Teaching Ethical Analysis in Occupational Therapy

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Ethical decision making is a cognitive skill requiring education in ethical principles and an understanding of specific ethical issues. It is also a psychodynamic process involving personalities, values, opinions, and perceptions. This article proposes the use of case studies and role-playing techniques in teaching ethics in occupational therapy to supplement conventional methods of presenting ethical theories and principles. These two approaches invite students to discuss and analyze crucial issues in occupational therapy from a variety of viewpoints. Methodology of developing case studies and role-playing exercises are discussed. The techniques are evaluated and their application to the teaching of ethics is examined.

O ccupational therapists are often faced with ethical problems. Experiencing simultaneously increasing independence and interdependence in practice, the occupational therapist is surrounded by ever more complex ethical questions and concerns. Without formal training, the therapist will find this process of ethical choice highly individualistic and intuitive (Ketefian, 1981).

These changes in clinical reality have caused changes in the academic preparation of occupational therapists:

In the past, allied health professionals received instruction regarding the moral aspects of their role. For example, they learned they should be honest, keep confidences, be faithful to colleagues, accept only just remuneration for services, and respect patients' dignity. The application of these moral norms in most patient care situations requires no reflection or discernment (i.e., the person does not have to use the tools of education). Today, however, education is needed for the challenge that arises when to act according to one moral norm compromises another norm. (Purtilo, 1983, p. 213)

The American Occupational Therapy Association (AOTA) is aware of the occupational therapist's involvement in ethical issues. This awareness is reflected in Standard IX of AOTA'S Standards of Practice for Occupational Therapy, which states that "Occupational therapists shall be familiar with and abide by the ethical practices of the specific facility or system in which service is provided" (AOTA, 1983, p. 804). Additionally, all occupational therapists shall observe the ethical practices as defined by AOTA in the Principles of Occupational Therapy Ethics (AOTA, 1984).

Clearly, there is need and support for ethics courses in the occupational therapy curriculum. However, there is controversy regarding the most appropriate method of teaching ethics. Most experts agree that there must be some exposure to formal ethical theories and principles as well as opportunity to apply these theories to actual clinical situations (Mahon & Fowler, 1979; Johnston, 1980; Crisham, 1981; Bebeau, 1985).

Since the general content of ethics courses in occupational therapy as stated above is so broad, it is helpful to rework it into a set of goals to put the content into focus. Callahan & Bok (1980) suggested the following goals for ethics courses in the health science curriculum: (a) to stimulate the moral imagination, (b) to teach the student to recognize ethical issues, (c) to elicit a sense of moral obligation, (d) to develop analytical skills, and (e) to teach the student to tolerate—and resist—disagreement and ambiguity.

Overview of Course Content

Callahan and Bok's (1980) goals were used as a framework to develop the course content for a required
course (3 semester hours) in applied ethics in the occupational therapy curriculum at Creighton University. The specific objectives of the course are to (a) increase and refine the students' basic grasp of ethics by teaching them the terminology they need to analyze ethical dilemmas, (b) compare and contrast traditions of ethical thought, (c) develop the students' abilities to apply ethical theories to actual ethical problems in the field of occupational therapy, and (d) increase the students' understanding of the psychological dimensions of ethical decision making through small group discussions of case studies and role-playing.

The course content includes the presentation of key ethical principles (autonomy, beneficence, fidelity, and justice) and their relationship to ethical decision making. Deontological and teleological theories are compared and contrasted. The AOTA Principles of Occupational Therapy Ethics are examined along with codes of ethics from other disciplines. To meet the goal of tolerating—and resisting—disagreement and ambiguity, case studies and role-playing exercises of actual ethical problems from clinical situations are used.

Case Studies as Teaching Tools

Ethical decision making is a cognitive skill requiring education in ethical principles and an understanding of specific ethical issues. It is also a psychodynamic process involving personalities, values, perceptions, and opinions. An experimental technique such as the use of case studies highlights this psychodynamic process.

Case studies can be an effective teaching tool if, rather than rushing through a discussion of ethical theories, the instructor can intersperse the case studies with didactic content to allow the students to work through the theories. The first step in this process is the identification of the ethical issue in the case. Jameton (1984) sorted ethical problems in the hospital into three different categories: (a) moral uncertainty (one is unsure of what principles or values apply, or even what the moral problem is); (b) moral dilemmas (two or more clear moral principles apply, but they support mutually inconsistent courses of action); and (c) moral distress (one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action).

The following case study is an example of the type presented in class. After reading the case study, the students are asked to identify the kind of ethical problem presented in the case and to justify their choice. The case study is based on the real clinical experience of a practicing occupational therapist.

The Responsibility of the Occupational Therapist—A Case Study

You have enjoyed your new position for the last 2 months on the adolescent psychiatry unit. You feel fortunate to have gotten the job, because the hospital is nationally known and the occupational therapy program is well established. You are involved in care conferences on all of the patients. Your input is valued because of your honesty and insight into the problems of your adolescent patients.

At a unit meeting, the chief psychiatrist informs the group that he is going to begin using a new type of behavior modification with his patients whose behavior has been diagnosed as an “adjustment disorder with mixed disturbance of emotions and conduct.” He is vague as to the exact type of treatment he plans to use, but he has a solid reputation in the community and in the hospital, hence the rest of the staff supports him. He admits the majority of the inpatients on the unit and is therefore quite valuable to the hospital.

Two weeks later, you sit in on a care conference on a new adolescent male patient. The nurse reads the case history. The patient has a history of running away from foster homes, extended absences from school, possible drug abuse, and a violent temper. He is 14 years old. The chief psychiatrist is his attending physician. The patient has been in an isolation room for the past 2 days because of aggressive behavior shortly after his admission. The psychiatrist says, “I have been withholding food and water from him and intend to continue with this behavior modification until he is willing to comply with the rules and regulations on the unit.”

You are not sure if you heard him correctly. You ask for clarification. The psychiatrist replies, “This is a new type of behavior modification therapy that has proven quite effective for recalcitrant youths. He is healthy and a few days without food and water won’t hurt him.” The psychiatrist leaves the group to make rounds. The rest of the care team discusses what has happened. A staff colleague asks you, “What do you think of all this? Is it right?”

The ethical problem presented in the case is clearly one of moral distress because the withholding of food and water is not the right thing to do, but the institutional constraints in the case study make it very difficult for the occupational therapist to pursue the right course of action. Students are then asked to identify a situation in which it would be ethically correct to withhold food and water from a patient. Generally, the students identify the situation of a patient preparing for surgery who is not allowed to eat or drink anything. This leads to a discussion of the inherent differences in the two situations: the difference

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between (a) the intentions of the action in each case, (b) the terms upon which each patient consented to the action, and (c) the consequences of the two actions.

The students practice constructing logical arguments based on the ethical principles and theories they learn in class. They learn that “it is the logic of the decision-making process with its associated justification that is debatable rather than the decision/action” (Gilbert, 1986, p. 212).

François (1983) suggested two additional exercises that could be used with the same case study:
1. The student is asked to write an analysis of the implied social contract between health professional and patient in terms of rights, obligations, nature of the relation, who makes the decisions, and the handling of conflicting rights. The student is asked to consider a case study and list as many treatment options as possible.
2. Having limited life experience, young people are often satisfied with identifying half a dozen options where 20 to 30 are available. Challenging the student to list as many options as possible for a case study can emphasize the importance of knowing all the options before making a decision.

Discussion of case studies allows the student to be a more active learner. It encourages original thinking rather than mimicry and memorization. Piaget (1976, p. 93), commenting on the advantages of active learning over traditional instruction, said that “he will learn to make his own function by himself and will build his own ideas freely.” Occupational therapists need to learn how to think critically, for not only must they be prepared to recognize and think about ethical problems, they must also have the confidence to act upon their analyses (Steinfels, 1977).

Case studies should not be used exclusively, for alone they provide no basis for resolving ethical conflicts. As was noted earlier in this discussion, the most effective teaching of ethics combines a study of ethical theory with analyses of concrete problems of clinical practice. The use of role-playing is one way to provide students with the opportunity to examine problems they are likely to encounter in practice.

Role-Playing as a Teaching Tool
Clearly, ethical problems are human problems and are therefore fraught with human emotions. “What learners should be helped to appreciate is that ethics does not demand the elimination of the affective response. Rather, ethics provides individuals with the means to redirect their emotional, illogical reactions in the face of moral conflict into passionate, logically reasoned responses” (Gilbert, 1986, p. 213).

Role-playing and the opportunities to observe differences in reactions offer unique kinds of learning that cannot be gained in other ways. Role-playing allows us to simulate life experiences and the psychodynamic processes that are part of them in a safe environment. “Only practice makes us sensitive to interpersonal skills and expands our behavior repertoire” (Maier, Solem & Maier, 1975, p. v).

The technique of role-playing is an outgrowth of the work of Moreno (1953), who initially developed the method while working with the mentally disturbed. The technique is recognized and accepted as a training method in interpersonal relationships and can be modified in a variety of ways for use in teaching ethics. The unique values of role-playing include the following:

- It requires students to carry through a thought or a decision. It demonstrates the difference between doing and thinking.
- It permits practice in carrying out an action and makes clear that maintaining good interpersonal relations between various health care providers requires skill.
- It accomplishes attitude changes effectively by placing students in specified roles. Playing a role demonstrates that a person’s behavior is a function not only of personality but of role expectations.
- It helps students become aware of the feelings of others and their value systems (Maier, Solem & Maier, 1975, pp. 2–3). Students are often startled to learn that others disagree with them, especially when the right course of action is so obvious to them.

Role-playing exercises can be developed from actual cases with a high interest value. Such cases generally involve a conflict or a crisis that forces a decision of some type by the participants in the role-playing. The framework for the exercise consists of a brief case study followed by an acting-out of the value scripts (scripts containing the opinions of the principals in the case study) by the characters in the role-playing. The value script is a starting point for the discussion in the role-playing, but the participants are not limited to the content in the scripts.

The students need not be actors but should be encouraged to display genuine responses and ask questions as the role-playing progresses. The instructor is encouraged to use volunteers for the role-playing exercises. The students who are not directly involved in the role-playing can participate as objective observers and critics of the decision-making process they are observing. Participants and observers should be encouraged to become process-minded rather than solution-minded.
An example of a role-playing exercise is given below. This exercise was developed from the case study described above, involving the withholding of food and water from an adolescent patient. The objective for the participants in the exercise is to decide what the morally correct action would be in the case. The instructor assigns the roles and sets a time limit of no more than 30 minutes for the role-playing.

**Occupational Therapist**

I don’t see how withholding food and water could ever be considered therapeutic.

Even though the patient is a minor, he still has rights. He has the same rights that any person has. That doesn’t change just because he is in the hospital.

Would the treatment be the same if the patient had parents who were involved in his care?

I am concerned about the long-term harm this may cause. How can we be sure that we’re not doing him permanent harm?

I just don’t think this is right.

**Psychiatric Technician**

I’ve noticed that all of the other patients have really shaped up since we started this therapy. If it helps keep the number of fights down, I’m all for it.

He’s healthy. A few days without food and water won’t hurt him.

I know that his physician would never do anything really harmful. I trust his judgment.

**Physician**

This type of behavior modification has proven very effective for this kind of patient. I would like the support of the staff to make this work.

I have ordered a consultation with an internist to make sure that the patient does not suffer any harm from fluid and electrolyte imbalances.

I think I know what is best for a patient. After all, I have been practicing psychiatry for the last 30 years.

I can’t understand how this differs from any other restriction of privileges.

**Hospital Administrator**

Our adolescent unit has the reputation for being on the leading edge of treatment innovations. I trust the physician’s judgment.

I am sure the physician is doing what is best for the patient.

The last thing we would like to see happen is for the concerns of some of the staff to be taken outside the institution. I know we can come to some sort of resolution that will make everyone happy.

**Recreational Therapist**

I cannot agree with this form of treatment. In fact, I consider it a form of torture.

I refuse to participate in this patient’s care. I would be ashamed of myself if I did.

How can you justify depriving someone of food and water?

After the participants in the role-playing have come to a resolution, the participants and the rest of the students should analyze what occurred. A discussion of what really happened from the participants’ perspective and the observations of the group help clarify the experience. The discussion should be limited, however, because much of the learning from role-playing is of a personal nature. Frequently, role-playing experiences have considerable impact on the student’s perception of a problem. The new attitudes and behaviors experienced in the role-playing tend to carry over into clinical practice.

The students’ reaction to the use of case studies and role-playing has been overwhelmingly positive. They often bring case studies to class from their own clinical practice for use in discussions. Initially, there is some reluctance to participate in the role-playing exercises. After the first session, however, the number of volunteers steadily increases as the students realize that they are not expected to “act.” Animated discussions of the case studies often continue as the students depart.

**Conclusion**

Ethical issues and moral dilemmas do not occur in a vacuum. Occupational therapists deal with real-life dilemmas that demand a response. At Creighton University, we have found that the use of case studies and role-playing breathes life into ethical decision making and prepares the occupational therapy student to make an informed, rational contribution to the decision-making process. The success of these two unconventional teaching methods warrants a formal investigation into their impact on clinical practice and ethical decision making.

**References**


