The delivery of occupational therapy in ever changing systems has resulted in an increased focus on ethical concerns (Brown & Gabriel, 1995; Curtin, 2000; Fisher, 1997; Jacobson & Pomfret, 2000; Lohman & Brown, 1997). In recognition of ethical issues, the American Occupational Therapy Association (AOTA) has developed three documents that guide ethical practice: the Occupational Therapy Code of Ethics (American Occupational Therapy Association [AOTA], 2000), the Core Values and Attitudes of Occupational Therapy Practice (AOTA, 1993), and the Guidelines to the Occupational Therapy Code of Ethics (AOTA, 1998).

When society cannot solve ethical and other societal concerns, then public policy develops and these policies reflect values considered to be important by society (Shapiro, 1999). Therefore, understanding ethical principles and ethical reasoning applies not only to clinical practice but also to larger health care and disability issues addressed by public policies. In this paper the authors propose that therapy practitioners consider the Occupational Therapy Code of Ethics (AOTA, 2000) in a broad manner by applying the document to health care and disability public policies. Application of this document involves critical analysis of policy issues enabling therapists to come to their own positions. Therapists do not necessarily need to support the AOTA position about a particular policy, or any another suggested position. However, they do need to apply clinical reasoning to arrive at a position that they can defend ethically. The Individuals With Disabilities Education Act (IDEA) (1997) (Pub. L. 105-117) will be used as an exemplar for this discussion.

In the first section of the paper, we present a brief history of the IDEA as a foundation for further discussion. Understanding the history of a public policy helps to develop a broader perspective about the issues influencing legislation. In the second section we discuss how the Occupational Therapy Code of Ethics (AOTA, 2000) can be applied to understand and critically analyze ethical issues with the IDEA or with any public policy. The last section includes a list of reflective questions to help therapy practitioners critically analyze the ethical issues of public policy.

**Brief History of the IDEA As a Public Policy**

In 1975 Congress passed the Education of the Handicapped Act (EHA), (Pub. L. 94-142), which mandated special education and related services to children between the ages of 5 and 21 years of age who have disabilities. Prior to 1975, school-age children with moderate to severe disabilities were frequently excluded from the public education system or were receiving inadequate services (Case-Smith, Rogers, & Johnson, 2001; Hanft & Place, 1996). The intent of this legislation was to create a more just public educational system that provided appropriate education and related services for school-age children with disabilities. The law was amended in 1986 (Pub. L. 99-457) to require preschool services, as society recognized the importance of early intervention (AOTA, 1999). Amendments in 1990 (Pub. L. 101-476) and 1991 (Pub. L. 102-119) changed the name of the EHA to the Individuals With Disabilities Education Act and added services such as assistive technology (AOTA, 1999). The reauthorization of the IDEA passed in 1997 (Pub. L. 105-117) recognized the values and attitudes of integration, or including children with disabilities with their nondisabled peers, and the central and essential role of families in shaping a child's life. The changes in 1997, which are relevant to occupational therapy practice, included expanding parent participation, requiring functional assessments, assistive technology, transition plans, attendance at Individual Education Plan (IEP) meetings, and changes in the nature and frequency of writing goals and reporting progress (AOTA, 1999; Muhlenhaupt, Miller, Sanders, & Swinth, 1998).

The next round of changes to the IDEA was debated during the 2002 legislative year (although as of this writing, final legislation had not yet been passed). The 2002 reauthorization bill, “Helping Children Succeed by Fully Funding the Individuals With Disabilities Education Act (IDEA),” is intended to provide full funding of the federal contribution to IDEA to the states. The original legislation called for the federal government to provide 40% of the funding for special education services under part B of IDEA (for school-age children). However, the actual level of federal...
dollars has never exceeded 15% of the maximum state grant allocation for education of children with disabilities (Library of Congress, 2001). The proposed changes with the reauthorization legislation include the need for well-trained related services personnel (such as occupational therapists) and the importance of a full partnership between parents and the educational team members.

The Bridge From Ethical Issues in Practice To Public Policy

From a broader perspective the 1975 enactment of what is now the IDEA was developed at a time when other legislation for people with disabilities was being enacted, such as the Developmental Disabilities Assistance and Bill of Rights Act (P.L. 94-103, 89 Stat. 486) and the Rehabilitation Act of 1973 (PL 93-112, 87 Stat. 355). All these policies developed when civil rights for all people in America gained prominence. Values such as liberty, justice, and access were behind the civil rights movement and resulting disability policies. Furthermore, valuing the youth of this society is also evident in the strong societal support of the IDEA.

As this brief overview of the historical beginnings of the IDEA reflects, public policy develops because of broad societal concerns, often related to ethical issues. Therefore, it behooves therapists to consider ethics beyond their individual patient practice world to the larger societal context to help the population of current and future patients. Brown and Gabriel (1995) addressed this important link between ethics and policy in a discussion of ethical perspectives on school-based practice from the viewpoints of an ethic of care, rights-based ethics, distributive justice, and an integrity-preserving compromise. They urged occupational therapists to take part in policy debates on allocation of resources and other ethical issues.

In order to fully participate in an ethical discussion about policy and practice under the IDEA, it is important to first consider the AOTA Code of Ethics (AOTA, 2000). Ethical issues are quite complex and the following discussion will illustrate another application of some parts of this ethical document beyond patient care. Because this ethical document was written primarily for patient care not all aspects of it will apply to policy.

Occupational Therapy Code of Ethics and Application to the IDEA

Principle 1 of the Occupational Therapy Code of Ethics states, “Occupational therapy personnel shall demonstrate a concern for the well-being of the recipients of their services (beneficence).” (AOTA, 2000, p. 614). Within this principle it states, “Occupational therapy personnel shall make every effort to advocate for recipients to obtain needed services through available means” (AOTA, 2000, p. 614). In a broader sense this statement could be interpreted to mean that occupational therapy practitioners should advocate for policies that help their clients obtain the best care. The spirit and intent of the IDEA is an example of advocacy for recipients to obtain needed services.

Principle 2 states, “Occupational therapy personnel shall take reasonable precautions to avoid imposing or inflicting harm upon the recipient of services or his or her property (nonmalfeasance)” (AOTA, 2000, p. 614). Principle 1 and 2 can be discussed together as they are mirror opposites of each other. Occupational therapy practitioners should help patients and not harm them. Some would argue that the underfunding of the IDEA exemplifies potential harm to children with disabilities. Underfunding has placed an increased financial burden on state and local governments. Given the current political climate, it is unlikely that significant sources of new revenue will become available. Lack of sufficient services, or inability to obtain occupational therapy services because of underfunding, can and does have consequences that are harmful to children. Ethically, occupational therapy practitioners aim to avoid client harm and to be concerned about the well-being of their clients. In addition, we believe that occupational therapy practitioners should engage in supporting public policy change designed to eliminate conditions that can potentially harm clients. Lack of involvement by occupational therapy practitioners in legislation and the development of policies minimize the benefit of one's education, skills, and ability to live out the Occupational Therapy Code of Ethics (AOTA, 2000). One way of doing harm to patients is to be passive politically and legislatively. One way to help patients (beneficence) is to be active in the public policy process.

Principle 3 of the Occupational Therapy Code of Ethics (AOTA, 2000) states that “Occupational therapy personnel shall respect the recipient and/or their surrogate(s) as well as the recipient’s rights (autonomy, privacy, confidentiality)” (p. 614). Autonomy is based on one’s rights to beliefs and values and the choices that influence one’s beliefs and values (Longest, 1994; Purtillo, 1999). Autonomy relates to the American value of self-determination (Longest, 1994). The IDEA requires that professionals collaborate with parents and students (when appropriate), to determine goals for the IEP that are of importance and have meaning to the child and family. Prior to the IDEA it was common for educators and therapists to develop goals independently and then inform the parents. The IDEA recognizes the importance of autonomy for parents and children and requires collaboration with, not just consultation to, families. Thus, this example illustrates how a principle of ethics can be related to the regulation of a public policy with patient care. The other aspect of this principle, maintaining confidentiality, is necessary for the establishment and maintenance of trust.

The importance of trust in relationships applies to both clinical practice and to policymaking, as during the policymaking process some information may be confidential (Longest, 1994).

Principle 4 of the Occupational Therapy Code of Ethics states that “Occupational therapy personnel shall achieve and continually maintain high standards of competence (duties)” (p. 615). This involves taking part in “professional development and education activities” (AOTA, 2000, p. 615) and being current with practice. This principle applies directly to the regulation of public policy within clinical practice. For example, occupational therapy practitioners who work in public schools need knowledge and competencies in many areas. Examples of knowledge include a full...
understanding of the IDEA, state rules and regulations for special education (which differ from state to state), school district policies for related services, and how to write objectives for IEPS and Individual Family Service Plans (IFSPs) (AOTA, 1999). Another example of a competency would be how to engage in collaborative consultation with educators and parents (Hanfl & Place, 1996). Therapists are ethically obligated to seek out this specialized training through activities such as mentoring, continuing education, additional course work, AOTA self-study, and independent reading. The authors suggest that maintaining high standards of competence also means being competent in understanding the political and legislative process. Occupational therapists can learn more about the political and legislative process by reading the Action Alerts on the AOTA Web site, taking public policy courses, reading public policy books and journal articles, attending continuing education conferences, networking with their state lobbyist, and by paying attention to the media. Competency is not just limited to clinical skills.

Principle 5 of the Occupational Therapy Code of Ethics (AOTA, 2000) states that “Occupational therapy personnel shall comply with laws and Association policies guiding the profession of occupational therapy (justice)” (AOTA, 2000, p. 615). Justice is a broad concept from political and theological philosophies (Longest, 1994). The principle of justice is typically used to describe ways of fairly distributing benefits and burdens in society and deciding what is rightfully due a person, institution, or society (Kornblau & Starling, 2000; Purtilo, 1999). The Core Values and Attitudes of Occupational Therapy Practice (AOTA, 1993) document describe justice in terms of fairness, equity, truthfulness, and objectivity. This section of the document also directs the practitioner to understand and abide by the local, state, and federal laws governing professional practice. The latter aspect of justice can be applied to the current discussion by suggesting that practitioners in school-based practice should follow the changes and reauthorization of the IDEA in order to ensure the best possible outcomes for their current and future clients.

Principle 6 (AOTA, 2000) states that “Occupational therapy personnel shall provide accurate information about occupational therapy services (veracity)” (AOTA, 2000, p. 615). In clinical practice therapists are encouraged to represent themselves accurately and to provide accurate information to ensure public trust. When working with public policies therapy practitioners need to apply the same concept of sharing truthful, factual information about the public policy with legislators and peer professionals. This involves being aware of the biases of information. Therefore, it is of benefit to the profession and to society to critically compare the actual language of bills to what is being stated in the media to determine the accuracy of information.

Principle 7 states that “Occupational therapy personnel shall treat colleagues and other professionals with fairness, discretion, and integrity (fidelity)” (AOTA, 2000, p. 615). It also includes responsibility to uphold the ethical practice of occupational therapy and to discourage (or expose if necessary) unethical practice of occupational therapy personnel. According to Beauchamp and Childress (2001), fidelity also extends to acting in good faith and fulfilling agreements with employers as well as clients. Therapy practitioners should exercise fidelity whether dealing with school districts, colleagues, parents, or policy makers when advocating for an issue, such as children’s rights. Diplomacy helps with good advocacy skills. When traits of fairness, discretion, and integrity are demonstrated, good public policy is more apt to result (Zererwek & Claborn, 2000).

Critical Analysis of Policy and Ethics

Supporting policies that help clients, such as the IDEA, involves considering the underlying ethical principals of the policy. Many public policies are utilitarian focused, meaning that they seek to create the most good for the greatest number of people (Edge & Groves, 1999). For this reason they may not contain everything that a particular interest group, such as occupational therapy practitioners, would want included. Therefore, occupational therapy practitioners need to critically weigh the language of a policy utilizing the critical thinking skills of questioning, reasoning, and reflection (Brookfield, 1987) to determine whether the policy generally supports their moral values. When critically reflecting about a health care policy, occupational therapy practitioners can consider the following questions: Why is it important to consider ethics related to this bill? What principles of the Occupational Therapy Code of Ethics (AOTA, 2000) are supported by the public policy? What values are inherent to the policy? Why is it important to consider the values related to this bill? How do these values compare with the Core Values and Attitudes of Occupational Therapy Practice (AOTA, 1993)? What agreements and or disagreements are there about crucial moral principles (Mappes & Zembaty, 1991)? Does the policy provide a “balance” of client concerns and other societal concerns, such as economics? Does the policy truly promote the over all well being of clients and society?

Conclusion

In summary, one typically thinks of applying the Occupational Therapy Code of Ethics (AOTA, 2000) to the micro world of individual clinical practice. We are suggesting that one can also think of applying parts of the document to the macro world of public policy to foster overall public well being. Therefore, we believe it is critical that occupational therapy practitioners become very aware of the ethical issues that occur in clinical practice, which have public policy implications.

Being an advocate for change, based on ethical principles, may be difficult. It may put the practitioner in conflict with a prevailing political climate that seems focused on the bottom line and costs, rather than quality of life for individuals with disabilities. Such advocacy requires moral courage, which is an ethically desirable characteristic (Purtilo, 2000). In discussing moral courage, Purtilo (2000) suggests that the opposite of moral courage is not cowardice, but apathy. She argues that apathy, which results in no action, can be considered a form of complicity in that one is allowing harm to occur by not taking action. Therefore we believe that occupational therapy practitioners should invest
the time and energy to stay informed about public policy and ethical debates and to intervene when debates, and subsequent decisions, are likely to affect persons with disabilities or special needs.

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References


