsh and inappropriate language during the therapy session or be completely unresponsive. A homebound patient who is 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 to separate personal feelings of aversion from the
treatment protocol and to 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 in 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 1: Conflict of Values

Keisha, an occupational therapist working in home care, meets her new patient, Rafaella, who recently had a hip replacement as a result of long-standing rheumatoid arthritis. Rafaella is currently estranged from her husband, who has been abusive in the past. On the second visit, Keisha notices a large bruise on Rafaella’s neck, which Rafaella has attempted to cover up with a scarf. The therapist inquires as to how Rafaella got bruised, and Rafaella responds that she fell out of bed, but she 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, and Rafaella discloses that her husband continues to stop by when he is intoxicated and can become 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 into 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 2: Unsafe Environment

One day, while Keisha is treating Rafaella, Rafaella’s estranged husband arrives with alcohol on his breath, is verbally abusive, and staggers around the house. 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 she 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 in which the provider, Keisha, questions her duty to continue treating Rafaella, her professional ethics may require her to act differently on the basis of the circumstances at hand. The moral dilemma facing Keisha stems from conflicts between the client’s and the professional’s autonomy and from Keisha’s obligation of beneficence.

Respect for an individual’s autonomy, or the right to make his or her own decisions (self-determination), has historically pervaded the field of ethics. Respect for the client’s autonomy requires the practitioner to acknowledge the individual as a moral agent and to recognize his or her “right to hold views, to make choices, and to take actions based on their values and beliefs” (Beauchamp & Childress, 2013, p. 106). The overriding question is, How far does this right extend? Does respect for client autonomy require the practitioner to place himself or herself in danger?

Although patient autonomy plays a significant role in the ethical delineation of services, according to Fleming (2005), “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.

In keeping with this line of thinking, in Scenario 1, Keisha needs to work with Rafaella 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 (2015) (referred to as the “Code”; American Occupational Therapy Association [AOTA], 2015), occupational therapy personnel are required to “respect the right of the individual to self-determination” (p. 4). Moral objections to a person’s life or lifestyle do not warrant discontinuation of services. Therefore, Keisha must respect Rafaella’s autonomy and does not have an ethical right to refrain from providing services on the basis of her moral
objections regarding Rafaella’s decision. However, if a law requires a health care practitioner to report abuse (e.g., of children or elderly clients), 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 to serve her clients. However, she 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 Code, which requires occupational therapy personnel to “demonstrate a concern for the well-being and safety of the recipients of their services” (AOTA, 2015, p. 2). In addition, Principle 4B requires the practitioner to “assist those in need of occupational therapy services in securing access through available means” (p. 5). 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 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 informed consent, 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 is obligated 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 not only by 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.

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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