International Encyclopedia of Rehabilitation

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Ethics in Rehabilitation

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Introduction

Rehabilitation is, by (my) definition, the health care provided to people with permanent or temporary disabilities in order to help them learn to overcome their disabilities, where disability means a loss of ability to perform personally meaningful and/or socially valued activities due to one or more health problems (World Health Organization 2001). As such, rehabilitation is rife with ethical problems, which are commonly viewed in health care as the tension between two or more morally defensible alternative health care actions, including inaction (Hebert 1996). The key underpinning of an ethical problem – termed a bioethical problem in the context of health care – is commonly viewed as a conflict of defensible values or moral principles related to the possible alternative health care actions relevant to a particular clinical situation (Beauchamp and Childress 2001).

A typical example of a bioethical problem, which is a legal issue in some jurisdictions, is the tension between abortion and continued pregnancy in relation to a malformed fetus, which has been recently discussed in relation to the ethics of prevention of congenital disability (Edwards 2005). Various ways of solving or resolving such bioethical problems have been considered and implemented, the most well established of which are consequentialism or utilitarianism, which considers outcomes, deontology, which considers duties, and virtue ethics, which considers intentions (Beauchamp and Childress 2001). Note that ethics is commonly viewed as also addressing legal and regulatory violations, such as illegal confidentiality violation as well as sexual and other professional boundary violations by health care providers, which are dealt with by institutions such as professional disciplinary committees; this article will not address such violations, as they are clearly spelled out in available ethics codes (Commission on Rehabilitation Counselor Certification 2001).

Objective and method

The objective of this article is to review bioethical problems in rehabilitation and their reasoned solutions, using a standard bioethics framework and illustrations from the literature as well as imaginary – yet realistic – vignettes. Although the article is not an exhaustive review of such problems or their solutions, and other reviews can be found in the recent literature (Reid and McReynolds 2007), my intent is to review important bioethical problems in rehabilitation and their reasoned solutions in sufficient detail to help readers understand key issues in bioethics of rehabilitation.

The standard bioethics framework that will be used here is Principlism, which is not without its challenges (Rudnick 2001), yet is still useful, perhaps more so if combined with as much dialogue as possible; this, in turn, requires institutional and interpersonal processes that support empowered participation of – and generation of solutions by – all stakeholders involved (Rudnick 2002a; Rudnick 2007a). Arguably, priniciplism may focus more on the individual/clinical level rather than on the organizational and societal levels of bioethics, as addressed in recent writings (Purtilo, Jensen and Brasic Royeen 2005), but for purposes of illustration, a principlist discussion will suffice.

According to Principlism, there are three or four main moral principles that drive moral action and that can come into conflict with each other (or within one principle), resulting in a bioethical problem. These principles are: 1. respect for autonomy (self-determination), 2. beneficence (doing good), 3. non-maleficence (doing no/least harm, which is sometimes combined with beneficence as a balance of most benefit and least harm), 4. justice (fairness, particularly to others involved or impacted, such as in resource allocation). In addition, context or circumstances are factored in, such as culture. Bioethical problems in rehabilitation will be analyzed in relation to conflicts within and across these principles in relation to rehabilitation situations. Note that some bioethical problems that arise in some treatment settings may not be pertinent or central in rehabilitation, such as those pertaining to end of life situations, as rehabilitation assumes that the patient's life expectancy is not extremely limited (if it is, then palliative care rather than rehabilitation is usually offered).

Bioethical problems in rehabilitation and their reasoned solutions

Some bioethical problems in rehabilitation address conflict of beneficence and non-maleficence. For instance, the use of a leg prosthesis can be beneficial for a patient with a leg amputation as it facilitates independent ambulation, yet it can be harmful as it may cause pain and other complications in the stump area, while the use of a wheelchair can be beneficial for that patient as it may avoid such pain and other complications, yet it can be harmful for that patient as it impedes independent ambulation. The solution to this problem is usually determined by appeal to the principle of respect for autonomy, according to which the patient decides whether to use a prosthesis or a wheelchair, although that solution is not fully tenable if the patient is not mentally capable of making such decisions, such as may occur with some head injured patients (in which case the patient's surrogate decision maker is expected to make that decision according to the patient's best interest, although without patient agreement it is very challenging to implement such rehabilitation interventions). In such cases, the solution may be to consider whether the patient, when capable, appreciated independence more than avoidance of pain and other health complications, or the other way around, if such information is available (e.g., in an advance directive that specifies health care wishes of a person), and if not, to consider what most people – particularly those who are similar with respect to important background factors such as age, gender, and more – with such a disability prefer.

Other bioethical problems in rehabilitation address conflict of respect for autonomy and justice. For instance, an elderly post-stroke patient may want to stay on a rehabilitation inpatient unit for more time than is needed clinically, due to uncertainty a about coping outside of hospital with the new disability, yet the rehabilitation unit's inpatient beds may be a scarce health care resource that is needed for other patients. The solution to this problem is usually determined by appeal to hospital or other relevant policy, which sometimes specifies acceptable and inacceptable actions on the part of patients as well as clinical teams involved in such situations, as well as by engaging all parties involved in a dialogue to reach common ground that is ethically acceptable (Rudnick 2007a), and possibly to generate or change relevant policies.

Yet other bioethical problems in rehabilitation address conflict of beneficence and justice. For instance, the post-stroke patient noted above may do best emotionally if discharged home to the family's care, yet the burden on the family related to such home care may be significant, even if home care support to the family is available. The solution to this problem is usually determined by family preference, which brings in the principle of respect for autonomy, although in relation to the family members' autonomy in this case. In cases where the family is not willing to provide home care, it is not uncommon to expect them to find alternative placement or at least to agree to such placement when arranged (while offering some choice to the patient and family from a selection of available placements that can provide suitable care to the patient).

Other bioethical problems in rehabilitation address conflict of respect for autonomy and beneficence or non-maleficence. For instance, a patient with schizophrenia may want to live independently, but may not have sufficient living skills to do that safely yet he or she may not have sufficient awareness of the risks involved. This raises the question of coercion in psychiatric rehabilitation, in this case coercion in relation to residential rehabilitation. While coercion in psychiatric treatment is sometimes possible and acceptable, e.g., if without such treatment the patient poses a danger to self or to others due to irresistible imperative auditory hallucinations commanding the patient to injure or kill self or others, coercion in psychiatric rehabilitation may be impossible or at least less acceptable. This is so because rehabilitation requires cooperation from the patient, and also because rehabilitation involves working towards the patient's life goals, such as residential goals, so that coercion that changes those goals may be considered particularly intrusive, more so than forced treatment which is aimed at changing – alleviating – symptoms (Rudnick 2007b). The solution to this problem may sometimes require temporary coercion to avoid serious danger, such as by involuntary commitment (Rudnick 2002b), while attempting to explore more realistic goals with the patient, e.g., supported residence in the case above, while maintaining hope of achieving the patient's original goals in the long term if possible.

Yet other bioethical problems in rehabilitation address conflict within justice considerations. For instance, deciding how to allocate resources for rehabilitation versus other health care foci – mainly treatment and (primary) prevention – and how to allocate resources among the various areas of rehabilitation – amputation rehabilitation, stroke rehabilitation, cardiac rehabilitation,

spinal injury rehabilitation, rehabilitation in relation to acquired blindness, and more – requires a reasoned process. There is more than one way of reasonably determining what is fair, e.g., according to severity of health problem (whereupon the more severely health-challenged a population is, the more deserving it is) versus according to prospects of (health care) success – which itself may be subject to differing criteria (whereupon the higher the prospects of such success, the more deserving is the population involved). Different values underlie such different ways of determining fairness, e.g., need underlies severity, implying a welfare theory of justice, whereas outcome underlies success, implying a utilitarian theory of justice (recognizing that these approaches are not mutually exclusive or exhaustive). The solution to this and other such problems of resource allocation in relation to rehabilitation may require policy making that is highly informed by formal public debate, grounding ethics in the political realm in a broad sense (Rudnick 2002a).

Conclusion

Ethics in rehabilitation addresses a variety of issues that can be formulated as bioethical problems of conflicts of values related to respect for autonomy, beneficence, non-maleficence and justice. Dialogue and policies that are informed by public debate are required in order to facilitate the determination of reasoned solutions that can be acceptable to all stakeholders and parties involved.

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