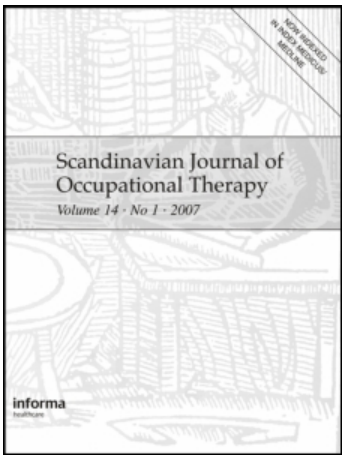


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# Occupational therapy, professional development, and ethics

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**ORIGINAL ARTICLE**

# Occupational therapy, professional development, and ethics

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**Abstract**
The aim of this article is to reflect on and contribute to developing occupational therapy as a profession. The author proposes an *ethical interpretation* of health and helping professions in general and occupational therapy in particular. According to this ethical interpretation, the essential function and mission of classical health and helping professions are defined by certain ethical values: the basic elements of a good human life. The author argues that the central concepts of occupational therapy, activity and participation, can plausibly be understood in this light. However, this seems to imply a rather substantial conception of well-being which the author tries to spell out. In addition, the basic principles of biomedical ethics are specified in the context of occupational therapy according to an ethical interpretation. In conclusion, four advantages of the ethical interpretation are highlighted: it adds precision and content to ethical principles and guidelines; it contributes to building up and preserving a shared professional identity; it puts emphasis on a client-centred perspective on professional work; and it provides a constructive framework for inter-professional cooperation.

**Key words:** *Activity, occupation, participation, professional values, well-being*



In the following, I will shine an ethical light upon the theoretical presuppositions and practice of occupational therapy. This will be done via an *ethical reading* of helping professions in general and occupational therapy in particular. My central claim is that these professions are essentially identified by certain ethical values and my aim is to contribute to the ongoing professional development of occupational therapy by unfolding the values at the heart of that particular profession. The author has worked as an external consultant for the ethical committee under *Dansk Ergoterapeutisk Professionsudvikling or DEPU* (*Danish Occupational Therapy Professional Development*). The starting point is thus Danish occupational therapy, but the considerations contained in the following have, I think, a broader geographical and professional aim. There seems to be an international consensus on the importance of ethical reflection for the future development of the profession (1).

In section 1, I outline part of the background for the type of initiative exemplified by DEPU. In section 2, I give an account of the ethical concept of professions and explain a possible distinction between ethical and moral values. In section 3, I argue that occupational therapy is an ethical profession in the sense described and try to bring the ethical values relevant to occupational therapy to light. In section 4, I briefly set out the significance of moral *principles* in connection with fundamental ethical values for professions. Lastly, in section 5, I enumerate some of the advantages of the account I offer.

## Background

The professional development initiative undertaken by Danish occupational therapists is part of a wide-ranging tendency. Initiatives and movements under the title of "professionalization" are well known within all public sector occupations and institutions. What has generally been seen is a form of rearmament aimed at sharpening an occupation's identity, position, and prestige in relation to other occupations and the institutional and societal environment. Professionalization has not least been viewed as a case of explicating the foundations of an occupation's knowledge and skills, wherein the widespread talk of evidence basing has been a conspicuous element.

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Furthermore, professionalization has played a role in relation to the political administrative agenda, which has been moving in the opposite direction, i.e. towards de-professionalization (this last point is very briefly taken up at the end of the article).

One of the questions that have arisen in this connection is what qualifies an occupation as a profession. This question will be taken up in the following section, though, to keep things simple, initially I will broadly refer to persons within pedagogical, social, and health-related helping occupations as professional practitioners: teachers, nursery nurses, kindergarten teachers, doctors, social and case workers, psychologists, carers, nurses, physiotherapists, occupational therapists, psychiatrists, midwives, and the like all refer to their respective occupations as professions.

An important element in the above-mentioned explication of a knowledge and skills foundation has been concerned with the core values and ethical principles of helping professions. It is thus interesting that all Danish occupations and professions within the social and health sectors have, as far as I am aware, drawn up (or redrawn) more or less detailed ethical codes, stating fundamental values and/or guidelines for the ethically correct performance of that profession and made them public from their websites (2). The same typically applies for international (including Nordic) associations of psychologists, nurses, occupational therapists, etc. (3). Most professions even have either temporary or permanent ethical committees whose task is to promote attention to professional values and ethics and to present recommendations concerning political initiatives, actual cases, and so on.

Ethical rearmament has, however, also been accompanied by scepticism and frustration. Many professional practitioners have had difficulty seeing the relevance of the many fine slogans about values and ethics. These have typically been accused of being too *vague* and *non-committal*, so that they cannot really be employed to distinguish the ethically correct from the ethically incorrect; for being too *general*, so that they cannot be used as concrete guidelines in practice; for being *idealistic* and *idolizing* with regard to everyday life, where one has to compromise. In my view these complaints have been justified in many cases, where the fundamental values of a profession have been formulated as a number of "grounding values", with mutually very different origins, scopes, and points of focus; typically 5–6 of the following: openness, engagement, respect, responsibility, professionalism, quality, acknowledgement, development, effectiveness, dialogue, well-being, security, accountability, flexibility, dignity, cooperation, humour, presence, democracy, trust. These are the most quoted values in the Danish health service ((4), p. 111).

Of course, these values are all goals and ideals, which are very difficult to oppose. But they are also very vague, general, and idealistic. In the vast majority of cases, attempts are made to concretize fundamental values in more tangible handling instructions, for example by having a sub-section for each fundamental value such as "this means that in regard to the client we do such-and-such in this and that situation" or "the patient has the right to ...".

There is, however, another important complaint against selecting such universal values as one's fundamental values: that they fail to capture the *special nature* of the particular profession's ethical considerations and issues. Any- and everybody should in principle live up to the values mentioned above, meaning that occupational therapists, for example, do not have any *special* ethical aims or ideals which plumbers or postmen could not also be expected to live up to. But, as we now shall see, there are good grounds for thinking that the individual helping professions are characterized by having a unique core service which must be understood in the context of what are, *for the profession*, *unique* grounding values.

## The ethical reading of professions

When does an occupation or trade have the status of a profession? According to David Carr (5), five criteria present themselves:

1. The occupation provides an important public service (a social task which cannot simply be left to free enterprise).
2. Occupational practice requires both extensive theoretically and practically based expertise (a unique knowledge and skills foundation).
3. Occupational practice has a prominent ethical dimension, which calls for a professional code and gives individual practitioners a special ethical legitimacy (and special ethical obligations!) by virtue of an authentic attempt to live up to a client-orientated consideration (that one will act in accordance with the client's best interest).
4. The occupation requires well-organized degree and recruitment programmes (shown by for example a monopoly on education and authorization requirements).
5. The occupation requires a high degree of autonomy and discernment from individual professional practitioners (due to the dissimilarity and variability of tasks) and from the occupation in general (due to what is often a very open job definition).

According to an "ethical reading" of professions, the third point is the central one: it carries more weight than the others and pervades them in significant ways: certain public sector tasks are important because they are concerned with fulfilling a moral duty towards citizens (e.g. helping the sick); the extensive knowledge and skills foundation is necessary to be able to provide qualified, professional help; the high ethical requirements demanded of the practitioner require selective recruitment and ethical development (often via a type of craft apprenticeship programme); the task of helping individual persons requires a well-developed ability to take on personal responsibility and to show discernment.

The "ethical dimension" is rather broadly conceived by Carr. I want in this section to focus on an important and somewhat overlooked aspect of it. In order to capture this, I am going to distinguish between *ethical* values and *moral* values (even if there is no standard way to distinguish between the ethical and the moral or between ethics and morality). Some values concern what makes someone's life go well—they are values in so far as they contribute to or are elements in personal well-being (6). They can appropriately be called *ethical* values in a more specific sense since the term "ethics" was coined by Aristotle who made the idea of well-being or *eudaimonia* central to ethical considerations (7). *Moral* values, on the other hand, concern what we *owe to each other*—they are values in so far as they contribute to or are elements in morally right conduct towards other human beings (8).

The fact that professional codes of ethics are as old as the classical professions has to do with two factors: the moral and ethical dimensions of these professions are essential, and its practitioners have to *profess* them. The word *profession* comes from the Latin *profiteri*: to submit a public declaration. Thus, in an etymological sense, belonging to a profession implies an affirmation of a certain set of fundamental values. Some of these are *moral* values reflecting the fact that patients and clients are in an especially vulnerable position when seeking professional help and support and consequently need a strong affirmation of the professional practitioner's trustworthiness—that they do in fact have both the professional qualifications and a well-developed sense of their special moral responsibilities. What is probably the oldest example of a professional code of ethics, i.e. the Hippocratic Oath, served this purpose. The profession made its fundamental moral values public, so that one simply knew what to expect when seeing one's doctor: that he (or she) would not reveal one's most intimate secrets to others for fun, that he would not undertake risky interventions etc. (text, translation, and interpretation in (9)).

But important as these moral values are, they do not state the basic function and core service of classical helping professions. The basic function relates instead to essential elements of a good life. Therefore, the unique value base of a profession is, I propose, *ethical*. Unfortunately, the ethical values have been somewhat overlooked in much professional ethics where focus has been laid on *moral* principles (even if they are often called ethical principles). As a result such principles have been ridden with the problems mentioned in section 1: being vague and non-committal, too general etc. What moral principles need is some directedness towards a conception of the good life. *Beneficence*, for example, is a moral value that imposes on us some duty of doing good to and helping other people. But how? The answer becomes obvious when we bring ethical values into consideration. *Health*, for example, is beyond discussion an ethical value. So we have a specific duty to help people with health problems and to do good in terms of people's health.

This, I think, brings us to the heart of the ethical reading of professions. The medical and legal professions are considered the classical helping professions. Since antiquity they have been surrounded by a special aura because each in its own way has a primary mission or *core service*: to help persons not in a general way but related to specific elements of a good life and based on specific professional procedures. With the art of medicine one can give people afflicted by illness professional aid and with jurisprudence one can do the same to people facing prosecution.

Since antiquity, certain counselling functions, particularly pedagogy, psychology, and social work, have also acquired the status of professions. The reason, according to the ethical reading, is that such functions relate to equally important elements of a good life. Pedagogy and teaching can help children professionally with their positive development and education. With psychology one can—due to another, special professionalism—help people with psychic disorders. And with professional social work one can help people with social problems.

The underlying reason is the general fact that people who are *at risk* or *vulnerable* in certain respects need to receive help in such vulnerable situations, for otherwise the opportunity of living a good life will go to waste. We are able to take care of many of the problems that we encounter in the course of our life just by pulling ourselves together. On the other hand, one of the conditions of human life is that many other problems can *not* be overcome without the help of others. If one is not helped to valuable development and education as a child, if one is not helped when illness strikes, if one does not receive help when

charged, accused, and prosecuted, if one is not helped through psychic crises and affliction, if one does not receive assistance when unable to provide for oneself and one's own—then one is cut off from really basic human goods: capability to lead one's own life, physical health, justice, inner autonomy, and social welfare ((5), pp. 23–32).

In sum, the ethical professions can thus primarily be identified and distinguished by virtue of their fundamental ethical value and core service (see Table I).

Can (even) deeper criteria be found for assigning the classical helping professions this special status? This question clearly becomes relevant as soon as other occupational groups begin queuing for recognition as professions in this sense: can they plausibly claim that their core service is attached to fundamental ethical values? Well, the criteria were laid out earlier: health, justice, life capability, inner autonomy, and welfare & social justice are basic human goods, since they are essential elements for being able to live a good life. All ethical professions thus include an implicit theory which claims that the particular fundamental value or values of the profession unavoidably belongs to the good human life.

To keep the record straight it ought to be mentioned that this type of ethical account of the classical helping professions and their values is not unrivalled. Alternative accounts of the basis of social work could be mentioned: that it is primarily the capitalistic economy's patching-up of destabilizing social inequality and wretchedness (Marxism); that it is just a sophisticated type of control, suppression, and discipline (Foucault); that it is just illegitimate governmental interference in the mechanisms of the free markets and/or a symptom of a social-governmental slave-like mindset (laissez faire liberalism). All of these alternatives obviously place the professional practitioner in a completely different—and in my view highly implausible—light.

Table I. Ethical professions and their fundamental values.

| Profession | Core service | Fundamental value(s) |
|---|---|---|
| Medicine | Cure, alleviation, consolation | Health/healthiness |
| Law | Judicial/legal assistance | Justice |
| Pedagogy | Training, education | Basic capabilities |
| Psychology | Treatment of psychic disorders | Inner autonomy |
| Social work | Social counselling | Welfare, social justice |

## Occupational therapy as an ethical profession

If we are to consider whether occupational therapy is an ethical profession in accordance with the "ethical reading", then our consideration should be directed at the issue of whether basic human goods are provided in a corresponding way, goods which the occupational therapist, by virtue of his/her professionalism, is in a special position to uphold and promote. I do not think we need to begin searching among the more exotic corners of occupational therapy's theory and practice before finding the obvious candidates: *activity* and *participation*. These are not just central professional concepts; they should rightfully be understood as fundamental ethical values. One of the central tenets of occupational therapy's theory and practice is that a good life must be imbued with activity and participation and that a life characterized by passiveness and social exclusion will be inadequate by comparison.

This is made plain by taking a look at occupational therapy associations' mission statements: A draft version of the fundamental values of Danish occupational therapists states the following: "A basic assumption of occupational therapy is that a person requires a meaningful and expedient level of activity throughout their whole life to be able to maintain health and wellness" (10). This is really a very plausible hypothesis; but is the aim of occupational therapeutic efforts only health and wellness? I believe this is a case of aiming too low, because persons affected by activity-related problems are typically interested in restoring their ability to take part in activities for other reasons than the sake of their health. We regard a range of activities as valuable for other reasons than providing health and wellness; indeed, we view some activities as being valuable in themselves, as essential elements in a good life. In its statement of goals, the World Federation of Occupational Therapists (WFOT) seems to share this view:

> "Occupational therapy is a profession concerned with promoting health and well-being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by enabling people to do things that will enhance their ability to participate or by modifying the environment to better support participation" (11).

I would claim that *well-being* comprises more than "wellness" in this context, i.e. a broader understanding of a good human life.

What does a good human life fundamentally consist of? Well, this is something that philosophers (and many others) have discussed intensively for at least 2 500 years, so the following will be slightly simplified! One candidate is "wellness". But a good life is not only a question of wellness; were this so, heroin would be a serious rival to occupational therapeutic efforts. Neither is it simply a question of being content with one's life if one happens to be content with a life of passivity and exclusion. In such situations a competent occupational therapist will recognize a challenge to create opportunities for activity and participation, thus providing satisfaction on a qualitatively higher level. Many conceptions of well-being in the health sciences focus on mere temporal instances of satisfaction or contentment (a number of theses are reviewed in (12,13) but from an ethical perspective the problem is that even a large sum of such instances of satisfaction or contentment does not necessarily add up to a good life ((6), part I).

Fortunately, a type of theory about the good life is to be found which better fits the central occupational therapeutic tenet concerning the importance of activity and participation. Instead of focusing on wellness or contentedness with one's life, it talks of well-being understood as "good being", that one's life *goes well* (welfare probably had the same meaning originally: that the way one fared through life went well which, as we know, is not only a question of material welfare and welfare benefits). What we need is an overall concept of well-being understood as a way of living which is good for the person whose life it is. The contemporary philosopher Joseph Raz is the originator of a formula for well-being in this sense. It maintains that well-being consists of the (1) whole-hearted and (2) successful carrying out of (3) valuable (4) activities (14). Let us look closer at these four elements in reverse order.

### *Activities*

A good life fundamentally comprises *activities*. A person can be alive without being involved in any type of activity (e.g. if someone is in a lasting coma), but such a person cannot *have a life*, and the latter is a precondition for having a *good* life. Similarly, a person subjected to radical types of confinement (e.g. continuous solitary confinement in very small cells) will have such limited opportunities for activity that they he/she almost certainly cease having a life that he/she finds worth living. If a person comes through such ordeals with a reasonably sound mind it would be because he/she manages, despite everything, to uphold a form of activity with an intellectual or religious stamp, actively defies his/her situation or otherwise succeeds, in a minimal sense, in taking the situation into his/her own hands (15) contains a captivating(!) description of such an example: the Greek politician Alexandros Panagoulis's overcoming of his brutal imprisonment during the Greek military dictatorship 1968–1973).

Activities entail that a person is part of a relation to something outside of him/herself, as he/she is generally connected to *relations* and *functions*, i.e. with other human beings with whom one enters into relations and with the environment in which one functions. This means that well-being has a *connection* with a person's objective circumstances (though, as we will shortly see, it cannot be reduced to this). We must include a person's *situation* to be able to discover how good his/her life is. This explains why stating how the person subjectively *feels* or how contented he/she is does not tell us how good his/her life is. An occupational therapist would be ill advised to design therapeutic interventions solely on the client's reports about how he/she subjectively feels.

### *Valuable*

Activities by themselves, however, are not enough, because the activities that fill a life can be so trivial, frustrating, undeserving, and wretched that in this context they do more harm than good. Extremely monotone work does not, for example, contribute to a good life; and a life that consists only of hectic activity just to be able to avoid hunger, thirst, cold, and physical harm is simply not worth living (though it is a different matter if that life also contains hope for better times).

I would claim that occupational therapy is founded on such a qualification of the importance of activity for well-being. Most definitions of *occupation* involve the idea of *meaningful* activity (for a list of definitions see (13), p. 601f). An activity becomes meaningful in so far as it as it serves some *purpose* of the person in question. Therefore, the idea that activity is not valuable in and of itself seems to be stressed by the central concepts of the profession and even in the profession's very name in the English-speaking countries. I shall return to the meaning of "occupation" shortly.

Interestingly, in Denmark the name "ergoterapi" refers to the Greek concept of *ergon*, meaning (among other things) basic function or purpose. In the ethics of Aristotle the concept plays an important role, since he maintained that a good life for human beings is a matter of fulfilment and flourishing in the characteristically human functions which are rational and social activities (7).

To the question of whether we can say something universal about what it is that makes some activities

meaningful and valuable for human beings, the Aristotelian answer (and the one implied by the term "ergoterapi") would be that valuable activities are generally rational and social. Perhaps all we can say is that under normal circumstances certain activities—work, play, sport, family life, friendship, intellectual and artistic immersion and artisitic development etc.—are simply inspirational, stimulating, rewarding, and elevating for human beings and that being cut off from these activities will, all things being equal, lead to a worse life. In other words, this concerns everyday activities during the conduct of life. There is not necessarily a common benchmark for the amount of value carried by these very varied activities—each has its own way of being valuable and they may not be mutually comparable (6,16).

It is worth observing that valuable activities are not measured by how hectic and dashing a person is. Activities are not primarily hard work and extreme sports. Depending on the situation such activities as relaxation, enjoying a quiet moment, and watching TV could be valuable activities. They are all something that we *do*. Neither can one conclude that a person afflicted by an activity-limiting handicap will have a poor life. Even people with severe handicaps can have the opportunity (with proper help and support) of partaking in valuable activities and this should of course be the purpose of occupational therapy. An obvious example is the leading theoretical physicist Stephen Hawking, who is almost completely paralyzed by a severe form of sclerosis (ALS), which, however, does not prevent him from taking a very active part in family life, friendships, and intellectual absorption.



### *Successfulness*

However, neither are valuable activities sufficient on their own, because one must also be successful to a certain extent. But being successful is being successful *at something*, i.e. activities; and having success is to have success *as something*, i.e. as the practitioner of an activity, whether mountain-climbing, choral singing, or the practice of occupational therapy. Thus, a subjective experience or attitude will once again not be enough, as objective criteria for succeeding with an activity can be given. Success criteria can be more or less precise and individual interpretations of them can be possible, but the individual practitioner of an activity can never single-handedly decide what constitutes successfulness. I might think I am an excellent choral singer, but should in fairness expect to be corrected by the conductor and my fellow singers. Here it is not so much a question of one of us being right, but of there being something objective that we are right or wrong in relation to.

Success is also inextricably connected with being presented with and being able to meet *challenges*. To be able to *succeed* with an activity it must necessarily be possible to *fail*; without the possibility of *failure* there cannot be *success*. It is therefore not certain that making things easier for people, or even doing things for them, actually makes people's lives better:

> No one would suggest that the way to ensure success for aspiring mountaineers is to flatten mountains, so that the tallest will be only 1,000 ft. high with gentle slopes. Clearly, the accomplishment of being a good mountaineer will not be what it is if the skills it requires are those needed to climb a molehill. In many enterprises, the value of success to those engaged in them is in their success in skilful, taxing, challenging activities. ((14), p. 14)

Thus, when faced with either supporting a person wishing to plunge into an activity that will almost certainly lead to failure or instead trying to convince him/her to attempt an easier challenge, it is not a forgone conclusion that one should choose the latter. Grandiose failure is, on the whole, better then "succeeding" at something easy.

Finally, success is also connected to activities that constitute rather well-defined social practices because these are the ones that provide reasonably clear criteria for success. Again, Aristotle's definition seems apt: entirely private and entirely mindless activities would have only very vague criteria for success and therefore one could neither succeed nor fail in any strong sense. According to flow theory there is an intense satisfaction precisely in succeeding in complex and highly structured activities (17).

### *Wholeheartedness*

However, neither is success in valuable activities enough. We have all probably met people who are generally successful in activities which are, when judged from the outside, valuable but who are nevertheless very unhappy and totally without that "spark", which ought to be a characteristic of a good life. What is missing is unreserved involvement, which allows them to wholeheartedly support the relations and deeds in which they are involved. Wholeheartedness is not just the icing on the cake; it is not as if a person's life is 75% successful, because neither mountain-climbing, choral singing, nor occupational therapy will make life better for a person without wholehearted engagement. It is not possible to *succeed* with these activities with a half-hearted

effort; it is better to leave them alone completely. It is not just that a half-hearted participant in such activities is a nuisance to others; he/she is also a nuisance to him/herself. Even though that individual might succeed (a successful choral performance) it will not contribute to *his/her* well-being if he/she has not, as it were, been present during the whole process.

In occupational therapy literature this point is stressed by insisting on *participation* in occupation as the end as well as the means for therapeutic interventions. This should be understood in a strong sense: participation implies *taking part*, being involved, engaged, making choices (18). In a sense all this is implied by the word "occupation" itself. An occupation is something that *occupies* you, ideally involving the whole person.

The allusion to the heart is no coincidence: this aspect of well-being has very much to do with volition and emotional identification. Faced with a variety of possible valuable relations and activities, there are limits to how far purely rational grounds can bring us when selecting those that one considers (or wants to make) *one's own* relations and activities. There are many good reasons to pursue mountain-climbing, ornithology, and genealogy. And choral singing, gastronomy, and role play are quality leisure-time activities, just as the practice of occupational therapy, farming, and journalism are all respectable jobs. The factor that determines which of these activities contributes to my well-being is whether they are "something for me", something that in the end must be put down to personality, temperament, and inclination.

With wholeheartedness a crucial subjective component is introduced into well-being which at the same time provides a strong safeguard against paternalism; one cannot—in a person's best interests—force or manipulate a particular person into partaking in activities that, when viewed "objectively", are valuable. Any attempt to live other person's lives for them is not only a question of employing an ineffective means of promoting their well-being; it is fundamentally irreconcilable with this. As Raz concisely puts it: "While it is logically impossible to make other people's lives go well, it is possible to try to do so, and such attempts are often disastrous" ((14), p. 9). Professional relations are thus a moral high-risk zone, because while it is possible to ensure a bad life for others, it is also impossible to ensure a good life for them. On the other hand, one can markedly improve human beings' external and internal *preconditions* for a good life and this is where the task for the helping professions lies.

In summing up, we can say that in a therapeutic situation keeping the patient free from pain and other symptoms of illness is only the first step; the actual goal must be to (re-)establish the abilities required for entering into valuable activities.

In addition, it must once again be underlined that there should be no activity for activity's sake, because regardless of the activity's objective value, it does not gain value in a life unless the person in question wholeheartedly *participates* in it. First because simply being an onlooker to an activity at best makes a person's life only marginally better, second because the activities need to have importance and meaning from the perspective of the person's view of life, personality, values, and priorities and third because it is crucial that the persons *themselves* contribute to the activity as subjects of recognition and equal worth and as cooperating participants ((19), chapter 4). It is crucial that the person has the opportunity to *succeed* at his/her activity him/herself. The much criticized (and certainly caricatured) "centre-cane paradigm" for occupational therapy could rightly be blamed for failing to live up to the two latter provisos. To be "activated" for therapeutic reasons only has value in so far as it is individually drawn up and includes the patient as an equally respected participant.

Finally, following from this, occupational therapy's *core service* is to carry out examinations, prevention, treatment, and compensation in connection with activity-related problems. The goal is to create coherence between person, activities, and environment in order to facilitate, promote, and safeguard participation in valuable activities—that is to say, activities that do in fact enrich a person's life.

## Professional moral principles

In this sense, fundamental values specify "only" overriding objectives and do not in themselves provide any instructions on how they are best realized. This is why a profession's core values must also contain *moral principles and guidelines*, which should help deal with the type of problems and dilemma typical of the profession in question. Simplifying a little one could say that whereas the core ethical values state the therapy's ideal *goals*, the moral principles and guidelines state the morally justifiable *means* for pursuing these goals.

I will not go into detail on these principles and guidelines, but I will point out two theoretical frameworks, which could serve as a useful background for their formulation.

First, there appears to be a very strong and consistent connection between fundamental values and the principles for their realization in the established occupational therapeutic practice standards. Activity and participation are not just the goal of therapeutic efforts; they are also the key instruments

or *means* in such efforts. Pursuit of activity and participation via means that pacify and exclude is an expression of poor professional standards. Occupational therapy builds on the *experience* that activity and participation are the pre-eminent means of achieving activity and participation ((19), chapter 4).

Second, occupational therapeutic principles and guidelines must obviously be in agreement with universal human principles of our moral duty toward one another. Tom Beauchamp & James Childress's *Principles of Biomedical Ethics* (20) presents four principles, claiming that they form the cornerstones of a common morality:

> A set of principles in a moral account should function as an analytical framework that expresses the general values underlying rules in the common morality. These principles can then function as guidelines for professional ethics.... (W)e defend four clusters of moral principles that serve this function. The four clusters are (1) *respect for autonomy* (a norm of respecting the decision-making capacities of autonomous persons), (2) *nonmaleficence* (a norm of avoiding the causation of harm), (3) *beneficence* (a group of norms for providing benefits against risks and costs), and (4) *justice* (a group of norms for distributing benefits, risks, and costs fairly. ((20), p. 12)

This principle-orientated approach to professional ethics has been widely criticized (21–25), but at least it has proved itself able to deliver an *analytical framework* which has been taken up by a number of professions other than medicine. Some professions have added further principles but these should be understood, I think, as profession-specific basic principles, not cornerstones in the common morality (26–29). According to this view, occupational therapists are, along with all others, bound by universal moral principles of showing respect for persons, doing good, avoiding harm, and being just. But the universal principles present themselves in a particular manner for the occupational therapist due to his or her professionalism:

- Respecting the patient's *self-determination* is here a case of examination, preventative measures, treatment, and compensation, which take the patient's specific personality, outlook on life, and set of values as his/her point of departure. This means that in principle there are no "standard" occupational therapeutic treatments, but that professional practice must be marked by attentiveness and ingenuity.
- Due to his/her professionalism, the occupational therapist has special opportunities to *do good* by clearing away obstacles to activity and participation in everyday life. The universal human obligation to help is here both concretized and expanded because the occupational therapist is specially positioned to help people with activity problems due to his or her professionalism and because the occupational therapist should be constantly attentive to, and even search for, citizens in need of his/her help to a much higher degree than non-professionals.
- Correspondingly, occupational therapy involves a particular risk of *doing harm*, because the professional practice is based on impact on and intervention in the patient's life which, if not characterized by care and conscientiousness, can certainly do more harm than good.
- By virtue of the occupational therapist having to relate to patients with highly variable treatment requirements, it is vital that the profession continually makes its priorities clear in relation to its core service and core ethical values, based on considerations of *justice*.

## Advantages of the ethical reading

Uncovering the profession's core ethical values (activity and participation) has at least four advantages.

One advantage is to bring the core ethical *values* into mutual reflection with the moral *principles*. With Beauchamp & Childress's theory the four principles establish frameworks for how the foundational values can and ought to be pursued and at the same time the core values provide a more substantial content for the principles. When an occupational therapist engages in a client's rehabilitation he/she should do so in a way that respects the patient's self-determination (e.g. by presupposing informed consent), promotes a fair distribution of health resources and burdens (e.g. by taking place in a framework of transparent allocation policies), and does not cause undue risk of harm.

The value of activity and participation also provide a more concrete goal for the principle of beneficence and for the occupational therapist this entails a more far-reaching duty than for most other persons. There are some special complications with regard to the principle of respect for autonomy because one is dealing with people who have severe activity problems and are often desperate, frightened, or, at least, confused. One cannot as a matter of course expect

that the person is able to *practise* any self-determination. Consequently, leaving the therapeutic decisions to the patient without helping him/her to reach a state of decision-making ability must be regarded as failure to live up to one's obligations. Unfortunately, it is not unknown for clients or relatives in critical situations to be bombarded with information and then required to make decisions immediately (30,31).

Another, no less important, advantage is the contribution of the fundamental values to maintaining and promoting a *shared professional identity*. The profession can be bound together across professional areas of expertise, functions and organizational cultures by a common mission and an ongoing reflection on the meaning and professional implications of the core values. Relating to all the new professional challenges such as collegial relations, the profession's institutional setting, demands for documentation, transparency, and uniformity of services is obviously important. But keeping hold of the profession's core service is absolutely crucial, as everything else should hopefully make sense in the light of this. The core values should therefore permeate the profession's total set of values. For example, if one has "efficiency" as a value, then in the end this should be about efficiency in relation to the helping efforts, which are the profession's *raison d'être*. But the value is *derivative* in relation to this; if efficiency affects the profession's clients adversely, then this is *not* a conflict between equal values. "Openness" as a value should be understood as a means to facilitate helping efforts; "commitment" and "conscientiousness" should first of all apply to helping, not all kinds of other things; "credibility" must be a result of a clear manifestation of the core service and fundamental values in one's practice. "Trustworthiness" is first of all a necessary condition for any successful joint effort to achieve health or participation or life capability, and so on and so forth.

Values such as "commitment", "credibility", and "openness" are what I call "facilitation values": they are values due to their contribution to realizing the core values. They are to be found in a great many "sets of values", which is not surprising considering what a profession manned by uncommitted, untrustworthy. and uncommunicative persons would be like. But if fundamental values are only made up of this type of value, they easily become banal or bland. A good rule of thumb is therefore that, by looking at a set of values, one should be able to identify which profession they apply to. If welfare and social justice figure as fundamental values, then one has a sporting chance of guessing that we have to do with social work (28). But how should one be able to guess that "respect, equality, transparency, responsibility, creativity, knowledge & competence" are a set of values for occupational therapy? Nevertheless, they are the "core values" formulated by the Association of Danish Occupational Therapists in 2004 (10).

On the other hand, it would be an oversimplification and naive to focus solely on the values arising from the "core service", i.e. helping efforts in direct practitioner–client relations. A professional practitioner also enters into relations with other people—including colleagues and the whole institutional complex of which she/he is part—and moral values are in play here as well. But it is a good idea to clearly distinguish between values and guidelines with relation to the client, colleagues, and other non-clients as well as the political system and the surrounding society in general. This is a way of bringing value conflicts connected to these differing considerations more clearly into focus, and of discovering whether one really does stand by watchwords such as "patient/client centred efforts". For example, one would be keen to know which restrictions such efforts put on loyalty toward colleagues or toward administrative and political norms within the relevant field.

The third advantage is that an elaboration of the profession's core ethical values can help to maintain a *profession-orientated view* in (professional) practice. The profession-orientated view has come under intense pressure in recent years from an organization-orientated view, which is not least driven by the *New Public Management* (NPM) trend (32,33). NPM has a de-professionalization strategy as an important element, since it puts several of the criteria in the "ethical reading" under pressure:

- The monopoly on professional *authorization* and the *unique knowledge and skills foundation* is under pressure from requirements for flexibility, removal of professional barriers, interdisciplinarity etc.
- Professional *autonomy* with its independent organization of work, professional assessment, and peer quality control is under pressure from requirements for centrally laid-down procedures, external quality control etc.
- Professional *authenticity* with its adherence to the client-orientated perspective (acting exclusively in the client's best interests) is under pressure from requirements for loyalty toward the organization, "overall assessments" etc.

Many of these requirements may well be supported by good reasons seen from a profession-orientated view—it all depends on what the many buzz-words actually cover. But in overall terms, I will venture the claim that the choice between professional and organizational orientation is not ethically neutral.

The first insists on a client-orientated perspective, while the other views this as one perspective among others.

The fourth advantage is connected to a profession-orientated view: to strengthen professional identity in interdisciplinary (inter-professional) cooperation. A precondition for coherence in the therapeutic process in healthcare service, in efforts for the benefit of the mentally ill etc., is that the different professional practitioners involved are all pulling in the same direction. My supposition is that professional practitioners with a strong professional identity will be *more* inclined to collaborate than those with a weaker identity, who will be more likely to cling to a narrow understanding of their own professionalism. In so far as cooperation has to do with a clear assignment of tasks, elaboration of core ethical values will also help to put the objective problem in focus: are we dealing with an activity-related problem or rather, for example, a specific function-related problem or a psychic disorder? In institutions that are continually becoming more centralized and multi-professional it will become more and more necessary to be able to handle such considerations—on a professional basis.

## Conclusions

A central element in professional development deals with the formulation of the unique value base of the profession in question. The core ethical values of occupational therapy are *activity* and *participation*. Hence, the core service of occupational therapy is to deal with obstacles to these since activity and participation are necessary elements in *well-being*, which consists of the wholehearted and successful carrying out of valuable activities. The core ethical values also lend concrete shape to a profession's moral principles and guidelines, e.g. the principles of respect for autonomy, nonmaleficence, beneficence, and justice. Philosophical reflection on the good human life and the place of activity and participation in it thus leads to a stronger professional identity and a much needed emphasis on the client-orientated perspective.

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