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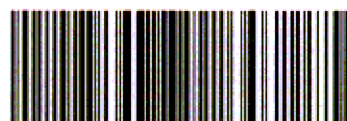

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Articles

The allied health care professions: New fields for philosophical exploration *

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The aim of this essay is to introduce the Allied Health Professions as individually and collectively constituting a rich field of issues for philosophers and other humanists interested in the applied focusing of their fields of inquiry to the medical and health sciences and Professions. I do not presume familiarity with Allied Health, and I discuss these professions and their origins before identifying some of the issues I find of greatest interest in them.[1]

1. Emergence of the allied health professions

While several factors account for the emergence of individual Allied Health Professions, three more general factors may be identified. (1) The explosion in technological aids to medical treatment and care have led to specialization and divisions of labor. The physician, who once handled all aspects of treatment, has yielded to the pressures both to specialize and to delegate those portions of responsibilities requiring routine, simple, and non-cognitive acts. Concordantly, the physician found that the increasing demands of a growing population for services could be better met through creation of support systems than through increasing medical school enrollment.

(2) Many functions which traditionally were performed by nurses have been taken over by Allied Health professionals. Besides factors in nursing similar to those in medicine, which press professionals toward specialization, splits between nursing and medicine over questions of professional subordination of nursing to medicine, and over the best model of the relation of health care professional to consumer, have resulted in nursing

* This essay is a revised version of the 1979 Presidential Address delivered before the American Society of Value Inquiry, 25 April 1980, in Detroit, Michigan.

proceeding to develop its own theories and practices. Medicine has responded to the independence of nursing by creating new occupations to which it can delegate responsibilities without worrying that contrary role traditions will frustrate the ultimate authority of the physician.

In sum, the complexity of medical practice and research in the mid-twentieth century, as well as the widening rift between nursing and medicine, have fostered increasing specialization and delegation in areas formerly a part of the direct practice of the physician or nurse, with the result that separate, quasi-independent professions and trades have been created.

(3) A third factor involves the impact of increased legal, third-party payor, and bureaucratic scrutiny of the physician's practice. Standardized patient records to facilitate insurance claims, increased record-keeping and accountability for controlled substances, and evidentiary concerns in anticipation of possible malpractice actions, have all contributed to the increased need for specialized handling of patient records. More positively, the technology of computerized records has greatly facilitated research using demographic data. The need of transient patients to have medical records readily transferable and interpretable as locations are changed has increased in proportion to the increased mobility of the population. Such pressures have created information specialist positions where once the physician's handwritten notes sufficed.

It is customary to refer to these new professions by the general term, "Allied Health Professions," and divisions of educational institutions which train persons in these professions are usually referred to as "Allied Health Sciences." Among them are found disciplines training occupational therapists, physical therapists, medical records administrators, physician's assistants, hospital administrators, and various medical technologists. Professionals in these fields have completed either four-year baccalaureate programs or the master's degree, and are frequently licensed or otherwise certified by state examining boards. In addition, there is yet another level of Allied Health occupations, entry into which involves completion of a two or three-year program. Individuals trained in these technologies include electroencephalographic and sonographic technicians, surgical technologists, accredited records technologists, occupational therapy assistants, physical therapy assistants, unit clerks, radiation and respiratory technicians.

All of these professions and occupations are found in the typical general hospital. Many will be represented on the staffs of convalescent centers, nursing homes, specialized hospitals, hospices, and the like. A few, notably occupational and physical therapists, are found in the employ of American public schools, particularly under the impact of Federal legislation in the

Developmental Disabilities Act of 1970, and the Education for All Handicapped Children and Rehabilitation Acts of 1973, together with subsequent amendments to these. Physical therapists also practice individually or through the auspices of home care agencies. Medical technologists can be found either in hospitals or in private laboratories with which small hospitals contract their pathological services. Finally, most of the professions and occupations are represented in the office staffs of private physicians and clinics.

We thus find that a variety of factors determine the relationships, responsibilities, and loyalties of the Allied Health professional. Depending on the character of the service provided, the location of employment, and the type and source of clientele, the Allied Health professional may have a chiefly client-centered practice, one that is physician-centered, or one that is institution-centered.

Only in the case of a client-centered practice can we expect an exact transfer of the principles governing ethical practice by the physician to be valid. Even there the matter is complicated by the fact that the Allied Health professional frequently employs a non-medical model of treatment (this is an attitude signalled by the use of the term "client" instead of the term "patient"). And, unlike some (though not all) patient-physician relationships, such Allied Health professionals are generally supplied to the patient through a process of referral or prescription from physicians, rather than by individual contact initiated by the client.

In the following section, I focus on a variety of the contrasts between the ethical questions in medicine and in the Allied Health Professions.

2. Ethical problems of the allied health professional

Let me illustrate how ethical problems arise for the Allied Health professional in ways that differ from those encountered by the physician, by reference to the Physician's Assistant. The Physician's Assistant performs tasks such as interviewing, examining, compiling case record data, administering treatment, writing prescriptions, and providing follow-up examinations and care. These activities are usually performed in preparation for, or in the wake of, the physician's contact with the patient: less frequently the Physician's Assistant may be the patient's sole contact with a health care professional.[2]

Viewed functionally, the Physician's Assistant seems to stand to the patient as a kind of proto- or surrogate physician, and consequently much of the ethical character of the physician-patient relationship holds for the Physician's Assistant-patient relationship as well. The Physician's Assistant

and patient are involved in the disclosures of history and data that occasion an understanding of confidentiality when they occur between the patient and physician; the Physician's Assistant, like the physician, may examine, touch, and treat the patient – acts normally viewed as batteries or invasions of privacy unless authorized by the patient; and so on. In these respects the Physician's Assistant might be viewed as similar to the intern or medical student who does many things that a licensed physician does, though under the supervision of a resident, staff physician, or physician with a private practice. Even in those cases where a Physician's Assistant serves in a line position in a hospital, performing technical, administrative, or supervisory activities in clinical, research, or diagnostic laboratory contexts, the Physician's Assistant appears to function as a proto- or surrogate internist, nephrologist, cardiologist, and so forth.

The functional parallels with the physician's activities, however, obscure important differences in the Physician's Assistant's responsibilities. First, unlike the medical student or intern, the Physician's Assistant does not interact with the patient as part of the learner's education. Nor does the Physician's Assistant relate to the physician as student to teacher. Most fundamentally, the Physician's Assistant who assists a physician does so as the physician's employee or agent. The Physician's Assistant's contact with the patient is at the behest of the physician; the degree and nature of the involvement with the patient is determined by the physician's wishes as to the role that the Assistant will play. Not only does this lead to a wide variability in the tasks that Physician's Assistants perform from physician to physician, it muddles the character of the relationship with the patient. The physician wants the Physician's Assistant to function as an instrument of the physician's will; the physician sees the Physician's Assistant like a stethoscope or diathermy machine – a means of gathering information and administering treatment under the patient's informed consent. But of course the Physician's Assistant is fundamentally unlike an instrument, in that he or she is an embodiment of perceptions, beliefs, intentions, values, aspirations – in short, another person.

At least three types of moral problems arise out of the Physician's Assistant's ambiguous status. The first comes from the Physician's Assistant's lack of participation in decision-making with respect to the patient's treatment. The patient and physician may decide to deal with an unwanted pregnancy through abortion, and the Physician's Assistant is then expected to assist in the dilation and curettage or even to administer the abortifacent. Physician's Assistants on hospital or long-term care facility staffs are frequently confronted with "no code" or "slow code" notes on patients' charts (terms indicating a physician's orders not to respond, or to respond but with deliberate slowness, to a cardiac or respiratory arrest in a patient),

or with orders that result in prolongation of the dying of a patient. They are expected to carry out these orders, despite any moral qualms or questions they may have individually as to how such decisions were reached.

In the literature of recent years on the physician-patient relationship, a general consensus has been reached that the physician has the right to refuse a patient's request for even a recognized medical procedure (such as an abortion) if the physician would find providing it morally offensive. No clear consensus has emerged concerning the nurse's right to refuse to participate in morally objectionable actions, although strong stances have been taken on both sides. But nurses are guided and buttressed in their view of themselves as no longer handmaidens to medicine by increasingly accepted articulations of that right on a model of their relationship to their clients which is not only non-medical but antagonistic to medicine. This has proceeded to the extent that the Code of Ethics of the American Nursing Association enjoins nurses to serve as advocates for their clients' interests.

The Physician's Assistant, created by medicine, lacking independent standing for practice, without the nurturing traditions of nursing, has much less to fall back on as sources of support for asserting moral claims in practice.

A second type of problem arises with respect to the Physician's Assistant's witnessing instances of malpractice or ethically questionable behavior in physicians. Is there a responsibility, as employee, to protect the physician from disclosure of mistakes, from criticism for ill-gotten consent? Should a Physician's Assistant support a physician's recommendation of surgery, when the Physician's Assistant questions its necessity or advisability? Or, does the fact of contact with the patient impose an overriding obligation to the protection of the patient's interests? And, if so, how does that contact generate that obligation?

The third closely related type of problem arises with respect to issues of responsibility and accountability, and it is as much if not more a problem for the physician as for the Physician's Assistant. The problem turns on the question of who is to be held accountable for the Physician's Assistant's participation in tasks assigned by the physician. If a physician writes an order for what is in fact a toxic dose of a legitimate drug for a patient, and it is administered by the Physician's Assistant under the physician's order, and then the patient dies from the resultant reaction, has the physician or the Physician's Assistant, or both, committed manslaughter? Does the Physician's Assistant's cognitive state make a difference to the question of responsibility (for example, if the Physician's Assistant believes the drug is fatally toxic for this patient or at this dosage, but because of prudential considerations, simply elects to follow orders)? Is there generally an obligation on the part of the Physician's Assistant to act in defense of her or

his conception of the patient's welfare, even at the risk of loss of employment? If so, what is its source? The source is obviously not in the "contract" between patient and physician, since the Physician's Assistant was not a party to the negotiations. It is likely not in the contract with the physician, since that amounts to a basic agreement to provide those services within the Physician's Assistant's competence as ordered by the physician, with the physician agreeing to "take responsibility."

This characterization of the professional, authoritarian relationship between physician and Physician's Assistant leads to the conclusion that, where the Physician's Assistant malpractices and acts contrary to the physician's orders or performs negligently or incompetently to the patient's detriment, the physician is the one to be held responsible for the actions of another. One can, of course, render such findings more sophisticated by applying standards of adequate supervision, but deeper reflection on alternative models of inter-professional relations may yield a better characterization of responsibility and accountability.[3]

3. Allied health care professions as sources for new models and concepts for thinking about bioethics

Much of our perplexity about these cases stems from the model of the Physician's Assistant's relation to the physician as essentially instrumental. One other model structure for relating patients, physicians, nurses, Physician's Assistants, and other health care professionals, which has met with much favor in nursing and some Allied Health circles, is the so-called team approach.

An extensive literature in medical education and medical sociology concerns aspects and examples of the team approach. Most of the literature is positive; some authors use discussions of the team approach as vehicles for political attacks on medical paternalism and authoritarianism; a few writers attempt comparative assessment of the impact of the team approach on quality of patient care.

I have not yet seen any clear exploration of the concept and root analogy of the team approach. Professional enthusiasm for the team approach as an alternative to the agency model suggests that several practical and theoretical issues would benefit from the clarification of the model. These issues include team-based decision-making, assignment of final authority, group accountability and shared responsibility, and other areas of inter-professional conflict. Philosophers interested in applying philosophical analyses to professional issues should find investigation of this approach fruitful.

Philosophers may wish to ponder the possibility of a conceptual syn-

thesis or criticism of the differing models of therapy employed by the different professions, the types of explanations and concepts employed in describing, explaining, and predicting the course of diseases and illness, and determining the direction of their therapy. Medicine, for the most part, favors the medical model which emphasizes the passivity of the patient in therapy, and it sees the health care professional as the agent of therapy. Non-medical models avoid such passive uses of the sick role and attempt to preserve as much autonomous decision-making as possible for those receiving care – also signalled by use of the term "client" instead of "patient." Health care professionals are seen as aids to the patient's therapeutic decisions and actions.

Somatic models can be constrasted with psychological and social models of disease occurrence and prevention, and in the explanatory models as in the therapeutic models an enormous component of the choice between these alternatives is valuational. A nice example of much of this range of issues can be found in Norman Cousins's book, *Anatomy of an Illness*,[4] a book which could serve as a central text in a medically oriented course in values in medicine.

4. Physical therapy, paternalism, and patient autonomy

Persons recovering from physical injury or surgical procedures, and from diseases of the nervous system, often experience loss of movement or other abilities. Recovery of such function may be possible to a degree, and it is the job of the Physical Therapist (sometimes, "physiotherapist") to assist in that recovery.

Depending on the nature of the impairment, physical therapy may involve manipulations which are painful in that force must be applied to stretch ligaments which have contracted through non-use. Then, there are impairments that result from neurological damage; in these cases, recovery of function awaits subtle "retraining" of other areas of the brain to take over the neurological functions of damaged ones. In these therapeutic endeavors as well, patients are confronted with therapeutic demands which they cannot initially meet, and which, in exceeding their capacities, confront them with repeated failure and frustration.

Patients, in seeking assistance from Physical Therapists, conform at a general level to the requirements of informed consent and enter into agreements with Physical Therapists for the provision of their services. Yet, in the therapeutic situation, patients often resist therapy at an effective level, confronting the Physical Therapist with what appears to be withdrawal of consent. Physical Therapists thus find themselves thrown into the position

of either acting paternalistically toward the patient or acceding to the patient's dissent to the patient's detriment. The conflict between the patient's needs and the patient's wishes places the Physical Therapist in the role of one who must discriminate between expressions of dissent interpreted as expressions of anger and grief at bodily losses, and expressions of dissent interpreted as competent decisions to settle with less than achievable function. This is, phenomenologically, a gray zone between competence and incompetence, between respect for autonomy and paternalism. Physical Therapists sometimes express their experience of this range of interactions in terms of having the informed consent of the patient at one level to treat the patient paternalistically at another level.

The experience of the Physical Therapist with the patient in therapy thus provides a reminder of the limits of such philosophical categories as autonomy and paternalism – a reminder which should counter the sometimes over-simplifying, rationalistic tendencies of bioethicists without a rich clinical background. Further, Physical Therapists are acutely aware of often-neglected aspects of the mind-body problem, especially the irreducibly functional character of the notion of embodiment. This is an awareness that Physical Therapists share with Occupational Therapists, the Allied Health Profession to which we now turn.

5. Occupational therapy as applied Heideggerian philosophy

I knew little about Occupational Therapists (other than the usual stereotypes of students majoring in basket weaving) when I began getting calls from Houston hospitals whose Occupational Therapists were being hired away by the city's school system. As I began to read on the subject, I became intrigued with the richness of the profession's differences from those which adopt the more standard medical model.

The therapeutic activities of Occupational Therapists are deceptively easy to describe. Occupational Therapists work with three types of clients: those who suffer from developmental retardation or disability, those who have become physically handicapped by accident or disease, and those who have emotional and psychiatric disorders. The therapy proceeds either through design of creative activities carefully planned to increase the client's sense of pleasure in life, happiness, and sense of well-being, or through retraining clients, with or without mechanical aids, to regain autonomy in the activities of daily living.

But the fascination of Occupational Therapy for philosophers of value lies in its theories about how its therapies work and how those theories embody a distinctive view of human nature. For paramount to Occupational

Therapy theory is the view that maximally attainable daily independence and the achievement of satisfaction through involvement in productive activity are central to human well-being.

H. Tristram Engelhardt, Jr., one of the few philosophers to have written on Occupational Therapy, sums it up as follows:

> Occupational therapy is…strikingly holistic. Because its goal is the fulfillment of patients in and through function, it tends to place a special accent upon considerations of the person as a whole – it appeals to broad and basic human values of activity and engagement in reality. Occupational therapy is, in this sense, an essentially humanistic project – it places its focus on the achievement of value in human activity.[5]

Engelhardt coins the term "praxial" (from "praxis") to describe the model of health employed by Occupational Therapy, for Occupational Therapy involves a commitment to the possibility of restructuring the apparent state of the experienced world in order to re-empower individuals whom illness and disability have isolated from robust human functioning. It dignifies fulfillment in tasks and esteem for tasks, and it emphasizes the holistic character of the human person, however disabled or handicapped physically or functionally. The praxical model of health is thus radically distinct from, and at odds with, other models in which health is understood in passive terms – as the absence of disease or disability. The praxial model of health understands health in a way that brings content and plausibility to the World Health Organization definition of health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[6] And, while lacking his technical vocabulary, Occupational Therapy enthusiastically endorses Heidegger's view of *Dasein* as essentially involving "being-in-the-world to hand and at hand" – that is, the essential integration of human existence in both the natural world and the world of human artifacts.

6. Conclusion

This presentation is designed to stimulate philosophers' interest in the Allied Health Professions, as areas of inquiry appropriate to philosophical reflection and particularly rewarding to those with a major focus on value and its experience. With their careful attention to the ways in which value is present in human experience, their second-order principles for designating priority relations among conflicting values, their ability to transfer the results of sustained inquiry into issues of responsibility and decision making from one context to another, philosophers should find the study of the Allied Health Professions rewarding and fulfilling. But with the long-

standing commitment to education and the new commitment to applied ethics and values represented by the emergence of institutes and centers devoted to value inquiry in the many professions, philosophers will find these fields increasingly receptive to measured overtures to integrate the humanistic concerns of philosophy into the Allied Health Science curriculum. Attention to the nature and theory of the activities of the Allied Health Professions may also serve to limit the hegemony of medicine in bioethics courses and texts, and thus better enable teachers of bioethics to assist pre-professional students in understanding their chosen professions as embodying the values about which axiology and ethics theorize.

Notes

1. The Address on which this essay is based was delivered while I was on leave from State University of New York at Buffalo, serving as a Personnel Consultant for M. David Lowe Personnel Services in Houston, Texas. My chief duties were to assist medical institutions in obtaining qualified employees, and to assist persons looking for work in the health professions in obtaining suitable employment. I have revised the wording of the Address as an essay, and I have slightly updated the work and added a small section, but I have not found a need to alter my position on the attractiveness of the Allied Health Professions as worthy of philosophical examination. My thanks to Karen Iseminger for assistance in the revisions.
2. Since this Address was given, a national organization of Physician's Assistants has formed, a journal has been started, Physician's Assistant standards of practice acts have been passed by several state legislatures, a certification program has been instituted, and a code of ethics for Physician's Assistants has been adopted.
3. I have explored some of these questions in the context of nursing and medicine in "Models of Nurse/Patient/Physician relations," *The Kansas Nurse* 55 (9): 19–24 (October 1980); in "Responsibility and Accountability analyzed," *Nursing Outlook* 29 (12): 707–712 (December 1981); and in "Reply to Erde's 'Notions of Teams and Team Talk in Health Care: Implications for Responsibilities'," *Law, Medicine, and Health Care* 9 (6): 2 (December 1981).
4. Norman Cousins, *Anatomy of an Illness as Perceived by the Patient: Reflections on Healing and Regeneration* (New York: Norton, 1979). Also see his *Head First: the Biology of Hope* (New York, Dutton, 1989).
5. H. Tristram Engelhardt, Jr., "Defining OT: The Meaning of Therapy and the Virtues of Occupation," *American Journal of Occupational Therapy* 31 (10) (November-December, 1977), p. 670.
6. "Constitution of the World Health Organization (Preamble)," in *The First Ten Years of the World Health Organization* (Geneva: World Health Organization, 1958), p. 459.