Ethical Considerations for Occupational Therapy Assistants in Management Roles

The occupational therapy profession has multiple levels of entry. Occupational therapy assistants are typically employed in positions in which they work collaboratively with occupational therapists, who supervise them and delegate clinical work. In clinical practice, a supervisory relationship is required, both legally and ethically, between occupational therapy assistants and occupational therapists.

In most settings, occupational therapy assistants receive clinical supervision for client-related interventions as delegated by an occupational therapist. However, in some settings, occupational therapy assistants assume dual roles, providing managerial and administrative oversight of occupational therapists and other professionals in the rehabilitation program while also implementing all or part of the plan of care delegated by the supervising occupational therapist. It is both acceptable and ethical for qualified occupational therapy assistants to serve in management roles in which they have administrative responsibility for occupational therapists. Nonetheless, it is important to consider the special issues that may arise from these roles and relationships.

In this Ethics Advisory Opinion, we explore situations in which occupational therapy assistants are in management positions with administrative oversight of the work of occupational therapists. We examine the ethical considerations and challenges that may arise and offer guidance on how to align these relationships with occupational therapy practice guidelines and ethics standards. Specific principles from the Occupational Therapy Code of Ethics (referred to as the “Code”; American Occupational Therapy Association [AOTA], 2015) that may apply to these dual relationships are provided.

Core Values Related to Management Roles

Occupational therapy practitioners who assume managerial roles must be mindful of the ethical challenges inherent in their positions and guided by the values of the profession. Leadership
values relevant to managers include attributes related to concepts found in the Code, specifically trustworthiness, respect, responsibility and fairness, and caring:

- **Trustworthiness** relates to the principles of Veracity and Fidelity. Veracity is based on the virtues of truthfulness, candor, and honesty. The principle of Veracity refers to comprehensive, accurate, and objective transmission of information and includes fostering understanding of such information (Beauchamp & Childress, 2013). Fidelity is based on respect owed to others, carefully balanced with other potentially competing ethical principles, cultural beliefs, and organizational policies.

- **Respect** relates to the principles of Fidelity and Autonomy. Fidelity requires occupational therapy practitioners to maintain respectful collegial and organizational relationships (Doherty & Purtilo, 2016). Professional relationships are greatly influenced by the complexity of the environments in which occupational therapy personnel work. Practitioners, educators, and researchers alike must consistently balance their duties to service recipients, students, research participants, and other professionals as well as to organizations that influence decision making and professional practice. Autonomy requires that managers allow practitioners to use their clinical judgment as independently as possible without unnecessary rules or overbearing oversight.

- The concepts of **responsibility and fairness** can be found in each of the principles of the Code. The principle of Justice relates to the fair, equitable, and appropriate treatment of persons (Beauchamp & Childress, 2013). Occupational therapy practitioners should relate in a respectful, fair, and impartial manner with whomever they interact. They should also respect the applicable laws, regulations, policies, and standards related to their area of practice. Principle 4E of the Code requires occupational therapy practitioners to “maintain awareness of current laws and AOTA policies and Official Documents that apply to the profession of occupational therapy,” and Principle 4H requires them to “provide appropriate supervision in accordance with AOTA Official Documents and relevant laws, regulations, policies, procedures, standards, and guidelines.”

- **Caring** relates to the principles of Beneficence and Nonmaleficence, which involve concern for well-being and prevention of harm. Specifically, Principle 1F requires occupational therapy practitioners to “take steps (e.g., continuing education, research, supervision, training) to ensure proficiency, use careful judgment, and weigh potential for harm when generally recognized standards do not exist in emerging technology or areas of practice,” and Principle 1G requires them to “maintain competency by ongoing participation in education relevant to one’s practice area.” Principle 2H requires occupational therapy practitioners to “avoid compromising the rights or well-being of others based on arbitrary directives (e.g., unrealistic productivity expectations, falsification of documentation, inaccurate coding) by exercising professional judgment and critical analysis.” Principle 2I requires them to “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, students, research participants, employees, or colleagues.”
Occupational Therapy Supervision

The Official Documents of the AOTA describe and support the framework for supervisory relationships in the delivery of occupational therapy services. For example, the Code includes principles and standards of conduct that guide ethical behavior in supervisory relationships. The Code’s discussion of the principle of Beneficence addresses the duty to delegate responsibly on the basis of credentials, competency, and scope of practice.

Although these documents focus on the relationship between occupational therapist and occupational therapy assistant, the same principles apply to any supervisory relationship. The Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services (AOTA, 2014) notes that supervision occurs in a variety of settings: “The education and expertise of occupational therapists and occupational therapy assistants prepare them for employment in arenas other than those related to the delivery of occupational therapy. In these other arenas, supervision may be provided by non–occupational therapy professionals” (p. S18). AOTA thus both acknowledges and provides guidance for occupational therapy assistants’ practice in settings and roles that are outside the structure of a traditional clinical supervisory relationship between occupational therapist and occupational therapy assistant. Nonetheless, lack of clarity or nontraditional organizational structures may lead to conflicts and ethical challenges for occupational therapy assistants serving in dual roles (i.e., clinician and manager).

Occupational Therapy Assistants in Management Roles

Occupational therapy managers are “task oriented and experts at creating and managing systems and processes needed to accomplish organizational goals” (Sweetman, 2016, p. CE-1). Kotter (2013) described management as “a set of well-known processes, like planning, budgeting, structuring jobs, staffing jobs, measuring performance, and problem solving” (para. 8).

Managers’ responsibilities typically include the following:

- Ensuring the delivery of the highest standard and quality of rehabilitation services while also being accountable for the profitable management of these services
- Reviewing and reporting monthly departmental and individual outcomes
- Developing and supporting all staff
• Completing staff performance reviews

• Hiring and scheduling therapy staff

• Administering financial controls during budget preparation and management

• Ensuring effective clinical management, including case management for all patients receiving rehabilitation services, quality improvement, care planning, clinical utilization, and patient identification as overseen by a licensed therapist of the appropriate discipline.

The educational requirements for a director or manager of rehabilitation services vary among organizations and typically are embedded in the job description. In many cases, a bachelor’s degree is required or preferred. Additional requirements may also include experience in direct patient care and previous management experience in a rehabilitation setting.

Occupational therapy publications that address the transition to management roles or describe the skills and attributes of managers refer to occupational therapy practitioners, the preferred generic term when referring to both occupational therapists and occupational therapy assistants. The AOTA Administration and Management Special Interest Section, which includes both of these levels of the profession, offers a continuing education course, “Authentic Leadership in Occupational Therapy,” that uses the term practitioner throughout (Sweetman, 2016). In a survey of AOTA members, Bondoc, Kroll, and Herz (2008) found that the essentials skills and attributes of occupational therapy practitioners who moved from clinician to manager, which included both occupational therapists and occupational therapy assistants, required enhanced knowledge regarding the service area, a good understanding of reimbursement mechanisms, proficiency in budget planning, and the ability to manage people, as well as past experience, a strong work ethic, readiness to take on the tasks at hand, communication and organizational skills, and flexibility.

No occupational therapy documents explicitly state that only occupational therapists can fulfill the role of manager. The qualities and characteristics of good managers include the skills needed to lead organizations and teams and are not restricted to one level of occupational therapy practitioner (Rogers, Killian, Hudgins, & Polland, 2016). Occupational therapy assistants who possess enhanced knowledge regarding the service area, have a good understanding of reimbursement, and are proficient in budget and financial management can be competent
managers. When occupational therapy assistants fill management roles, however, they need to be aware of potential ethical issues that may arise out of the clinical portion of their job.

**Potential Ethical Considerations**

Occupational therapy assistants serving in dual roles as manager and clinician may face challenges that lead to ethical dilemmas or concerns. For example, in the role of manager, occupational therapy assistants are likely to be required to complete annual performance reviews of those whom they manage, even the occupational therapists who supervise them clinically. This responsibility can lead to ethical conflict because the annual review typically rates clinical abilities and skill sets of occupational therapists that are not within the scope of practice of occupational therapy assistants. The occupational therapy assistant as manager has a responsibility to collect data to complete the review through peer reviews and guidance from occupational therapists with the same or more advanced skill set and experience.

In addition, occupational therapy assistant managers may feel conflicted when issuing disciplinary action to an occupational therapist for unprofessional conduct, for being disrespectful to patients and peers within the organization, or for violating organizational policies for attendance and absenteeism. If an occupational therapist has responsibility for clinical supervision of an occupational therapy assistant manager, there may be potential for retaliation. For example, the occupational therapist might delegate a disproportionate share of difficult patients to the occupational therapy assistant manager.

One challenge of serving in dual roles is keeping in mind the differences between managing employees independently as an administrator while also providing clinical treatment that requires supervision by an occupational therapist. Successfully balancing these dual roles requires occupational therapy assistants to “stay in your own lane” by observing the boundaries between their role as manager with administrative oversight and their role as clinician collaborating with and delegated to by an occupational therapist. As a manager, an occupational therapy assistant may have the task of establishing treatment schedules, which have implications for delivery of clinical services. The occupational therapist may not agree with the time allotted for patients with a specific diagnosis, yet the manager is the decision authority. As a clinician, the occupational therapy assistant must be fully cognizant both of the limits of his or her clinical
skill set and, when treating patients, of the necessity to confer with the supervising occupational therapist.

An occupational therapy assistant cannot direct a supervising occupational therapist to do something the therapist does not clinically agree with, nor is it within the scope of an occupational therapy assistant manager to do so. Therefore, during a clinical discussion, the occupational therapy assistant should open dialogue with the occupational therapist with questions or concerns regarding clinical intervention and seek guidance. This dialogue opening indicates to the occupational therapist that the occupational therapy assistant is not overstepping his or her bounds as a clinician.

**Case Study**

**Case Description**

A regional health care organization operated five small acute care hospitals dispersed across a rural part of the state. The rehab manager role included responsibility for staffing resources for acute care occupational therapy, physical therapy, and speech–language pathology at these hospitals. Recruiting and retaining therapists in this rural area was a continual challenge. However, an abundance of occupational therapy assistants were available for hire because of an occupational therapy assistant education program in the area, and the organization hired Phyllis, an occupational therapy assistant with many years of experience, because she met the requirements for the job of rehab manager—a bachelor’s degree and licensure in a rehabilitation profession.

As a method of managing resources, therapists were required to float to two or more of the organization’s hospitals as needed. This requirement was explained to potential employees during the interview and was a condition of employment to receive full-time benefits.

Shane joined the organization 11 months ago as a full-time occupational therapist. It soon became clear that, compared to the other occupational therapists, Shane spent significantly more time with each new patient conducting the evaluation, developing the intervention plan, and documenting. The workload productivity expectation for therapists was for all record review, patient contact for evaluation, and documentation associated with new patients to be completed
within 60 minutes. Two part-time occupational therapists and one PRN (as needed) occupational therapist regularly met the productivity standard, but Shane frequently called the other occupational therapists asking them to cover his caseload at the second hospital to which he was assigned because, as Shane stated “he was running behind schedule.”

Knowing that Shane was struggling to meet the productivity standard, Phyllis assigned Shane a mentor, Marty, an occupational therapist with 10 years of experience. Although Shane seemed appreciative of Marty’s help, Shane continued to perform below the expected productivity standard. After 4 months of mentoring, Marty reported to Phyllis that Shane had shared how much he hated traveling between hospitals in the middle of the day and preferred being able to “clock in and clock out.” Shane had also commented, “Besides, the PRN OT appreciates the extra hours.” Marty expressed frustration with being “dumped on” when Shane called in the middle of the day for someone to cover his assigned work. After two counseling meetings and review of the performance expectations, Phyllis determined that Shane was not a “good fit” and terminated his employment.

Shane filed a complaint with the state’s occupational therapy licensing board claiming that Phyllis, an occupational therapy assistant, violated the supervision rules outlined in the state’s occupational therapy administrative code. Shane contended that Phyllis was incompetent and took actions outside the scope of practice of occupational therapy assistants by assessing his performance and terminating his employment. Shane also hired an attorney specializing in employment law to represent him in claiming unlawful dismissal by the hospital corporation.

**Analysis**

This case study describes an occupational therapy assistant employed as manager of the rehabilitation services team in a regional health care organization. The manager, Phyllis, was responsible for the efficient management of rehabilitation services within the organization. Phyllis had made a commitment to her leadership role and knew that “being able to recognize, verbalize, and implement values provides a ‘sound base for decisions regarding when individuals want to be leaders, how to act as a leader, and to what degree they want to lead’” (Alexander, as quoted in Amanat, Lingelbach, & Schoen, 2016, p. 23).
Phyllis upheld the principle of Beneficence by working to ensure Shane’s proficiency in his delivery of services. By assigning another occupational therapist as a mentor, Phyllis demonstrated respect for Shane by providing him with clinically appropriate assistance rather than assuming the role of clinical supervisor herself. Phyllis demonstrated the principle of Veracity by being “honest, fair, accurate, respectful, and timely in gathering and reporting fact-based information regarding employee job performance” (Principle 5G). Phyllis also complied with the principle of Fidelity by objectively and truthfully addressing Shane’s substandard performance.

Shane confused the practice of occupational therapy with the role of manager. Shane’s deficiency in meeting performance expectations reflected a lack of diligence in stewardship of resources, insufficient interprofessional collaboration, and noncompliance with organizational policies. Shane violated the principle of Fidelity by not being respectful of his coworkers and manager and by taking advantage of employer-sponsored benefits while not complying with the conditions of employment, which included working in more than one location and making a reasonable effort to meet productivity expectations. Shane also violated the principle of Justice by improperly challenging the supervisory relationship with his manager and claiming that the clinical–supervisory relationship and occupational therapy assistant scope of practice had been violated. For these reasons, Shane lost his claim against the hospital corporation, and the state licensing complaint was investigated and dismissed as being without cause.

**Conclusion**

Occupational therapy assistants can fulfill the role of manager, and they can administratively manage occupational therapists. Occupational therapy assistants who assume the manager role have a duty to maintain clarity about the distinctions between clinical supervision and administrative or management oversight. Open, transparent, and clear descriptions of each role must be defined and adhered to. Occupational therapy assistants in leadership roles should take an assertive approach to explaining the differences in the dual roles and scope of each to subordinates and colleagues. In addition, occupational therapy assistant managers can be advocates and role models for the advancement of the profession into progressively more responsible organizational roles.
References


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