Moral Tensions and Obligations of Occupational Therapy Practitioners Providing Home Care

Karin J. Opacich

Key Words: ethics, occupational therapy • home health occupational therapy

Home care has been valued as a relevant context for the provision of occupational therapy since the inception of the field. The setting provides rich opportunities to restore meaningfulness in living for clients whose lives have been disrupted by illness or untoward events. Additionally the home care setting allows practitioners to exercise professional commitments and to meet ethical obligations congruent with the field of occupational therapy. Nevertheless, the home care arena is not exempt from the pressures that pervade the health care industry.

To thrive in the provision of home care, occupational therapy practitioners must prepare themselves to deal with the philosophic, economic, and moral challenges inherent in the setting. This article explores the moral obligations of occupational therapy practitioners who provide home care. More specifically, it addresses obligations to self, to patients, to caregivers, to society, to the profession, to fellow health care providers, and to agencies and payers. Ethical principles associated with each are highlighted, and issues are raised. Home care practitioners who are attuned to the moral commitments imbedded in occupational therapy philosophy will most likely incorporate these tenets into their clinical decisions.

These are turbulent times for the health care enterprise in America. Many of the proposed reforms represent economic strategies designed to cut costs in traditional health care settings. In addition, new markets and more efficient models for the delivery of health care continually emerge. Given the complexity of problems in the industry, it is no surprise that health care practitioners must also address ethical content in the clinical reasoning process. Each health care setting poses unique conditions and situations that must be considered carefully, and home care affords particularly rich opportunities.

The Moral Context of Home Care

After a period of institution-centered health care in the late 19th and early 20th centuries (Bayer, 1984), the movement toward home care appears to be both logical and welcome. According to Bayer (1984), "a mixture of humane considerations and fiscal dread forced the issue of home care onto the public agenda" (p. 58). To occupational therapy practitioners, however, home care has been valued as a relevant context for intervention since the inception of the field in the early 1900s. Typified by the Hull House movement, community outreach was an integral part of occupational therapy (Reed & Sander-
son, 1992). Because occupational therapy addresses meaningfulness in living as it is expressed in the roles, habits, behaviors, and activities of each person, the importance of home cannot be understated, nor can the potential for home as a therapeutic setting be overlooked.

The philosophical underpinnings of home care and the professional philosophy of occupational therapy are highly compatible. Both place the patient (or the patient's surrogate) as central in health care decision making. When home care is determined to be appropriate, the interests of the patient (e.g., autonomy, dignity) can be served both by the home care context and in the provision of occupational therapy. Ideally, the person who is ill can be supported and restored to health or cared for in the community. An ethic of caring that respects the life that the patient has created can best be served in a familiar environment and among those with whom he or she has established relationships (Beauchamp & Childress, 1994; Monagle & Thomasma, 1994; Sherwin, 1992). Occupations that are personally meaningful, developmentally appropriate, and culturally relevant can be evaluated and addressed within the patient's lived experience rather than conjectured in the often surrealistic institutional context.

Both the Occupational Therapy Code of Ethics (American Occupational Therapy Association [AOTA], 1994) and the Core Values and Attitudes of Occupational Therapy Practice (AOTA, 1993) support the premises of home care. In the ethics document, Principle 2A pertains to autonomy, privacy, and confidentiality and explicitly states: “Occupational therapy personnel shall collaborate with service recipients or their surrogate(s) in determining goals and priorities throughout the intervention process” (AOTA, 1994, p. 1037). Among the seven concepts named in the core values and attitudes document is the concept of freedom, a central theme of occupational therapy:

> Purposeful activity plays a major role in developing and exercising self-direction, initiative, interdependence, and relatedness to the world. Activities verify the individual’s ability to adapt, and they establish a satisfying balance between autonomy and societal membership. As professionals, we affirm the freedom of choice for each individual to pursue goals that have personal and social meaning. (AOTA, 1993, p. 1085)

The home setting is the patient’s domain and reflects an array of choices and artifacts of the life that this person has constructed.

When ethical commitments are explicitly articulated by occupational therapy programs and practitioners, interventions can be generated that are congruent with professional philosophy. Explicit statements that reflect ethical priorities aid in reinforcing ethical underpinnings that yield viable options, especially when priorities conflict. These ethical or moral commitments distinguish the occupational therapy endeavor as covenantal rather than contractual (May, 1975).

Tensions in the Prevailing Health Care Paradigm

In an era of political and social uncertainty, the notion of health and the provision of health care continue to be controversial. Pluralistic by nature, American society yields contrasting interpretations of rights and privileges, duties and opportunities, and benefits and burdens pertaining to health (Engelhardt, 1996). Occupational therapy practitioners, along with other stakeholders, must advocate for consumers and the profession in light of the sociopolitical climate. Being apprised and prepared to face ethical challenges will facilitate practitioners’ decisions and actions, and toward that end, some of the salient issues resounding in the health care arena follow.

The controversy about health as the right of every citizen or as a privilege to attain stems from the protection of individual liberties assured by the U.S. Constitution (Goldwin, 1986). The current health care structure favors the notion of health as a privilege. Consequently, health and health care are not equally distributed among American citizens. Additionally, the debate about health care reform has been framed as an issue of cost control rather than that of social ethics. Even more narrowly, the discussions and strategies pertaining to cost containment have defined health in terms of medical status and have minimized the dialogue and resources devoted to social conditions that affect health. Changes made in recent years are largely insurance reforms, among which is the movement toward the U.S. version of managed care.

The American managed care paradigm raises some critical questions for occupational therapy practitioners who are accustomed to reimbursement from private or public medical insurance. One might ask: Who is managing what care on whose behalf? Because occupational therapy is historically a health profession rather than a medical profession, changes in alliances and reimbursement can be anticipated in the near future. Even more importantly, occupational therapy practitioners must reiterate which philosophical beliefs and ethical commitments they hold dear or risk being defined by cost-controlling strategies that do not accommodate occupational therapy values (Peloquin, 1996; Rosenfeld, 1995).

Directly or indirectly, the broader health care agenda will affect occupational therapy practitioners who provide home care. At the least, health politics will determine who has access to occupational therapy services. Interpretations of occupational therapy in the managed care context may not accurately reflect the depth and breadth of human occupation in favor of a reduced but more readily understood iteration. It may become increasingly harder to defend and uphold the core values and commitments.
of the profession, which are laden with intrinsic value and which elude mechanistic analysis. Such tensions will undoubtedly affect the nature of interventions, documentation, reimbursement, and relationships with patients and fellow health professionals.

Overarching Ethical Questions and Situational Ethics

In *The Foundations of Bioethics*, Engelhardt (1996) attempted to demonstrate that it is possible to reach ethical solutions to contentious health problems in the absence of ethical consensus. Although occupational therapy practitioners will perceive ethical tensions within everyday experience, specific potential solutions will reflect more global assumptions. For example, problems associated with access to occupational therapy services allude to the responsibilities of a humane society to its citizens. Given that occupational therapy is a limited resource, the good that can result must be consciously distributed (Christiansen, 1996). By what criteria can the need for home occupational therapy be established? The often-used criterion—confined to home—seems far too simplistic to be useful.

The occupational therapy literature reflects the rhetoric of feminist ethics (Sherwin, 1992), particularly the ethic of care (Beauchamp & Childress, 1994; Braithwaite, 1994; Campbell, 1993; Gilligan, 1982). How might these belief systems shape and enhance occupational therapy in home care? It is apparent that as cost-control strategies are implemented, both the power structure and nature of relationships in the health care arena will change (Abramowitz, 1991). Exploring how these changing relationships affect the occupational therapy process in home care settings will be important in supporting practitioners to achieve positive outcomes.

Given the converging demands of advocacy and practice, occupational therapy practitioners would do well to develop a process of ethical reflection that parallels clinical reasoning. To begin reflecting, it may be useful to contemplate the moral obligations of home care practitioners to self, to patients, to caregivers, to society, to the profession, to fellow health care providers, and to agencies and payers. (The ethical principles associated with the following discussion are highlighted in boldface type.)

**Moral Obligations of Occupational Therapy Practitioners Providing Home Care**

**To Self**

Each member of the occupational therapy professional community is expected to achieve and maintain competency. Toward this end, there are many checkpoints through which the aspiring occupational therapy practitioner must pass before exercising full autonomy (Opacich, 1996). The process begins with meeting the admission and selection criteria of an accredited occupational therapy program. After graduating: passing the certification exam; and, in most cases, obtaining state licensure, occupational therapy practitioners, as do other professionals, assume more independent responsibility for maintaining competence. Continued competency may be demonstrated through continuing education, involvement in professional organizations, pursuit of advanced education, and so forth. More formal measures of continued competency are currently being developed by the National Board for Certification of Occupational Therapists. Many states require proof of continued competence as a condition of license renewal.1

Assurance of competency is particularly at issue in home care where therapy is conducted in relative privacy with little direct supervision. Practitioners providing home care must be wholeheartedly committed to maintaining high standards of practice and to the ethical principles governing relationships (e.g., fidelity, veracity).

**To Patients**

According to the historical tenets of the profession, occupational therapy practitioners have a duty to promote meaningfulness in living (beneficence, autonomy) (Engelhardt, 1983, 1986; Reed & Sanderson, 1992). Consistent with the code of ethics and the core values and attitudes, practitioners accept autonomy as an ethical priority in patient care. Such a duty requires that the practitioner preserve the dignity of home care patients and promote quality of life. The habits, rituals, and sensibilities that the patient has developed reveal the aesthetic values that he or she weaves into a meaningful existence.

**To Caregivers**

Not all families are adequate to the task of caring for their family members in the home setting. Especially when advanced technology is part of the home care routine, occupational therapy practitioners must refrain from placing undue burden on family members. Arras and Dubler (1994) warned that “the burdens to caregivers imposed by high-tech home care will vary with the level of technologi cal intensity, the duration of care, and the presence or absence of good communication, case management, and intermediate institutions” (p. S22).

Another major caregiver consideration is the potential

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1According to AOTA, as of November 1994, the District of Columbia, Puerto Rico, and the following states maintain continuing education requirements: Alabama, Alaska, Arizona, Arkansas, Connecticut, Delaware, Florida, Georgia, Iowa, Kansas, Louisiana, Maine, Maryland, Mississippi, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, South Dakota, Texas, and Vermont.
for inequity in home care, particularly in assigning responsibility to women (Noddings, 1994). Several authors have noted that women commonly bear a disproportionate part of this burden in addition to maintaining established roles and responsibilities in family structures (nonmaleficence) (Brakman, 1994; Callahan, 1988; Noddings, 1994). Caregiver demands can preclude pursuit of personal goals and fulfillment or attention to intact family members. Because family structures and roles emerge in the family culture, it behooves the practitioner to develop cultural competency to best serve recipients of care (Hinojosa, Anderson, & Strauch, 1988).

Occupational therapy practitioners in home settings must attend to power and decisional authority in the family, distribution of work and responsibility, and observance of cultural taboos. The informed practitioner will establish realistic expectations, plans, and supports for the patient and caregivers. By doing so, they can actively promote good (beneficence) while keeping faith with the family (fidelity). Consideration of the social and emotional content in addition to medical status is consistent with an ethic of caring.

To Society

Although a number of converging complex political, social, and economic phenomena have resulted in exorbitantly costly health care in America, all stakeholders bear some responsibility for scrutinizing and curtailing frivolous expenditure. Fair distribution and use of resources pertain to the ethical principle of justice. Occupational therapy practitioners providing home care must be forthright and accountable in the delivery of service. However, accountability need not take the form of externally determined, reductionistic measures ill suited to address the value of occupational therapy. Practitioners can best serve the interests of patients by carefully designing outcome measures and selecting measures that express the richness of occupation and occupational therapy. Qualitative methodology lends itself well toward this end, and triangulated data can be particularly useful in program evaluation efforts (Lincoln & Guba, 1985; Patton, 1990). Practitioners providing home care should remember that occupational therapy is a health profession that promotes wellness in addition to remediating events and conditions that result in illness. Because home settings are likely to reveal the very real obstacles to achieving a better state of health, practitioners can seize the opportunity to apply their most highly evolved forms of clinical reasoning to benefit patients (Atchison, 1993; Mattingly & Fleming, 1994).

Anyone representing himself or herself as an occupational therapy practitioner assumes the status and the privileges that the profession confers upon its members. The reciprocal moral obligation to represent the profession honorably and accurately follows (Engelhardt, 1986; Hansen, 1988; Opacich, 1996; Rogers, 1983). Keeping faith (fidelity) with the noble historical tenets of occupational therapy as it was conceptualized by the founders and fostered by subsequent generations of occupational therapy philosophers will preserve the integrity of the field and its practitioners in trying times.

After admitted to the profession, each occupational therapy practitioner becomes an ambassador who expresses the values and commitments of the field in each individual action and in collective endeavors. Peloquin’s (1996) invitation to inspire care is both timely and critical to the preservation and advancement of the field. Interwoven in the fabric of occupational therapy are numerous ethical commitments (e.g., autonomy, beneficence, justice) that can only be met by informed, contemplative practitioners who can translate these moral obligations into clinical decisions.

To Fellow Health Care Providers

Occupational therapy emerged from the collaborative efforts of philanthropists, theologians, physicians, nurses, social workers, and others who responded to events and conditions that were affecting public health (Reed & Sanderson, 1992). This precedent for collaboration with other professionals is an important tradition to perpetuate. Especially in an era of intense competition, occupational therapy practitioners need to make special efforts to clarify values, resolve territorial differences, and act in the best interests of patients. As with patients and their family members, veracity and fidelity are the cornerstones of trusting relationships among professionals. Trust is predicated on mutual respect and shared commitment rather than on competition for recognition or market dominance.

To Agencies and Payers

Probably the most contentious ethical problems are occurring around cost of care and reimbursement. The controversies highlight the differences between contracts and covenants. Generally, contracts are not based on social or moral agendas as are covenants. Contracts are based on the exchange of goods or services for mutual benefit. In the prevailing health care industry, contracts are negotiated around cost of services and the profit motive (Abramowitz, 1991). Consequently, many of the emerging moral tensions reflect the limited ability of the free market to attend to altruism. Furthermore, the market does not address inequity in the original distribution of social goods (e.g., health) and opportunities, nor does it attempt to allocate “pain,” the economic burden of inequity in the social lot-
These are turbulent times for health care, and change and uncertainty give rise to many ethical questions. Although occupational therapy practitioners are well prepared to engage in the reasoning underlying practice, they may be less comfortable with the process of ethical reasoning. Nevertheless, ethical tensions will accrue and require contemplation and generation of morally acceptable courses of action not only in the home care setting, but also in acute care settings, in community care settings, and in school-based practice.

Home care provides some of the best opportunities for restoring meaningfulness in living. Nevertheless, the home care arena will not be exempt from the pressures that pervade the health care industry. Occupational therapy practitioners must prepare themselves to deal with the philosophic, economic, and moral challenges that lie ahead to assure that home care remains a viable setting for the delivery of occupational therapy.

References


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