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

The health care system has changed in recent years from a model wherein health care relationships were defined primarily by the provider and patient to a more complex model wherein the organization in which the health care professional practices has a direct impact on the care provided to patients. The role of the organization in the delivery of care has introduced business, financial, and management pressures into the health care environment, which often lead to ethical conflict among delivery, access, and reimbursement for service. As the American Society for Bioethics and Humanities (1998) stated, “ethical issues in organizational behavior have become more evident in recent years with the emergence of a more explicit market approach to medicine” (p. 24). The market approach has resulted in the need for organizational ethics to be integrated into the health care environment. This integration has led to speculation regarding how business ethics and clinical ethics will coexist within the infrastructure of the health care institution. However, organizational ethics is more than clinical ethics and business ethics combined. Organizations must take into account values and moral positions that are defined both internally and externally (Spencer & Mills, 1999), including the professionals and the codes that shape their behavior and guide practice.

Strategies for shaping an ethical organization must include health care values and codes of ethics. Health care professionals have always been held to a high ethical standard; therefore, organizations that provide health care services also must be held to this standard. Ethics in organizations are often complicated by business pressures. Health care organizations have become more complex and more involved in managing care, especially in times of limited resources. Ethical tensions result from pressures to do more with less. Health care organizations are expected to improve quality and expand access while reducing cost (Veterans Health Administration, National Center for Ethics, 2002). However, these pressures do not excuse organizations from their primary purpose of caring for people. In addition, if a health care professional works for an organization, ethical or otherwise, he or she cannot hide behind the policies or administration of the institution; his or her professional code and values must continue to guide practice. Ethical action requires the organization and the health care provider to demonstrate “integrity in the face of patients’ exploitable
vulnerability, [and] loyalty even to the point of personal sacrifice” (Emanuel, 2000, p. 155).

THE ISSUES
Occupational therapy practitioners are not immune to these market-based pressures. Most clinicians are familiar with the pressure to do more with less, whether manifested in lack of resources or in increased productivity standards. Constraints on time and money will continue to exist in health care; therefore, occupational therapy practitioners must understand how to handle these problems ethically while addressing the needs of the patients and the communities they serve. Practitioners may work in an organization, but they also belong to a profession with core values based on the concepts of altruism, equality, freedom, justice, dignity, truth, and prudence.

Health care providers are finding themselves enmeshed in relationships that extend beyond the provider and patient. These providers “interact on matters of accountability over many different domains and mechanisms [creating] what we might call a complex reciprocating matrix of accountability” (Emanuel & Emanuel, 1996, p. 231). The organization in which a health care professional practices often acts as a domain that influences his or her behavior. If the practitioner is an employee of the organization, then he or she subsumes a level of accountability to that organization’s culture, standards, and viability. Although the focus of accountability is often limited to the dynamic of the provider–patient relationship, service delivery is influenced by relationships external to this dyad. The occupational therapy practitioner may be placed in situations in which it is difficult to protect and maintain the provider–patient relationship. In some circumstances, occupational therapy practitioners are pressured to provide services that conflict with their personal or professional code of ethics to support decisions made by individual physicians or made within the organization.

Ethics focuses on choices in at least three domains: (1) choices about what we ought to do or not do—that is, the actions we might undertake; (2) choices about the kind of people we ought to be or not be—that is, the kind of character we ought to have or develop; and, in the abstract, (3) choices about the conditions of doing and being, which are perhaps best illustrated in the context of the organizational cultures, structures, or policies that influence but do not determine what we do and who we are as persons (Heller, 1999, p. 346).

This influence of the organization often leaves practitioners in the difficult position of attempting to respect the patient’s rights while also attempting to support the organization’s policies, procedures,
and financial viability. Organizations are dominant moral actors in today’s health arena, not only influencing policies in the hospital but also creating role expectations for health care providers that affect how they perform professionally in the organization (Goold, 2001).

In years past, relationships in health care were less complicated. Practitioners’ ethical obligations were primarily limited to the patient and acting in that patient’s best interest (Gervais, 1998). Practitioners’ roles and accountabilities were outlined by oaths and professional codes of ethics. These codes are designed to address conflict specific to the patient–provider relationship but are lacking when used to address more complex ethical dilemmas that extend beyond the bedside and encompass organizational ethics issues. With growing changes in health care, and with the shift in focus from health care providers to corporate institutions, “greater attention must be paid to the moral content or moral character of the actions of health care organizations” (Goold, Kamil, Cohan, & Sefansky, 2000, p. 69). In particular, one must be aware of the impact an organization’s moral character has on its practitioners. Although organizations must consider the relationships among “institutions and patients, patient populations, professionals, and other institutions” (Khushf, 1998, p. 133), the organization cannot undermine the integrity of the provider–patient relationship:

[Organizations must take into] account interaction among individuals, health care workers, institutions, integrated delivery systems and the entire health care environment. Any account of organizational ethics that focuses only on one level of the environment, such as the team or the institution, without examining and accounting for interaction among the levels of the environment, is inadequate. (Boyle, DuBose, Ellingson, Guinn, & McCurdy, 2001, p. 8)

This goal of organizations to meet individual as well as comprehensive societal needs may at times seem to conflict with the provider’s responsibility to the patient. When this conflict occurs, the provider is often presented with a dilemma regarding whether to support the organization’s goals or the patient’s rights. A therapist encounters an ethical dilemma when a morally correct course of action requires him or her to support both the organization and the patient but the supporting actions are mutually exclusive, so the therapist cannot do both (Doherty & Purtilo, 2016).

Although the organization is responsible for responding to all of these levels of the environment, the occupational therapy practitioner working in the organization cannot be accountable to all of these groups without risking an erosion of the provider–patient relationship. This dynamic seems to be a conflict between the organization’s ethics and those of the practitioner. A health care
organization must be accountable to multiple parties and the community, but this extended accountability should not detract from the provider’s relationship with the patient. The organization, therefore, cannot ethically require a practitioner to engage in decision making or actions that will undermine the provider–patient relationship: “Any social, organizational, administrative, and financial arrangement with practice settings that contribute to distancing [providers] from their patients will result in tendencies to dehumanize them and will ultimately diminish the [provider’s] competence to heal” (Scott, Aiken, Mechanic, & Moravcsik, 1995, p. 81). Therefore, although organizational and clinical ethics may seem to conflict initially, the care of the individual patient is the common tenet in both areas of ethics, and, ultimately, the destruction of the provider–patient relationship detracts from delivery of care and patients’ outcomes (Mills, Spencer, Rorty, & Werhane, 2000). Unfortunately, not all health care organizations recognize the role the institution plays in sustaining the provider–patient relationship, and, inevitably, the provider encounters situations in which he or she must choose to act as directed by the organizational administration or on behalf of the patient.

The conflict that arises from the health care professional’s complex matrix of accountability often leads to lack of trust between patients and providers. Trust is a necessary component of the health care relationship between therapist and patient: “The need for trust and the reliance on trust are especially important in health care because of the patient’s acute vulnerability to suffering, lost opportunity, and lack of power” (Goold, 2001, p. 26). In the provider–patient relationship, the occupational therapy practitioner has more power, and how he or she wishes to use that power can quickly degrade the trust of a patient. One potential abuse of that power presents itself in the form of paternalism. Practitioners who independently define the patient’s best interest and provide care on the basis of their assumptions of best interest—without the consent or, worse, against the will of the patient—are acting in a paternalistic manner. Health care in the United States has shifted away from a paternalistic manner that affords the professional the power to make decisions in the health care environment and has moved toward a focus on patient autonomy (Quill & Brody, 1996).

**CASE SCENARIO AND DISCUSSION**

An occupational therapist has received a referral to see a patient on the cardiac floor of a community hospital. When the therapist enters the room to complete her evaluation, the patient refuses occupational therapy services. The occupational therapist continues to see the patient over the
course of the next week. On all occasions, the patient refuses to participate in therapy. During each visit, the therapist explains to the patient and her family the importance of occupational therapy services, why her physician has referred her for treatment, and the risks of minimal activity after cardiac surgery. In addition, the occupational therapist speaks with nursing staff to determine whether the patient has been seen by a psychiatrist to rule out depression or any other emotional state that may be affecting her participation. The nurse refers the occupational therapist to a report compiled by the psychiatrist, which indicates that the patient is slightly depressed but has full decision-making capacity and is therefore able to make health care–related decisions. The occupational therapist decides to call the physician to tell her that she will be discharging the patient from services because of the patient’s informed refusal of treatment. During this discussion, the physician states to the therapist that she will need to continue treatment and that she should “not allow the patient to refuse services” and then abruptly hangs up the phone.

When the occupational therapist arrives to work the next day, she has another written physician referral on her desk that states, “Evaluate and treat for occupational therapy services; do not allow the patient to refuse.” This new order places the occupational therapist in a difficult position, and she does not know how to proceed. She wants to respect the patient’s autonomy, yet she feels a responsibility to maintain a positive working relationship with the physician. Her confusion is complicated by her obligation to the health care organization for which she is working, and she fears that aggravating the physician may result in a decrease in referrals for patients who may benefit from occupational therapy services and subsequent decreased revenue for the department.

Occupational therapists often work under the direction of a physician and in a health care organization. Organizations drive care because they have a vested interest in services provided and in ensuring continued physician referrals that support the financial solvency of the institution. This situation is especially true in communities in which the physicians are not employed by the facility itself but also have privileges at competing hospitals in the same town. Of the three relationships—patient, physician, and organization—the patient relationship is often seen as the one to which the occupational therapy practitioner is most responsible. There are serious questions about what accountability occupational therapy practitioners have to the organizations that employ them. Do employees have a fiduciary responsibility to support the organizations that employ them as well as other health care professionals in the organization, even if that relationship conflicts with their patient relationship?
Occupational therapy practitioners may perceive that the organization would support a team environment, which favors the physician, because there may be negative financial fallout if physician relationships are strained. However, it is in the organization’s best interest to support provider–patient relationships that build trust, because these relationships make for better medical care (Goold, 2001). Ethical health care organizations should not require a practitioner to compromise his or her standards in the delivery of care. Organizations that place providers in situations that jeopardize the patient–provider relationship are also jeopardizing the organization’s relationship with the customer. In the case scenario above, if the occupational therapist were to violate the trust of the patient by forcing her to participate in therapy against her will, the therapist would inadvertently make the institution less trustworthy in the eyes of the patient. Because of this need to support individual provider–patient relationships, most organizations have policies and resources in place that can support the provider in making ethical choices.

In the case scenario, the occupational therapist should ask her supervisor to help her in communicating with the physician. If a supervisor is not available, a medical director or administrator may be able to facilitate communication with the physician. Often, organizational management can communicate with physicians in a way that minimizes power imbalances. In addition, a supervisor or administrator should be familiar with and able to locate patients’ rights policies that objectively identify patient and provider roles and can assist the employee in identification of other organizational resources. The hospital ethics committee or consultation services may help resolve conflict between health care providers within the confines of the organization. In addition, organizational structures, such as incident reporting systems or safety hotlines, can be used to influence the behavior of providers to protect patient rights while keeping the reporting source anonymous, so as to avoid strained relationships among team members. The occupational therapist walks a difficult line in balancing these team relationships with her responsibilities to the patient.

Helping patients exercise their autonomy effectively in today’s health care environment has become more and more complicated. However, Principle 3 of the *Occupational Therapy Code of Ethics* (2015) (referred to as the “Code”; American Occupational Therapy Association [AOTA], 2015) requires occupational therapy personnel to respect their patients and ensure that patients’ rights are being upheld. Because of the complex matrix of accountability practitioners face when practicing in health care organizations, they often find themselves not only in a relationship with the patient but
also in collegial relationships with other health care providers and the institution. Although the provider–patient relationship is typically the theoretical focus for conflict resolution, the provider also must maintain other relationships to ensure safe, effective, and ethical delivery of health care services.

This concept of fidelity is also present in the Code under Principle 6: “Occupational therapy personnel shall treat clients, colleagues, and other professionals with respect, fairness, discretion, and integrity” (AOTA, 2015, p. 7). However, an occupational therapist need not compromise a relationship with a patient to maintain other relationships. In fact, respecting the patient’s right to refuse—thus maintaining the integrity of the provider–patient relationship—is ethically mandated to ensure ethical practices that support the moral structure of the health care environment.

for communication with the physician; however, if the physician continues to rebuff her attempts at dialogue, the therapist should pursue another avenue for communication involving the administration. Depending on the organization’s understanding of its role in fostering relationships between providers and patients, the therapist may or may not encounter a supportive advocate for resolution of the ethical dilemma. If this option does not resolve the conflict, she may ultimately decide to transfer care of the patient to another therapist; refuse to treat the patient, which may result in termination of employment; or continue treating the patient. Continuing to treat a patient who is refusing services and has decision-making capacity is not ethically justifiable. This option could lead to many adverse outcomes, including a decline in trust between patient and provider; the potential harm—both psychological and physical—imposed on the patient; the lack of benefit incurred when a patient is treated against his or her will (also a legal issue, because it can be construed as assault and battery); and, ultimately, a decline in trust among health care providers, organizations, and the individuals served. Although the previously mentioned options are viable, it is important to actively advocate for the patient, but in a respectful manner that is least damaging to the relationship between physician and therapist. Although patient trust is essential, one must also work to maintain trust among colleagues and team members.

CONCLUSION

Research has demonstrated over and over again that patients most highly value having a strong relationship with their health care provider (Gervais, 1998). The humanistic characteristics of the occupational therapy profession, in which emphasis is placed on the patient’s view of meaningful
life, morally require respect for the patient’s wishes, even when these wishes seem to conflict with clinical reasoning and the patient’s own benefit. It is not that autonomy-based obligations trump beneficence-based obligations; however, when there is no compelling beneficence-based obligation to consider, as demonstrated in the case study, a health care provider has no morally based option but to adhere to the patient’s informed choice (Chervenak & McCullough, 1991). Although other health care professionals are often apprehensive about sharing decision-making powers with the patient (Henderson, 2003), occupational therapists rely on patient input to help identify the direction intervention should take. AOTA encourages the implementation of core occupational therapy tenets that require the active participation of the client. Occupational therapy is a traditionally holistic profession with humanistic roots that imply a “theoretical and practical commitment to treating patients in a caring, respectful and holistic manner that appreciates their dignity, individual needs and meaningful life circumstances” (Lohman & Brown, 1997, p. 11).

The occupational therapy practitioner has an ethical responsibility to maintain the integrity of the provider–patient relationship in the face of organizational pressures. Whether they maintain this relationship by respecting patients' autonomy or advocating for their rights and needs with regard to care, occupational therapists must be aware of their responsibilities to the well-being of the patient. The first principle of the Code calls on practitioners to act with beneficence. Although the therapist cannot disregard or neglect his or her relationships in an organization, he or she must remember that undermining the patient’s trust promotes neither the integrity of the organization nor the integrity of the patient–provider relationship.

REFERENCES


Veterans Health Administration, National Center for Ethics. (2002, February). Developing an integrated ethics program. Presentation for Veterans Health Administration: Ethics Training, Detroit, MI.

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