
The American Occupational Therapy Association Advisory Opinion for the Ethics Commission

An Ethical Response to the COVID-19 Pandemic

Occupational therapy practitioners are no strangers to a crisis. Birthed in the aftermath of World War I and seasoned by the Great Depression and World War II (Peters & Reed, 2006), the profession has survived and thrived while helping others live meaningfully. The years have brought increasingly complex health care challenges, and occupational therapy practitioners have met those challenges consistently.

However, the ethical challenges arising with the current COVID-19 global pandemic have caused a rise in the moral distress experienced by practitioners resulting from competing duties and obligations. Practitioners must balance issues surrounding personnel and supply allocation, a duty to provide care versus duty to self and their loved ones' safety. Additionally, concerns regarding equitable resource allocation and shifting scope of practice balanced against rising organizational demands cause further distress.

In this article, the American Occupational Therapy Association (AOTA) Ethics Commission (EC) explores the literature on ethical problem solving during disasters in health care, the ethical issues surrounding the COVID-19 pandemic that occupational therapy practitioners have reported experiencing, and resources available to practitioners needing support during a time of crisis.

Ethical Responses During Disasters in Health Care

Health Care Team Response

On a global front, health care practitioners are increasingly faced with emerging and re-emerging disease threats resulting from a wake of natural disasters, war, terror attacks, and pandemics. On the heels of the 9/11 terrorist attacks, the Ebola crisis, the SARS (severe acute respiratory syndrome) epidemic, and health crises post-Hurricane Katrina, questions regarding the preparedness of the health industry to adequately respond to these threats has arisen (Holt, 2008; World Health Organization, 2007).

Moreover, health care practitioners are experiencing an increase in moral distress while trying to negotiate the growing ethical concerns related to responding to these threats. Although there are numerous definitions of moral distress, AOTA's *Reference Guide to the Code of Ethics* (Slater & Brandt, 2015) currently uses Andrew Jameton's (1984) behavioral and emotional language: "The painful feelings and psychological disequilibrium that result from a moral conflict in which one knows the correct actions to take, but constraints prevent implementation of that action" (p. 117).

Practitioners' duty to care for their clients is in direct conflict with their duties to safeguard themselves and their families (Iserson, et al., 2008; Ulrich, 2020). Globally, there is a need to develop ethical guidelines and standards of care that will address the crisis practitioners face amid these growing threats.

A new specialty of medicine is emerging to address these particular needs. Disaster medicine focuses on changing current standards of care to meet the unique challenges faced during these unusual times (Holt, 2008). Additionally, in 2007, the World Health Organization (WHO) released specific guidelines for preventing infection and controlling disease during epidemic and pandemic outbreaks. These guidelines focus on continuous and sustainable improvements in safety in health care, specifically acute respiratory diseases. Additionally, the *Journal of Clinical Ethics* dedicated an entire volume to addressing medical practice during disasters and pandemics (Howe, 2010). This volume examined issues surrounding standards of care, resource allocation, and preparedness.

However, despite these discussions, few efforts have been made to apply consistent disaster management strategies on a macro or global level (Civaner et al., 2017; Leider et al., 2017). It is no wonder that health care workers are experiencing moral distress; the systems cannot be in place to support ethical decision making on a micro level when adequate disaster management planning is not in place on a macro level.

Moreover, the increased pressure confronting health care workers must be addressed. A review of the literature reflects these unique challenges. Two-fold in nature, health care workers struggle with the overwhelming burden that illness can have on the system as a whole while juggling the potential adverse effects that these diseases can have on the workers themselves (Adams & Walls, 2020). Practitioners have reported experiencing increased moral distress, trying to negotiate what needs to be done for clients while not being able to provide appropriate care (Ulrich, 2020).

Often in times of crisis, decision making turns away from altruism and duty to utilitarian considerations of outcomes (Berger, 2010). Practitioners have reported feeling powerless while emotionally and physically worn out (Ulrich, 2020). Health care providers routinely accept the inherent risks of their jobs on a daily basis; however, the rising risks during epidemic and pandemic situations call for clearer, evidence-based, and practical standards and protections. Providers have balanced competing duties to provide care, duties to society as a whole, and duties to themselves and their families. Thus, guidelines on how to prioritize care, protect clients, and protect the health care providers are of the utmost priority (Ulrich, 2020).

Berlinger and colleagues (2020) provided specific guidelines and standards to address health care needs during times of crisis. With an emphasis on fairness, duty to care, duty to steward resources, transparency, and accountability, these guidelines focus on preparation, resource allocation concerns, and adapting to the situation. Keys to help mitigate the distress experienced by practitioners must also include adequate education, staff training, organizational transparency, and communication (Ulrich, 2020). With appropriate standards in place, health care practitioners can have a greater sense of control along with opportunities to safely meet their professional obligations while also feeling protected (Iserson, et al., 2008).

The rising emergence of epidemics and pandemics is a global concern. It is clear efforts are emerging to address the rising concerns faced by health care practitioners worldwide. However, these efforts are small, and efforts on a larger, coordinated scale need to occur to secure optimal response during these times. Berlinger and colleagues (2020) indicated that global efforts must focus on three primary duties: duty to plan, including adequate triage measures; duty to safeguard health care providers; and duty to guide practice.

As part of this, health care providers need to balance between care for those who fall ill and care for themselves, and it is up to health care practitioners to advocate and take action to help ensure that sufficient standards and guidelines are in place to protect all those affected, including occupational therapy practitioners.

Occupational Therapy's Response

The role of occupational therapy practitioners in disaster response, including pandemics, is supported in the literature through professional statements and recommendations. Examples of occupational therapy practitioners as part of interprofessional disaster teams include responding to hurricanes, earthquakes, and displacement as a result of armed conflict (Parente et al., 2017). The World Federation of Occupational Therapists (WFOT) and the American Occupational Therapy Association (AOTA) support occupational therapy practitioners' involvement at all levels of disaster response planning, from local to national, and from preparation to post-disaster and long-term rehabilitation efforts (AOTA, 2017; WFOT, 2014). Practitioners are well prepared to support the health care team and community in such times, by assuming leadership roles on ethics committees and in team management to plan for moving and evacuating disaster survivors with disabilities, modifying environments to accommodate persons with disabilities and addressing infection control, monitoring physical and mental health barriers to functioning, and considering caregivers of survivors as indirect survivors of disaster (AOTA, 2017; Parente et al., 2017; WFOT, 2014). Following a disaster, displaced persons need to re-establish routines, occupations, and livelihoods; occupational therapy practitioners can focus on these concerns as well as the mental health and well-being of all disaster survivors (WFOT, 2014).

Practitioners are furthermore distinctly positioned to monitor and intervene for the health and well-being of the health care team responding to disasters. Practitioners in planning and response roles can ensure that health care workers have scheduled shifts and breaks, housing, food and water supply, and alternative childcare so the team can continue to provide needed care to survivors (Adams & Walls, 2020; Hick et al., 2020; Koh & Hoenig, 2020). Occupational therapy practitioners can help alleviate anxiety in the health care team by taking an educative role in infection control, self-care, and maintaining a sense of control and building trust within the team during a crisis (Adams & Walls, 2020; WFOT, 2020).

Inevitably in a health care crisis, resources become a concern. Occupational therapy practitioners can practice and educate others in strategies from the Crisis Standards of Care, including preparing, conserving, substituting, adapting, reusing, and re-allocating resources (Hick et al., 2020). The role of occupational therapy practitioners in disaster preparedness and response directly relates to alleviating ethical challenges: “It is only by making great efforts before disasters, that ethical challenges can be minimized in disaster responses” (Ozge Karadag & Kerim Hakan, 2012, p. 602).

Ethical Issues Surrounding the COVID-19 Pandemic

The AOTA Ethics Commission receives emails from occupational therapy practitioners experiencing moral distress and other ethical challenges. Since the beginning of the COVID-19 pandemic, practitioners have reported issues including:

- Scarcity of personal protective equipment (PPE) and resultant potential risk to self and others
- Scope of practice and duty reassignment
- Health Insurance Portability and Accountability Act (HIPAA) compliance, autonomy, and informed consent concerns
- Keeping track of records and billing, especially in telerehabilitation environments
- Concerns regarding duty to treat individuals who test positive for COVID-19 vs. protecting one’s loved ones from infection

Additional issues raised for medical personnel include HIPAA compliance vs. public health need to know (Health and Human Services Office for Civil Rights, 2020); and health disparities regarding resource allocation and illness recovery related to culture, race, ethnicity, disability, coexisting conditions, and age (Biddison et al., 2018; Leider et al., 2017; McCullough, 2010; Parente et al., 2017).

Case Examples

The case example of Briana, starting on page TK, highlights ethical issues surrounding the pandemic, including duty to provide care vs. duty to self and family, resource allocation, and scope of practice. Following a framework for ethical decision making (see Figure 1 on p. TK; Brandt & Slater, 2011), Brianna first identified the ethical problem: the competing duties to her employer (Fidelity; AOTA 2015) and to herself and family (Justice; AOTA 2015). Second, she considered all those involved, including clients, co-workers, supervisors, family members, and self. Next, she sought out more information through discussing the issue with her employer. Fourth and fifth, she found out all she could about options and resources, as well as consequences of those options. Finally, she decided to discuss the issue again with her employer to seek out a compromise, creating a new option. Reflecting on the outcome could help Brianna and her colleagues set new standards and come up with creative care solutions as they continued to provide care to their clients during the pandemic.

Case Example 2 highlights beneficence vs. risk to self in an acute care setting. The OT, Lee, is experiencing moral distress, because his employer is unable to provide PPE and guidelines for its use to assure safety for the health care team and patients, yet he has a duty to care for the patients. He was also contemplating the ethical dilemma of fidelity to his colleagues weighed against the risk of personal harm and harm to others through transmission of the COVID-19 virus. Before proceeding to resolution of the case, the reader is encouraged to use the framework for

ethical decision making (Figure 1) to work through the case and explore options for actions that Lee could take. With practice, an occupational therapy practitioner can improve on naming the moral distress and ethical dilemmas one is experiencing. By identifying and naming the distress, it is possible to mentally process options and ultimately decide on a satisfactory resolution.

Resources Available to OT Practitioners

Occupational therapy practice, interventions, services, and information/referral during an epidemic and pandemic must reflect the highest standards, duties, ethical principles, and professionalism of providers, supervisors, leaders, facilities, organizations, and policy makers. Although health care delivery at such times is not “normal,” occupational therapy practitioners strive to do their best work in challenging conditions, fraught with professional and personal choices that are almost unimaginable in other times.

To accomplish these ends, decisions must meet the following criteria:

1. Do no harm
2. Include and actively involve all relevant parties
3. Incorporate current information on the emerging epidemic or pandemic
4. Reinforce informed consent
5. Uphold AOTA core values
6. Be transparent and provide clear communication through documentation
7. Respect patient and client autonomy
8. Be consistent with public health declarations from appropriate government officials.

These criteria are consistent with the principles of the AOTA Code of Ethics (2015), including Nonmaleficence, Autonomy, Justice, and Fidelity.

AOTA and WFOT Resources

AOTA and WFOT have posted resources on their websites for use during the COVID-19 pandemic (AOTA, 2020a; WFOT 2020). These resources include telehealth advocacy and updates on permissions for provision of OT services via telehealth (AOTA 2020a), statements and policy resources, discussion forums (AOTA, 2020a; WFOT, 2020), and a free-to-members online continuing education course on disaster management (WFOT, 2020). Staying in touch with how other OT practitioners are coping during this disaster can help to alleviate the moral distress brought about by feeling isolated and overwhelmed.

Additional Resources

Many professional and interprofessional organizations have issued statements and provided resources for pragmatic and ethical management of a pandemic. The Hastings Center has provided an ethical framework and guidelines for responding to the pandemic (Berlinger et al., 2020). The Centers for Disease Control and Prevention (CDC; 2020) and WHO (2020) have likewise provided resources for disaster management. Other resources are available that were developed during current and previous health crises and can provide guidance during the current pandemic (Hick et al., 2020; Holt, 2008; McCullough, 2010). Information on how to support health care workers during a crisis is also available (Adams & Walls, 2020; Ulrich, 2020).

Conclusion

As OT practitioners navigate the challenging times of this global pandemic, we must focus on making the best possible choices we can, given the extreme circumstances. There are no answers that will be correct for every circumstance, nor are there perfect solutions when choosing between two options that are both fraught with ethical challenges. OT practitioners must weigh the options, confer with colleagues, seek out institutional and professional resources and guidance, follow ethical problem-solving steps, and make the best decisions they can in an extraordinarily difficult time. Furthermore, occupational therapists can and should step into leadership roles as part

of the interprofessional team making decisions regarding disaster preparedness and management. When people look back on these times, the question asked by history will not be, “did they do the right thing?” but rather, “did they do all they could?” (McCullough, 2010). As OT practitioners focus on the guiding values that make us strong advocates for clients, the resounding answer will be, “yes.”

As stated by AOTA President Wendy Hildenbrand, PhD, MPH, OTR/L, FAOTA; and AOTA Executive Director Sherry Keramidas, PhD, FASAE, CAE., “We will get to the other side of this pandemic by using our innate problem-solving skills, by coming together to advocate for the continued value of occupational therapy, and by recognizing that this challenging time may create new opportunities for occupational therapy practice now and in the future” (AOTA, 2020b).

Case Example 1: Community-Based Setting During a Pandemic

Brianna was an occupational therapy assistant (OTA) who worked in a community-based early intervention (EI) program in a rural area of the Southwest. She provided occupational therapy services to children from birth to age 5, and their families, many of whom struggled with poverty. Brianna served children in various settings, including their homes and daycare centers, as well as in community- and school-based preschool programs. She was a single mom with 12-year-old twin boys. She was also the primary caregiver for her mother, who had chronic obstructive pulmonary disease.

As the COVID-19 pandemic began to escalate rapidly around the country and cases of the disease began to be reported, the governor of Brianna’s state ordered all educational programs to close. Brianna, her occupational therapy supervisor, and the rest of her work team met virtually to discuss options for continued service provision. The team agreed that services via telehealth were an option to discuss and offer to families. However, the team discovered that most families did not have the technological resources necessary to access such services. The team agreed the next best option was to offer services and support via phone and text consultation, although data collection would be a challenge. Nearly all the families expressed interest in receiving continued support and services in this manner, but many mentioned that they had few educational materials or toys in their homes. The director of the EI program recommended the work team gather in groups of 10 people to assemble individual packets of educational and play materials for delivery to families that needed them.

Brianna expressed concern to both her occupational therapy supervisor and the program director about physically gathering in a group to prepare the materials. Her mother’s underlying respiratory concerns caused her significant apprehension regarding this plan. The supervisor responded by stating that if staff members were not experiencing any COVID-19 symptoms, it seemed safe to gather in groups.

The EI program director responded to Brianna’s concerns by reinforcing that all staff were expected to participate because, “We are a team and other people are getting together for essential work.” She offered no alternative options for Brianna or other staff members who expressed reluctance to participate, even though Brianna volunteered to assemble all the materials by herself. Brianna also initiated working with her team members to develop a resource document of educational and therapeutic activities using common household materials, negating the need for a work team to gather to prepare physical materials.

As the day to assemble materials approached, Brianna experienced significant moral distress, combined with general anxiety, as diagnosed cases of COVID-19 in her community increased. She remained conflicted on how to balance ethical responsibilities to her employer and clients, and to herself and her family, especially given her role as primary caregiver for her mother. She also believed she had an obligation to the community to minimize the potential spread of the virus.

***STOP and CONSIDER (questions for reflection and discussion):

1. What are the competing ethical issues Brianna must decide between?
2. How might Brianna use a framework for ethical decision making to help her decide what to do?

Figure 1. Framework for Ethical Decision Making

1. What is the nature of the perceived problem?

2. Who are the players?
3. What information is known, and what additional information is needed to thoroughly evaluate the situation and formulate options?
4. What resources are available to assist?
5. What are the options and likely consequences of each option?
6. Prioritize values
7. Take action; be able to defend your action
8. Reflect on the outcome

(From Brandt & Slater, 2011)

Case Example 1: Resolution

Brianna sought guidance from the Occupational Therapy Code of Ethics (2015) (American Occupational Therapy Association, 2015). She understood this situation required careful consideration of ethical obligations as they related to the Principles of Beneficence, Nonmaleficence, and Fidelity. Brianna also sought guidance and insight by reviewing AOTA's *Framework for Ethical Decision Making* (Brandt & Slater, 2011) to contemplate options and the likely consequences of each. She also relied on other sources of information, such as the CDC and her local public health agency, each of which relayed that the virus could be spread by persons who were asymptomatic, and thus strongly discouraged gathering in groups (CDC, 2020).

Brianna requested to follow-up with the EI program director regarding her concerns. Based on the discussion, they reached a compromise in which they agreed that a group limited to three staff members would gather to assemble the materials. The trio worked at separate workstations, following CDC guidelines related to social distance, wearing masks and gloves, proper handwashing techniques, and appropriately disinfecting surfaces. Brianna was satisfied with her contribution to the project and believed she successfully participated while taking appropriate precautions.

Case Example 2: The Acute Care Setting During a Pandemic

Lee was an OT practicing in an acute care hospital. He had been in this position for 6 years and typically enjoyed the fast-paced, high acuity demands of this setting. Lee's primary responsibilities included providing evaluation and intervention for clients who were admitted to the neurology service; however, since the COVID-19 pandemic had begun to escalate in his state, there had been many iterations of staffing adjustments, and he now covered a combination of intensive care and medical units.

At first, Lee felt confident in his role as an OT in acute care, but as time passed and the pandemic continued to escalate, he started to question his safety, the safety of others, and whether his services were essential. The constantly changing PPE guidelines, often with multiple as well as evolving reasons for the changes, caused significant moral distress. The changes, paired with strict conservation and reuse of PPE, overwhelmed Lee and his colleagues, who often questioned whether they had followed the correct procedures prior to entering the room of a client who was COVID-19 positive. Lee had mostly positive experiences with the interprofessional team, who came together to support each other in this time. For example, an ICU nurse helped check Lee's PPE before entering a room so he felt more confident. However, there was one instance when a physician saw him applying PPE prior to entering a client's room and commented that the patient did not need occupational therapy because it was not worth wasting the PPE. This made Lee question his value and role in the care of these clients.

Because of the moral distress and risk he was experiencing, Lee contemplated whether to stop coming to work. He was beginning to think that the benefit to his clients did not outweigh the risks.

*****STOP and CONSIDER (questions for reflection and discussion):**

1. Who can Lee turn to for assistance in clarifying options in this situation?
2. Can you come up with at least three different options besides not going to work?
3. What principles would you use to help select a course of action?
4. To whom would you communicate your decision(s)?

Case Example 2: Resolution

Lee decided to use the *Framework for Ethical Decision Making* (Figure 1; Brandt & Slater, 2011) to avoid making a reactive, emotional decision. Through this process, he decided to meet with his supervisor to outline his concerns and sources of moral distress. Together, Lee and his supervisor reviewed the AOTA Code of Ethics (2015) to understand their ethical obligations to clients during a pandemic. Lee realized that the principles of fidelity and beneficence could help guide his decision, but that he would still have to do his own personal risk assessment. They also reviewed current PPE guidelines, consulted with infection control administrators, and set up additional trainings for all the occupational therapy practitioners in the department to practice donning and doffing PPE.

To address Lee's concerns about the role of occupational therapy during a pandemic, he and his supervisor consulted AOTA's COVID-19 resource page (www.aota.org/coronavirus). Here, they found critical information for justifying the role of occupational therapy practitioners as essential health care professionals.

Lee and his supervisor discussed strategies for opening a dialogue if someone were to comment again on the need for occupational therapy in the context of conserving PPE. Lee felt that his supervisor not only validated his feelings but also addressed the practical sources of his moral distress. He recognized that in these unprecedented times there will always be some level of uncertainty and an evolution of guidelines, but going through this process gave him the confidence to continue to provide high-quality, skilled occupational therapy services to clients in acute care during this pandemic, and to advocate for safe practice environments.

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The authors would like to acknowledge Mark C. Franco, Ethics Commission Legal Counsel, for his input and review.