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Feature Article

Ethics, occupational therapy and discharge planning: Four broken principles

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Occupational therapists play a significant role in the discharge process and are often exposed to ethically challenging decision-making. This paper examines the moral basis of discharge planning, relating it to the four fundamental bio-ethical principles of respect for autonomy, beneficence, non-maleficence and justice. Using a case study design, data was collected from 10 occupational therapists and two elder care patients using the critical incident approach, as part of a wider study to determine their perceptions of discharge planning and multidisciplinary teamwork. Direct observation of interaction within multidisciplinary teams was also undertaken. The findings from the research suggest that occupational therapists are unintentionally breaching these four principles and therefore their code of ethics and professional conduct. It is suggested that further research is needed to determine how occupational therapists overcome these challenges. Furthermore, this research has important implications for education establishments regarding the teaching of ethics to occupational therapists.

KEY WORDS *decision-making, discharge planning, ethics.*

INTRODUCTION

Within health and social care it has been recognised that professional practice brings with it different types of ethical challenges. Henry (1995; p. 132) suggests that ethics 'assess the ways in which we behave and the quality of moral values that we have.' Ethical challenges have become an unavoidable part of occupational therapy clinical practice. A study by Barnitt (1993) found that occupational therapy, physiotherapy and speech and language therapy students constantly meet moral and ethical issues in the fieldwork setting. Likewise, Christakis and Feudtner (1993) and Clever, Edwards, Feudtner and Braddock (2001) found that medical students were party to ethical conflicts throughout their preclinical and clinical years.

Discharge planning is an activity where ethical conflicts may occur. It is defined as 'the primary means to ensure that patients needs will be met in the post discharge environment' (Mamon, Steinwarks, Fahey, Bone, Oakey & Klein, 1992, p. 156). One of the reasons being is that discharge planning is a process that is dependent upon interprofessional collaboration. Working together in an interprofessional health-care arena requires competence, commitment and the desire and will to cooperate. Ethical conflicts may occur because of different ethical beliefs, duties, principles and theories, in which each side of the conflict is a morally defendable position (Mitchell, 1990). Furthermore, resource issues influence discharge planning and force occupational therapists alongside other members of the multidisciplinary team to engage in ethically challenging decision-making.

In occupational therapy, much of the research on ethics has focused mainly on the teaching of ethics (Barnitt, 1993; Brockett, 1996; Haddad, 1988), confidentiality and ethical issues in occupational therapy (Sim, 1996) and ethics dilemmas in occupational therapy (Barnitt, Warbey &

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Rawlins, 1999). With the exception of Barnitt (1993), there is a limited research on the ethical dilemmas that occupational therapists face in clinical practice. Barnitt (1993), in a preliminary investigation of 35 occupational therapy and 37 physiotherapy clinicians and students, found that their most current concerns in rank order were regarding ineffective treatment, unethical/incompetent colleagues, priorities in treatment, causing pain and discomfort, treating patients despite refusal, misleading the patient and confidentiality. However, to date, no studies in occupational therapy have been found which have explored ethical issues in discharge planning. This paper discusses how the principles of autonomy, beneficence, non-maleficence and justice, impacts on discharge planning. To illustrate this, examples will be drawn from a research study that explored health care professionals' perceptions of discharge planning and multidisciplinary teamwork. The aim of this study is to explore ethical challenges that impact on discharge planning, and to consider ways in which occupational therapists might be empowered to take a more active role in ethical decision-making.

FOUR ETHICAL PRINCIPLES

In occupational therapy, the Code of Ethics and Professional Conduct for Occupational Therapists (College of Occupational Therapists, 2000) outlines the principles of the profession. These principles are guidelines for professional conduct in all areas of practice. Whilst client centred practice is one of the central principles underpinning occupational therapy, highlighting the importance of individualised care, it is essential to integrate into practice, for all clients, the four principles of autonomy, non-maleficence, beneficence and justice.

Personal autonomy is an important aspect of discharge planning. It is defined as:

> Being capable of making choices, being self determined, responsible and capable of independent judgement without being constrained by some other persons action (Henry, 1995, p. 4).

In discharge planning, the client must be involved in all stages of the decision-making process and given enough information to enable a decision to be made without being pressurised by the opinion of the therapist. Non-maleficence means to do no harm on others (Beauchamp & Childress, 1994). Therefore occupational therapists must respect the opinions of others, and value their autonomy and avoid harm to the client. Thus, in discharge planning, two ethical principles may conflict. The first is the belief that patients have the right to make independent decisions even though this may place them at risk, which can be seen to compromise the principle of non-maleficence. An important distinction that needs to be made are those risks that are taken voluntarily and those that are involuntary as the excessive concerns of professionals about patient safety may override the wishes of the patient (Clemens, 1995).

The principle of beneficence insists that we should take positive action in order to help others (Henry, 1995), which introduces the concept of advocacy as a professional activity. However, the principle of beneficence may conflict with the autonomy of the client, since a patient may refuse occupational therapy intervention which a therapist considers necessary for discharge but contradicts the wishes of the client. The principle of justice is linked to the notion of fairness and equity. Therefore, in discharge planning, the occupational therapist must ensure that policies are followed, and furthermore, the therapist needs to take into account resource constraints and the welfare of both colleagues and clients.

ETHICS AND THE PROFESSIONAL CODE OF CONDUCT

If ethical conflicts are not managed successfully then, not only does this lead to poor client interactions, but they may also impact upon morale and may even be a contributing factor to burnout and the practitioner leaving clinical practice (Rodney & Starzomski, 1993). Whilst the Code of Ethics and Professional Conduct for Occupational Therapists (College of Occupational Therapists, 2000) can support the discussion of ethical issues, it has been suggested that ethical codes of conduct cannot provide answers to the many problems encountered in clinical practice, and may even create further dilemmas (Brockett, 1996; Henry, 1995). Furthermore, professional organisations may not have the answers to ethical problems because ethical relationships are not solely based on rules and regulations (Brockett, 1996).

Education has been regarded as a means to help therapists manage ethical dilemmas in practice. When teaching ethics in occupational therapy, it has been suggested that case studies and role-playing techniques should be used to supplement complementary methods of presenting ethical theories and principles (Haddad, 1988). Likewise, Kanny and Kyler (1999) suggested that occupational therapy educators must challenge students to think about their own values, attitudes and ethics. One possible solution may be the introduction of a shared ethical principle for all the professions across nations (Smith, Howard & Berwick, 1999). It is hoped that a universal principle would emerge to work across disciplinary boundaries and to guide behaviours in health-care systems throughout the world.

The question remains unanswered as to why occupational therapists and members of the multidisciplinary team are not able to express or resolve ethical challenges. One rationale given by medical students (Clever *et al.*, 2001) for not challenging ethical issues were because of difficult personalities on the team (44%), too low on the team hierarchy (39%), and the team was too busy (18%). It has been suggested that professionals may not have the skills to resolve ethical conflict and that the unresolved conflict indicates that the professional does not have the decision-making authority to resolve the conflict (Redman & Fry, 1998). It is perhaps for this reason that Barnitt (1993) suggests the need for integration of ethics teaching with professionals so that ethics was not seen as just an academic subject.

METHODS AND DESIGN

This study is part of an action research project, located in a large acute National Health Service (NHS) Trust in London, UK. This project aimed to analyse and improve multidisciplinary teamwork in discharge planning, and was supported by both the hospital management and the Local Research Ethics Committee. The total project involved a series of interrelated stages, of which this paper reports on interviews undertaken with occupational therapists and patients involved in discharge planning, and of observation of multidisciplinary team meetings.

A case study design was selected as this enabled an in-depth understanding of discharge planning. Robson (1993) defines a case study as 'A strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real context using multiple sources of evidence' (p. 5).

Ten occupational therapists and two elder care patients were interviewed using the critical incident approach, a qualitative research methodology developed by Flanagan (1954). A direct observational study was carried out in elder care, orthopaedics and acute medicine to record interactions of multidisciplinary team members and its impact on discharge decision-making.

Sample

In this study, the sample has been taken from occupational therapists working on the acute wards. A convenience sample was used to recruit research participants. Research participants were invited to participate by responding to posters, letters and talks.

Ethical issues

Ethical clearance was obtained by meeting the criteria set by the Hospital Ethics Committee. Prior to seeking the consent of nurses to participate in the research, it was essential to gain the support of nurse and trust managers. For the observational study, it was imperative to gain the consent of all health care professionals. The researcher was unable to gain ethical approval to video record ward rounds in acute medicine and orthopaedics. The main difficulties were that patients being admitted to hospital by the on-call medical team were often confused, medically unwell and situated in many different areas of the hospital, including the Accident and Emergency Department. It would not have been possible to ascertain the informed consent of patients and members of the team prior to team meetings.

Observation of interactions in multidisciplinary meetings

Using a non-participant observation approach, the researcher observed and recorded interactions that occurred in multidisciplinary meetings. In the original study, the observations focused on all members of the multidisciplinary team, this paper reports those that were specific to occupational therapy and discharge planning. Teams headed by two elder care consultants (A and B), two orthopaedics consultants (C and D) and one acute medicine consultant (E) participated in the research. Multidisciplinary team meetings occurred weekly and this meeting was used to observe how each professional participated in the team meetings, and the content of the discussions.

Seven meetings with consultant A and seven meetings with consultant B were attended, all of which were video-recorded. The length of meetings varied considerably, with consultant A's lasting on average 50 min and consultant B's lasting on average two and a half hours. Nurses, occupational therapists, physiotherapists, doctors and social workers attended these meetings.

The researcher attended seven bedside multidisciplinary meetings with consultant D and seven meetings with consultant E, and interactions were recorded. The orthopaedic team visited each patient, and carried out a bedside review. The rounds occurred every week at 08.00 hours and were attended by occupational therapists, physiotherapists, doctors and nurses. Depending on the number of patients that needed to be reviewed, the meeting could last between 30 and 90 min.

Critical incident interviews

The critical incident approach is unique in that it does not measure satisfaction or dissatisfaction, but discloses individuals' likes or dislikes, and allows subjects to talk about

the events they consider important (Jones, 1988). It is therefore an extremely useful guide to illustrate what changes may need to be made. Flanagan (1954) described the approach as a method for '… collecting direct observations of human behaviour in such a way as to facilitate their potential involving practical problems' (p. 327). Critical incidents can be collected from either direct observation or retrospective accounts. It is an extremely flexible technique that has been adapted to evaluate patient perceptions of nursing care (Grant & Hryack, 1985; Norman, Redfern, Tomalin & Oliver, 1992) and to evaluate performance (Benner, 1984; Cormack, 1983; Flanagan, Gosnall & Fivars, 1963). The criteria outlined by Flanagan must be applied to determine what is a critical incident. This is defined as 'Any observable human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the act' (Flanagan, p. 327). It must occur in a situation:

> Where the purpose or the intent of the act seems fairly clear to the observer and where its consequences are sufficiently definite to leave little doubt concerning its effect (Flanagan, 1954, p. 327).

The critical incident technique was piloted with five female health professionals (two occupational therapists and three nurses). All were known to the researcher and consented to participate in the pilot study. The researcher, being aware of the potential for introducing bias, was able through a process of reflexivity to recognise and put this aside. In total, six multidisciplinary meetings (two each in elder care, orthopaedics and acute medicine) were attended prior to commencing the period of observation, in order to become familiar with group values, norms, rules, and culture. Furthermore, this enabled research participants to familiarise themselves with both the aims of the research and the researcher.

Interview guides were constructed from the results of a previous stage of the overall project. The themes of the interviews focused on the subjects' likes and dislikes of the discharge process. Participants were asked to:

- Describe and reflect upon the discharge process in the Trust.
- To give narratives from practice.
- To recall incidents when discharge planning did or did not go well.
- To explore and reflect on factors that impacted on the discharge process and the role that they had played in this process.

Interviews were approximately 45–60 min long and took place between 1998 and 1999. All were tape-recorded. It was important to allow enough time for participants to 'warm up' sufficiently prior to the interview as this provides a relaxed atmosphere. In addition the researcher ensured that the following criteria had been met when collecting the incidents: Is the actual behaviour reported? Had the reporter observed it? Were all relevant factors in the situation given? Has the reporter made a definite judgement regarding the criticalness of the behaviour? Has the reporter made it clear just why she or he views the behaviour as critical?

Data analysis

The interview and observation data were fully transcribed and content analysis undertaken. Transcripts from the observations were analysed by identifying the types of interaction in multidisciplinary meetings and which professional participated in each interaction. To ensure reliability, another researcher worked independently on samples of the data to identify categories which were then discussed to reach consensus.

The first step in analysis of interviews was to conceptualise the data by breaking down each sentence into something that represented an incident (Strauss & Corbin, 1990). Codes were applied to a group of words and ideas in order to categorise them together. These codes were assertiveness, confidence, time constraints, skills, knowledge and expertise. Once particular phenomena in the data were identified, their labels were grouped together, which is referred to as 'categorising.' Categories that emerged were each given a name, and those that were related to one another were merged.

Checking codes, an essential part of qualitative content analysis, improved the objectivity of the research data. It enabled the researcher to ascertain whether there was agreement regarding the definition of a code(s) and whether it needed to be expanded or rectified. This event took place as soon as the categories were formulated. Two independent judges performed the inter-rater agreement testing. One was an MSc student in research methods whist the second judge was a senior occupational therapist. They separately coded five pages of transcription. The two coded passages were then compared and disagreements amongst the two judges were discussed. To ascertain the rate of inter-coder agreement, the number of agreements was divided by the total number of agreements and disagreements. It is recommended that inter-coder agreement should be between 80 and 95% (Miles & Huberman, 1994). Initially, the two coders had only 65% agreement. The process was repeated until the two coders reached the standard required for the inter-coder agreement. The same procedure was repeated two-thirds of the way through the study to ensure that a high agreement between the two coders was maintained (83%).

FINDINGS

The findings are reported in relation to the four key components of ethical practice.

Autonomy

The Code of Ethics and Professional Conduct (College of Occupational Therapists, 2000; Section 2.1) clearly outlines that the occupational therapists should 'respect, uphold the autonomy of clients.' Whilst section 2.1.1 states that,

> Normally clients have a right to make choices and decisions about their own health and independence, and such choice should be respected even when in conflict with professional opinion.

In this instance, a patient who had been on an occupational therapy home visit was disillusioned by the whole experience and was frustrated because her perception of the outcome of the home visit was not listened to. Furthermore, her interpretation of the home visit differed significantly from the occupational therapists:

> Oh that was a complete and utter disaster! … We get in — I went to sit down in my chair and we just sat there while she was measuring the chair. Now all this had been done when I came out last time. I have got everything that I need and I told them that but they wanted to verify that … I made the tea, she took me back into the lounge and I sat down and I had one mouthful of tea and then she said, 'Well I think we will go in the bedroom now' … and I said 'You can look in the loo I've got my toilet seat in the bathroom' and then the entry phone rang and it was the driver back … You know I never felt like crying since I had my accident and I could have burst into tears … Well, when I got back they said 'How did it go?' and I said 'It was a disaster!' and I told the staff sister but she is not in charge is she? and then there was other nurses coming up who said 'Oh you did very well I hear and you made the tea and it was a great success', and I said 'It wasn't!'

In some instances, health care professionals may not always be involved in discharge decisions that a patient has made. A senior occupational therapist in medicine described an incident when a decision was made to discharge a patient without informing the key players in the process. The only reason she established that a discharge date had been set was when she looked by chance through the medical notes. An original decision had been made that the patient was not medically fit for discharge, however, the patient who was desperate to return home had been informed of the discharge date without consultation with the other team members:

> There was absolutely no consultation with us at all and it very hard when you have told a patient who wants to go home that we may have to review that date.… So everyone has been running around like headless chickens trying to sort things out.… So we are now having to react to all these urgent things that are having to be done.

Beneficence

The Code of Ethics and Professional Conduct (College of Occupational Therapists, 2000; Section 2.4) states that 'Occupational therapists should not be party to cruel and abusive behaviour.' Such deliberate acts of behaviour were not witnessed. However, the expertise of the therapist can affect the outcome as this case scenario demonstrated. Over a 3-week period, the orthopaedic team were attempting to manage the discharge of a patient who required a hoist. The meeting begins with the team awaiting the delivery of a hoist, which is taking a considerable time to arrive. However, on arrival (week two) the hoist would not fit under the bed. When interviewed, the occupational therapist admitted that she did not have the necessary skills to prescribe a hoist, which she had not shared with other members of the team '… I know nothing really about hoists to be honest you know … It really is quite stressful'.

Non-maleficence

The Code of Ethics and Professional Conduct (College of Occupational Therapists, 2000; Section 3.3.1) states that:

> … where relevant and appropriate, occupational therapists should negotiate and act on behalf of the clients in relation to upholding and promoting the autonomy of the individual.

Assertiveness and confidence were regarded as essential skills which one needed to possess to function as an effective team member. Likewise, not to speak on behalf of patients and or their carers can result in the wrong decision being made for the patient. There was a general feeling from occupational therapists that it was often difficult to predict whether their opinions would be listened to. A senior occupational therapist (orthopaedics) expressed disappointment that the consultant would never ask her whether a patient was able to transfer, about self-care activities or about their home situation. However, consultants in both orthopaedics and elder care would ask the physiotherapist whether a patient required a home visit even though it is the occupational therapist who is often regarded as the expert in this area.

In this instance the occupational therapist expresses her concerns about a patient, to two doctors who do not appear to acknowledge her concerns:

Is there anything, which we could give her for her distress (occupational therapist to consultant)

She is never distressed when we go round to see her (senior house officer to consultant)

She is often distressed because her hearing aid is either switched off and then she gets panicky and gets upset. I mean I have walked up to her in the morning and switched it on and she will say 'Oh thank you doctor' (house officer to occupational therapist)

I think now it is either switched on low or switched off. I don't know but anyway she is much better once the hearing aid is switched on. Which you can understand really! (senior house officer to occupational therapist)

Yes I can but it doesn't always seem to be the hearing aid (occupational therapist to consultant)

It is suggested that there is a personal cost of 'speaking up' and expressing opinions. Occupational therapists regarded themselves as being unpopular members of the team. They were of the opinion that they were always perceived as delaying the discharge '… get blamed, scapegoated when discharges are delayed'.

Justice

Occupational therapists must respect the rights of each individual and therefore ensure that they do not show disapproval of a patient's lifestyle and or culture (College of Occupational Therapists, 2000; Sections 3.2–3.22). In this study, occupational therapists were acutely aware of the pressure on beds and the need to discharge patients quickly. In orthopaedics and elder care, occupational therapists frequently reported that patient's discharges were delayed while they were awaiting equipment. One occupational therapist (orthopaedics) stated that the needs of the patients should be placed first as opposed to the organisation:

> They don't actually take much into consideration, they want the bed sort of thing and they are determined to get them out so they put them in another unit when it is not always necessary or appropriate … It seems pointless moving patients.

A junior occupational therapist (orthopaedics) responded to the pressure by 'cutting corners' in attempts to speed up the discharge process and by thinking about the needs of the organisation as opposed to the needs of the patient.

> … treating a patient and then with the same eye watching a patient in physiotherapy has not had time to assess the patient … I actually don't think that a home visit is appropriate … but then you think oh no residential care, God they will be in for ages.

This is a breech of the Code of Ethics and Professional Conduct for Occupational Therapists (College of Occupational Therapists, 2000; Sections 3.1–3.3.9) in that the occupational therapist fails to undertake that which is seen to be in the patient's best interests. Hence, occupational therapists need to ensure that they are able to provide an effective service for all patients.

DISCUSSION

Occupational therapists need to ensure that they are able to deliver an effective service to patients whilst ensuring that the Code of Ethics and Professional Conduct (College of Occupational Therapists, 2000) is adhered too. The need for speedier discharges will result in occupational therapists facing many ethical dilemmas. It is essential that occupational therapists consider how these changes impact on occupational therapy practice.

The findings from the research have demonstrated that failing to take patients opinions into consideration can have a significant effect on the outcome. A study by Roberts and Houghton (1996) found that 92% of discharges are delayed because of patients. To ensure that the autonomy of the patient is respected it is essential that occupational therapists are able to explain clearly the aims of the visit and that the therapist allocates enough time to meet both the aims of the patients and of the therapist. For this reason it is imperative that occupational therapists are able to discuss the findings of the assessment with the patient and ensure that the patient's opinions are documented, acknowledged and not dismissed. The few patients that were interviewed did not regard home visits as being productive. Similar findings have been reported by Clark, Dryer and Hartman (1996) who state that therapists must place the patients' priorities at the centre of the home visit process.

It is imperative that occupational therapists should only accept appropriate referral and for those which they have the resources (College of Occupational Therapists, 2000; Section 3.1). In ensuring a safe discharge, an occupational therapist may need to prioritise the type of intervention that a patient can receive. However, occupational therapists must ensure that patients are part of the decision-making process. Occupational therapists need to ensure that they are implementing the principles of evidence-based practice to ensure that resources are used most effectively. Barnitt (1996, unpublished data) suggests that there is evidence that supports the notion that occupational therapists will accept referrals despite there being uncertainty over the availability of resources to complete treatment.

In order to ensure that no harm occurs to the patient, occupational therapists must be competent practitioners.

It is suggested that teams could be used as a tool for junior professionals to discuss the most appropriate management of the patient, which in many cases could have been the wrong course of action. It is suggested that occupational therapists felt under pressure to conform to the wishes of the team and not to be seen as obstructing the discharge process. Occupational therapists expressed considerable reluctance to voice an opinion for fear of not being listened to. Therefore, leaders of multidisciplinary teams must aim to provide a safe environment and emphasise the individual responsibility that each member has to both give and receive information. Furthermore, multidisciplinary teams need to educate and support members. In order for this to occur, occupational therapists must consider how their role can be widely understood within the acute setting, and to consider how their professional image might be strengthened.

A means of enhancing interprofessional working is through the creation of an interprofessional code of ethics that makes explicit that health-care professionals are sharing an ethical framework for practice. Developing shared mission, vision and values statements could also be a strategy for ensuring that there is a interprofessional framework for professional conduct. Education establishments also have an important role in the teaching of ethics. Whilst understanding the code of ethics and professional conduct is an important component of an undergraduate course, it is important that this understanding is applied in practice and that occupational therapists are able to recognise, analyse and manage ethical issues. Additionally, moral certainty can be a strategy to resolve ethical challenges. Moral certainty is based upon the absolute belief to which the person is psychologically committed without doubt (Lichtenberg, 1994). In occupational therapy, the belief in client centred practice is an important aspect of moral certainty. Therefore, occupational therapists must speak up for the things in which they and or their patients believe. Wright-St Clair (2001) challenges occupational therapists to embrace the notion of caring into the profession as a foundation for good practice and is of the opinion that ethics of care can provide the moral motivation for good occupational therapy practice.

CONCLUSION

The findings from this study suggest that occupational therapists are unintentionally breaching a set of principles laid out in the Code of Ethics and Professional Conduct for Occupational Therapists (College of Occupational Therapists, 2000). It is important to ascertain why occupational therapists may have difficulty challenging ethical issues. It is suggested that occupational therapists should use multidisciplinary teams as a place where they can speak about their ethical concerns so that they are able to be effective client centred practitioners. Furthermore, there may be an extended role for ethics committees and or ethics consultants in health care to assist practitioners to overcome ethical challenges.

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