Ethics has become the buzzword of the eighties—ethics in politics, journalism, business, and health care. There are some interesting reasons why ethics is such a popular subject, one of them being the publicity surrounding the Watergate scandal and the Iran-Contra affair. Ethical issues closer to our profession would be attempts to maintain life by creating a completely sterile environment (the Boy in the Bubble) and the Baby Doe case.

There are several good reasons for the rise in ethical awareness among health professionals. Brody (1983) cites three: advances in medical technology, changes in social circumstances, and shifts in moral values. We are all aware that modern technology has made it possible to sustain life artificially, to use machines to perform vital functions for varying periods of time, and to transplant organs. Questions about when life ends, whether withholding treatment is the same as murder, and whether the individual has a right to die are only a few of those created by technology.

In addition, societal changes have created new issues for consideration. Fewer people live in extended families, the elderly have become more isolated, more women have careers outside of the home, and there are more single-parent homes. All of these changes press for a reexamination of our attitudes toward societal roles, suicide, euthanasia, and abortion.

Finally, the increased access to information has added complexity to what at one time were considered to be simple issues. Modern medical and technological advances have created choices that did not exist 20 to 25 years ago, and, thanks to extensive media coverage, most of us know about the options that are available. Health care professionals can no longer blindly abide by the rule that life is to be saved at all costs. The allocation of scarce health care resources forces us all to rethink our moral convictions. Tough choices must be made about who receives certain types of services and equipment and, ultimately, about who will live and who will die (Brody, 1983).

As occupational therapists we face dilemmas in day-to-day practice that may not be as dramatic as those discussed in the media, however, to the individual patients and families involved they are crucial. These dilemmas most frequently have to do with quality of life. Achieving the highest possible quality of life is extremely important for persons with chronic disabilities.

Joan Rogers in her 1983 Eleanor Clarke Slagle Lecture spoke of the importance of ethical considerations in the clinical reasoning process. She stated that the ethical question to be answered by clinicians is, "What ought to be done to enhance occupational competence?" (p. 608) and she continued, "We must avoid confusing action that can be taken with action that ought to be taken" (p. 608).

Rogers emphasized that for the ethical component of clinical reasoning to be present, the patient’s goals must be taken into account. She also stressed the importance of respecting the patient’s autonomy and the need for the therapist to empower the patient to make informed choices about treatment.

Carlotta Welles (1985) has pointed out the critical link between ethical conduct and professional liability. In her chapter in the Occupational Therapy Manager she stated, "One of the reasons the public trusts professionals is that professions promulgate, monitor, and enforce ethical standards. Most ethical standards are supported by law in some form. Therefore, ethics should not be considered separately from law, although in ethics there may be an ethical violation where there is no actual damage" (p. 360).

Both Mosey (1981) and Rogers (1983) have given examples of potential ethical conflicts for occupational therapists. Some of those Mosey mentions are the conflict between confidentiality and sharing information with team members, the responsibility to not follow orders or a referral...
that could cause harm, conflicts between the rights of the individual and the rights of society, and the question of who is ultimately responsible for assessment and intervention. Rogers (1983) discussed the conflicts that can arise when the goals of the patient are not the same as the goals of the therapist, when the therapist is trying to decide which treatment approach will be the "best" for a given patient, the possible disparity between the patient's goals and the goals the treatment team has for the patient, and the weighing of the rights of families against the patient's preferences (Rogers, 1983).

In my own 1984 study of ethical dilemmas in occupational therapy practice, I found that there are indeed several common types of dilemmas that therapists face in their daily practice. The most common dilemma for therapists was to decide which type of treatment to provide, and it was most effective for a given client. The second most common dilemma was receiving referrals for treatment that are inappropriate. The third most common dilemma was not being able to provide adequate therapy because of the constraints imposed by the setting in which the therapists were working (e.g., having an unmanageably large caseload, battling management's perception of a limited scope of practice for occupational therapy in the facility). Fourth were disagreements between the therapist and other team members about the preferred choices of treatment for a given client. And last were disagreements between the therapist and the client or the therapist and the client's family about treatment goals.

In this special issue, several authors explore a few of the many interesting problems involved in occupational therapy ethical decision making. The articles are organized to take you from the philosophical to the practical. The reader will move from a basic philosophical discussion of ethics to a discussion of several critical issues—Informed consent, cost containment, and access to health care. A further article presents educational approaches to the teaching of ethical reasoning and another provides an example of research in this area. The final feature article is a panel discussion of three occupational therapy practice dilemmas. The Brief of New Department introduces an index that you can use to assess your own ethical behavior.

In conclusion, Margaret Coffey presents the self-assessment index she developed to help occupational therapy assistant students examine their own ethical behavior. The index was written to coincide with the "Principles of Occupational Therapy Ethics" (AOTA, 1984) and provides first-person action statements for each of them. The author briefly discusses the response of students who used the index and its potential uses. I hope that you will find this issue both informative and useful. It is a reminder to us all that ethics is a vital part of our profession. As an educator I believe we must accept the challenge of preparing future professionals to deal with the inevitable...
conflicts they will face in daily practice as well as helping fellow professionals to acquire the analytic skills necessary to deal with these same conflicts.

Acknowledgments

This issue is the result of many peoples' efforts. My thanks go first to Elaine Viseltar for her faith, encouragement, and “can do” attitude. Many members responded to the call for manuscripts for this special issue. I appreciate their interest and valuable contributions. No issue is possible without the assistance of reviewers. I am most grateful to Virginia Dickie, Lillian Greenstein, Linda Kamp, Jean Linder, Joan Rogers, Sally Ryan, Phil Shannon, Lyfa Spelbrin, Yvonne Teske, Nancy Van Slyke, and Jan Hengel-Watson for their assistance. Finally, Jane Rourke deserves credit for spearheading the effort in the Representative Assembly that resulted in a resolution to encourage the dissemination of information about professional ethics to the membership. I'm proud to be part of that effort.

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