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## Introduction

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Once reserved for academic debate deemed interesting but, at best, only marginally relevant to the practical delivery of health care, ethical considerations are now viewed as inevitable and therefore integral to health care decisions. Whereas rehabilitation may have begun to contemplate its ethical dimensions only recently, there is absolutely no question about the pervasiveness of moral values — and the ethical conflicts that arise from collisions of those values — in the rehabilitation process.

This issue of NeuroRehabilitation presents a collection of essays that address a variety of ethical concerns affecting persons with disability, the professionals who care for them, and the society in which persons with disability attempt to live meaningful and productive lives. The first article by Tarvydas and Shaw presents an empirical study of ethical dilemmas confronting acute care rehabilitationists providing care to persons with traumatic brain injury. Among a number of interesting findings, the authors note the frequency of respondents' concerns about inadequate training of professionals, moral problems in determining the duration or intensity of treatment, and the lack of access to appropriate or least restrictive settings. On the other hand, they comment on how infrequently their respondents noted moral dilemmas that have attracted a great degree of professional interest, such as sexual relations with clients or the overuse of restrictive or aversive behavioral techniques. If Tarvydas and Shaw's

findings are generalizable, one wonders how well rehabilitationists have been served by a literature focusing on intellectually provocative incidents that perhaps appear only infrequently in rehabilitation settings.

A moral incident whose appearance is exceptionally common in rehabilitation settings, however, is providing care for patients with impaired decisional or judgmental ability. Rosenthal and Lourie provide an overview of this phenomenon and discuss the important association of competence with autonomy. Noting recent trends in guardianship laws as well as forensic psychological theory, they encourage competency to be viewed as functional or skill-oriented — i.e., as competency to 'do something' — and suggest that competency evaluations focus on domains or islands of competency, such as competency to manage financial affairs or to care for one's self or one's property. A significant implication of this approach is that persons might be deemed competent in one domain such as executing a will, but not in another, such as owning a business.

Auerbach and Banja then present an empirical study on the construction of an instrument to assess competency to consent to rehabilitation and then comment on how that assessment fared among a group of competency raters who viewed videotaped interviews of persons with cognitive impairments. The findings of this study showed that use of the interview format resulted in statistically insignificant disparities among the raters

and, hence, showed acceptable inter-rater reliability. Nevertheless, a few of the 21 patients interviewed elicited markedly differing assessments of their competence, for reasons which are discussed. Perhaps the most interesting finding of this paper, however, is that when the subjects' treating staff were also asked to rate their competence — without the staff having seen the videotaped interview — their ratings were markedly, statistically different from the videotape raters, primarily by way of the therapists consistently rating patients less competent than the videotape raters. Some speculation by the authors is offered by way of an explanation.

As the moral sensibilities of health care providers continue to grow, so grows a realization that organizations which employ them must provide a forum whereby moral contemplation might occur and whereby ethical dilemmas confronting the organization might be aired and remedied. Guenther and Webber provide a discussion of the role and value of an ethics committee in rehabilitation. They explain how policies on informed consent and confidentiality might differ in rehabilitation from those in acute care medicine, how issues over allocating rehabilitation might be highly influenced by familial and economic resources, and how therapists frequently but perhaps unwittingly inject their own values into any of these situations. Each of these moral situa-

tions, however, might call upon the organization itself to take a stance since, as employees, the values of the care providers should reflect the organization's understanding of its duties to its consumers. Furthermore, the organization must treat its consumers equally, or if it does not, be ready with a moral explanation as to why.

Issues of justice are key to the final manuscript in this issue by Wilkinson and Dresden. They discuss the moral underpinnings of the Americans with Disabilities Act and show how issues such as access and reasonable accommodation are moral expressions of what our society believes it owes persons with disabilities. In so doing, they also offer a straightforward explanation of the ultimate intentions of the ADA and how this piece of legislation, like virtually any piece of legislation involving civil rights, depends upon a society's moral attitudes about what is owed to persons who have historically experienced obstacles in accessing opportunities that dispose towards a life worth living.

Collectively, these articles attest to professional, organizational and social issues that are morally compelling in delivering services to persons with disability. One hopes that the contributions of these authors may spur further efforts that continue this extraordinarily important conversation.