Choice: Ethical and Legal Rehabilitation Challenges

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The concept of choice, which has been inherent in the rehabilitation process since its inception, has evolved into legal mandates and ethical challenges for rehabilitation professionals during the latter part of the 20th century. This article identifies the ethical and legal issues related to choice, summarizes a pilot project on rehabilitation counselors' perceptions of choice, and provides recommendations for rehabilitation professionals in resolving ethical dilemmas related to choice.

Choice is not a new concept in rehabilitation. Forty years ago, Levine (1959) described the partnership between the consumer and counselor and the counselor's role in assisting the individual in making choices and decisions. During this same time period, C. H. Patterson (1960) encouraged counselors to facilitate independence by helping consumers "go through the process" of deciding what they should have and should do. He noted, "The counselor can have no stereotypes of occupational choices" (p. 115). Although both of these examples focus on vocational choice, they are consistent with current principles related to enhancing the counselor-consumer partnership, facilitating empowerment, and fostering choice and independence in the rehabilitation process.

Choice has numerous definitions (e.g., Webster, 1985). A definition that is especially applicable to rehabilitation is that set forth by Brigham (1979). He defined choice as

the opportunity to make an uncoerced selection from two or more alternative events, consequences, or responses. By uncoerced, we mean that there are no programmed implicit or explicit consequences for selecting one alternative over the others except for the characteristics of the alternatives themselves. (p. 132)

This definition is consistent with the legal definition of personal liberties described by Bannerman, Sheldon Sher, man, and Harchik (1990). They indicated that the "legal conceptualization of personal liberty implies that people should have a variety of available options and be free from coercion when choosing between options" (p. 80).

The definition of informed choice and its relationship with informed consent, as it relates to medical or health care, is equally applicable to rehabilitation?

the process by which an individual arrives at a decision about health care. It is a process that is based upon access to, and full understanding Of, all necessary information from the client's perspective. The process should result in a free and informed decision by the individual about whether or not s/he desires to obtain health services and, if so, what method or procedure s/he will choose and consent to receive. Informed consent is the communication between client and provider that confirms that the client has made a voluntary choice to use or receive a medical method or

procedure. Informed consent can only be obtained after the client has been given information about the nature of the medical procedure, its associated risks and benefits, and other alternatives. Voluntary consent cannot be obtained by means of special inducement, force, fraud, deceit, duress, bias, or other forms of coercion or misrepresentation. (Association for Voluntary Surgical Contraception, 2000)

LEGISLATING CHOICE

Although vocational choice is evident in mid-20th century rehabilitation literature, the consumer rights movement in the early 1970s provided the foundation for subsequent legislation on choice. The 1973 Rehabilitation Act was the first legislation that most adroitly translated consumer issues into legislated action. Examples in the 1973 Act that provided the foundation for choice included the independent living projects, the client assistance projects, and the Individualized Written Rehabilitation Program (IWRP) now the Individualized Plan for Employment). The independent living projects (now programs) provided alternatives to the traditional focus on employment, whereas the client assistance projects (CAPS) now client assistance programs) provided alternatives to the resolution of differences between consumers and counselors (Patterson & Woodrich, 1986). Developing rehabilitation programs was not new to rehabilitation in 1973, but the use of the word individualized focused attention on individual differences and choices. In addition to including consumer involvement in the development of state vocational rehabilitation agency policies, the 1973 Rehabilitation Act included Title V, which enhanced choice for individuals with disabilities by prohibiting discrimination in certain types of employment and other programs. Although the word choice was not used in the 1973 Rehabilitation Act, many of its statutory elements (e.g., CAPS, IWRPs, and consumer boards) were consistent with the principle of choice.

Other legislation that expanded the foundation for choice included the 1986 Rehabilitation Act Amendments, which included supported employment, and the 1990 Americans with Disabilities Act (ADA). Whereas supported employment provided alternative training formats, the ADA enhanced an individual's choices in a variety of areas, ranging from the selection of a restaurant to the mode of transportation one might use.

The principle of informed choice was first included in the Rehabilitation Act Amendments of 1992 as a philosophy related to state agency policies. It stated, "Individuals must be active participants in their own rehabilitation programs, including making meaningful and informed choices about the selection of their vocational goals, objectives, and services" (Section 100 (a)). The Federal Register, which provides guidance related to laws, indicated that the state plan had to include a description of how individuals who were determined eligible for rehabilitation services, as well as those individuals who were receiving extended evaluation services, were provided with opportunities to make informed choices (2/11/97). Each state had to ensure that its policies enabled

each individual to make an informed choice with regard to the selection of a long-term vocational goal, intermediate rehabilitation objectives, vocational rehabilitation services, including assessment services, and service providers .... and ... that each individual receives, through appropriate modes of communication, information concerning the availability and scope of informed choice, the manner in which informed choice may be exercised, and the availability of support services for individuals with cognitive or other disabilities who require assistance in exercising informed choice .... (and the)

information must include, at a minimum, information relating to the cost, accessibility, and duration of potential services, the consumer satisfaction with those services to the extent that information relating to consumer satisfaction is available, the qualifications of potential service providers, the types of services offered by those providers, and the degree to which services are provided in integrated settings .... (p. 6357)

The Rehabilitation Act Amendments of 1998 reinforced and extended the t992 provisions by broadening them to all applicants to the state-federal program, and stated, "Individuals who are applicants for such programs or eligible to participate in such programs must be active and full partners in the vocational rehabilitation process, making meaningful and informed choices" (Sec. 100 (a) (3)(Q). Also, the 1998 Amendments included informed choice as a (a) mandatory procedure; M mandatory component in development of the Individualized Plan for Employment (IPE); and (c) part of the vocational rehabilitation services; that is, counseling and guidance included providing "information and support services to assist an individual in exercising informed choice" (Sec. 103(a) (2)). For the first time, an individual could choose to develop his or her own IPE. The individual was informed of "the availability of assistance ... from a qualified vocational rehabilitation counselor in developing all or part of the individuals' plan for employment for the individual, and the availability of technical assistance in developing all or part of the individualized plan for employment for the individual" (Sec. 102)(b)(1)).

ETHICAL FOUNDATIONS OF CHOICE

Promoting choice is directly related to ethical principles (Beauchamp & Childress, 1989; Kitchener, 1984) and the Code of Professional Ethics for Rehabilitation Counselors (1987). Cottone and Tarvydas (1998) summarized the "Golden Five" ethical principles as follows:

- Autonomy: To honor the right to individual decisions
- Beneficence: To do good to others
- Nonmaleficence: To do no harm to others
- Justice: To be fair, give equally to others
- Fidelity: To be loyal, honest, and keep promises. (p. 135)

Although the principle of choice is most obviously inherent in autonomy, it has a relationship with each of the other principles. In rehabilitation, the concept of choice promotes an individual's autonomy by extending the number and type of decisions he or she makes. Similarly, if counselors are to "do good and do no harm," they must promote choice. Upholding the principle of justice means that all individuals have choices, regardless of the type of disability, whereas upholding the principle of fidelity means that counselors keep their promise to promote choice and are honest with consumers about the types of choice available to them.

These ethical principles and concepts of choice are embodied in the Code of Professional Ethics for Rehabilitation Counselors. Choice is most evident in the first three canons to the Code: moral and legal standards, counselor-client relationship, and client advocacy. For example, state agency counselors must uphold the laws related to choice. Making clear to consumers the "purposes, goals, and limitations that may affect the counseling relationship" (Rule 2. 1) includes ensuring that

consumers understand the choices they have. In serving as advocates, rehabilitation counselors promote accessibility and are committed to eliminating attitudinal barriers that limit choice. In its discussion of the collaboration necessary in developing the rehabilitation plan, Rule 2.8 specifically states that rehabilitation counselors remember that consumers "have the right to make their own choices."

BARRIERS TO CHOICE

Historically, people with disabilities have been faced with environmental, architectural, and attitudinal barriers. Each of these categories of barriers has impinged on choice. For example, the environment was much more limiting 20, 30, and 50 years ago than it is today. At one time these barriers prevented some children who used wheelchairs from getting an education and prevented some adults from accessing jobs. As these barriers have been addressed through legislation, the choices available to individuals with disabilities have been expanded. However, many barriers still exist.

Corthell and Van Boskirk (1988) described social and attitudinal barriers to consumer involvement in rehabilitation. Many of these barriers to consumer involvement are not only barriers to choice but also are reflective of ethical challenges facing counselors: Being seen as the ((expert" may be ego-enhancing to the counselor, but some counselors fear "loss of control of the plan" or engage in minimal risk-taking behavior (p. 72). Any of these actions and beliefs can place the counselor's needs above those of the consumer.

Bannerman et al. (1990) identified ways in which personal liberties are compromised in habilitation, which parallel behaviors that compromise choice. These include (a) denying an individual's input into treatment goals, (b) making decisions for individuals without considering their preferences, (c) failing to teach choice or decision making, and (d) omitting opportunities for choice. Although the Code mandates counselor competence to assure that consumers receive "the highest quality of service the profession is capable of offering" (Canon 9), many of the behaviors that may compromise choice are related to a counselor's competence.

Most of the research related to choice focuses on the consumer's perspective (e.g., Stoddard, Hanson, & Tempkin, 1999a, 1999b). As a first step in identifying counselors' perceptions of choice barriers, a pilot project was conducted with a group of employed rehabilitation counselors who were enrolled in an introductory graduate rehabilitation counseling course.

COUNSELORS' PERCEPTIONS OF BARRIERS

A convenience sample of 21 employed rehabilitation counselors enrolled in an introductory graduate course in rehabilitation counseling was used in a pilot study of the use of the nominal group process as a means of identifying barriers to choice. The nominal group process is a procedure by which individuals respond to a question that focuses on problems rather than solutions. As Van de Ven and Delbecq (1972) pointed out, the nominal group process accomplishes three objectives: (a) identifying, ranking, and rating critical dimensions of a problem; (b) aggregating individual judgments; and (c) providing for multiple individual participation without allowing any one individual or group to dominate. The nominal group process has been used to identify issues or problems in a variety of community

settings (e.g., Center for Rural Studies, 1998). In rehabilitation, the nominal group process has been used to increase consumer involvement and also as a means of identifying continuing education needs of rehabilitation counselors (Boland, 1978).

In the nominal group process, individuals are divided into groups of five to eight persons with a recorder-leader in each group. Each participant silently records his or her responses to the stimulus question for 5 to 15 minutes. At the end of this period, a round-robin listing of the responses occurs. After all responses have been recorded, a 30- to 40-minute discussion and clarification of the responses occurs. Individuals then independently vote on the 10 most important statements. If time permits, the group may redefine some of the problem areas.

Although the authors were most interested in the ethical issues associated with choice, they determined that including the word ethics in the stimulus statement may restrict the response statements (i.e., individuals might eliminate problem statements if they thought that ethics was not related to the problem statement). Therefore, the researchers used the following stimulus statement: "What problems have you or your colleagues experienced in assuring choice throughout the rehabilitation process?"

METHOD

The participant group consisted of 17 counselors employed by the state-federal vocational rehabilitation program, 3 counselors who were employed by the state workers' compensation rehabilitation program, and I counselor from a community-based program. The latter 4 counselors were placed in one group, because their work setting did not legislate choice. The vocational rehabilitation agency counselors were randomly assigned to the other three groups. The senior author served as a leader for all groups during the silent generation of problem statements. Each group selected a recorder who noted the problem statements in round-robin manner, with the recorder listing his or her own problem statement on the flip chart in turn, until all problem statements had been recorded. Each group discussed the problem statements, with the senior author serving as leader for all groups during the individual prioritization portion of the process and totaling of scores. Each group then discussed the results and possible solutions to the major problem areas.

RESULTS

The four groups generated 74 problem statements. The problem statements receiving the highest number of votes in the individual groups were as follows: (a) unrealistic vocational goals held by consumer, (b) consumers request more services than are necessary to achieve suitable employment, (c) consumer wants the most expensive ser~ vices versus reasonable cost/professional recommendations, and (d) ways to balance consumer expectations with reality. When the total points were added across all groups, the top-ranked problem statement was unrealistic vocational goals held by consumers, which was the top, ranked problem statement for Groups 1 and 4 and the second most important problem statement for Groups 2 and 3 (see Table 1).

DISCUSSION

Although the pilot study has numerous limitations (e.g., convenience sample, individuals without master's degrees in rehabilitation counseling), the most frequently cited barrier to choice does indicate a major ethical dilemma for rehabilitation counselors-balancing autonomy with beneficence or justice. If a counselor views the vocational choice of an individual as unrealistic, given the individual's intelligence, aptitudes, age, past work experience, or functional limitations, the counselor is faced with honoring a choice that (a) may not be in the individual's best interest (beneficence) or (b) would spend taxpayers' dollars on a decision the counselor cannot support (justice), This ethical dilemma places great weight on the counselor who is working with limited resources. Also, one guide, line frequently used in weighing autonomy versus beneficence (i.e., "How serious are the consequences of the consumer making his or her own decision?") does not appear to be particularly applicable.

The ethical issue may be ameliorated with counselor interventions. Practitioners faced with choice issues would be well served to reflect upon theories of career development and decision making (Isaacson & Brown, 2000; Salomone, 1996). Regarding unrealistic vocational goals, Super's Life-Span, Life Space Theory (1990), which posits that individuals pass through a series of stages in developing a career, may be helpful. Super's stages include growth, exploration, establishment, maintenance, and decline. Each of these developmental stages contains challenges for the individual and the counselor. The exploration stage, a common one among rehabilitation clients, can be broken down into the fantasy, tentative, and realistic phases. The fantasy phase is often found in individuals with limited knowledge of work. Choices of potential careers by individuals in this phase are governed by wishful and unrealistic thinking. Those in the tentative phase are uncertain about the list of jobs they are considering because they lack knowledge about the match between their attributes and job requirements. Clearly, clients at the fantasy and tentative stages present particular difficulties to the rehabilitation counselor.

TABLE 1. Top-Rated Problem Statements Related to Choice by Group

Group	Problem statement	Total points
1	• Unrealistic vocational goals held by consumer	15
	• Lack of knowledge of vocational rehabilitation system	11
	• Vendors desired by consumers are not included in the vocational rehabilitation database	11
2	• Consumers request more services than are necessary to achieve employment outcome	12
	• Unrealistic vocational goals held by consumer	9

	• Lack of time and resources to explore more choices	9
3	• Consumer wants the most expensive services vs. reasonable cost/professional recommendation	19
	• Unrealistic vocational goals held by consumer	9
	• Consumers' unwillingness to deal with mental issues as well as physical issues	6
4	• Balancing consumer expectations with reality (e.g., lack of training, age)	17
	• Consumer comprehension of mandates (process is confusing)	8
	• Medical stability problems (attorney-carrier disagreements)	6

How does the counselor assist the client in proceeding through the fantasy and tentative stages to the realistic phase? Salomone (1988, 1996) presented a five-stage approach to vocational rehabilitation counseling. Simply stated, the approach involves assisting clients in (a) gaining an understanding of self, N gaining an understanding of the environment, (c) gaining an understanding of the decision-making process, (d) implementing educational and career decisions, and (e) adjusting and adapting to the world of work. The first three stages are most relevant to choice issues.

To foster gaining an understanding of self, clients must explore their values, needs, interests, abilities, and temperaments. Counselors may assist clients in selfexploration through asking the client to provide informal self-ratings on the five attributes mentioned above. Although often valid (Parker & Schaller, 1994), self-ratings may over, or underestimate an individual's actual characteristics; therefore, counselors may wish to rate their client and compare their ratings to the client's. If done properly, identifying counselor-client rating discrepancies will lead to useful discussions. Where differences persist, the counselor may offer vocational tests measuring the client characteristics in question (see Kapes, Mastie, & Whitfield, 1994).

Helping clients understand the environment may be accomplished through exploration of family, cultural, and societal factors affecting clients' perceptions and capacities concerning work. Obviously, family variables (e.g., family expectations and childcare arrangements) affect one's ability to do certain kinds of work. Similarly, cultural factors, which include such things as values, attire, or language, may impede or enhance job performance. Finally, societal factors may also impede or enhance job functioning; societal biases may favor or discriminate against certain groups while on the job (e.g., ethnic minorities or people with disabilities).

Exploration of environmental factors is furthered by the provision of educational and occupational information through resources such as the very useful Occupational Outlook Handbook (OOH; U.S. Department of Labor, 1998), a resource that all rehabilitation counselors should use and that can be easily accessed through the Internet. Consumers may be given homework involving assigned readings in the OOH. Other useful activities for the consumer include discussing work possibilities with friends and family members, perusing local newspaper job ads, job shadowing, informational interviews with employers, job simulations, job tryouts, and so on.

The third stage presented by Salomone (1988, 1996), and the final stage to be discussed here, is understanding the decision-making process. Although several useful decision-making strategies have been developed (see Isaacson, 1985; Janis & Mann, 1977), Salomone endorsed an approach presented by Harren (1979), who posited three decision-making styles: rational, intuitive, and dependent. A client who uses the rational style will reach decisions through a systematic, step-by-step approach of gathering and weighing information. In contrast, the intuitive style is typified by rapid decision making based on the individual's internal state and how It right" the decision feels. Individuals who employ the dependent style rely heavily on the expectations and opinions of peers and significant others. Actually, consumers may mix aspects of two or all three styles. The counselor can assist consumers by helping them understand the three styles and which ones they are using in making educational and vocational decisions. The process of discussing and identifying the styles often leads to more carefully considered decisions and tends to raise confidence levels of both consumer and counselor concerning the consumer's decisions.

Assisting consumers in traversing the fantasy and tentative stages and equipping them with knowledge of the decision-making process will help address the problem areas identified in this article. Although the foregoing discussion focuses on one set of approaches selected from many possibilities, the underlying process of analyzing the issue and applying theory and research to address it will serve the practicing rehabilitation counselor well in solving similar problems.

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REFERENCES

Association for Voluntary Surgical Contraception. (2000). Counseling, informed choice, informed consent, and the rights of the client in family planning and reproductive health care (On-line]. Available: http://www.avsc.org/avsciinformedJiwhat.html

Bannerman, D. J., Sheldon, J. B., Sherman, J. A., & Harchik, A. E. (1990). Balancing the right to habilitation with the right to personal liberties: The rights of people with developmental disabilities to eat too many doughnuts and take a nap. Journal of Applied Behavior Analysis, 23, 79-89.

Beauchamp, T. L., & Childress, J. F (1989). Principles of biomedical ethics. Oxford, Great Britain: Oxford University Press.

Boland, J. M. (1978). The nominal group process in vocational rehabilitation. Rehabilitation Counseling Bulletin, 21, 335-338.

Brigham, T A. (1979). Some effects of choice on academic performance. In L. C. Perlmuter & R. A. Monty (Eds.), Choice and perceived control (pp. 131-142). Hillsdale, NJ: Erlbaum.

Center for Rural Studies, University of Vermont. (1998). Making group decisions (On-line). Available: http://crs.uvm.edu/citizensl decision.htm

Code of professional ethics for rehabilitation counselors. (1987). journal of Applied Rehabilitation Counseling, 80), 25-31.

Corthell, D. W., & Van Boskirk, C. (1988). Client involvement: Partnerships in the vocational rehabilitation process (15th Institute on Rehabilitation Issues). Menomonie, WI: University of Wisconsin, Stout Research and Training Center.

Cottone, R. R., & Tarvydas, V M. (1998). Ethical and professional issues in counseling. Columbus, OH: Merrill.

Harren, V. (1979). A model of career decision-making for career students. Journal of Vocational Behavior, 14, 119-133.

Isaacson, L. (1985). Basics of career counseling. Boston: Allyn & Bacon.

Isaacson, L., & Brown, D. (2000). Career information, career counseling, and career development (7th ed.). Needham Heights, MA: Allyn & Bacon.

Janis, I., & Mann, L. (1977). Decision making: A psychological analysis of conflict, choice, and commitment. New York: Free Press.

Kapes, J., Mastie, M., & Whitfield, E. (1994). A counselor's guide to career assessment instruments (3rd ed.). Alexandria, VA: National Career Development Association.

Kitchener, K. (1984). Intuition, critical evaluation, and ethical principles: The foundation for ethical decisions in counseling psychology. Counseling Psychologist, 12(3), 43-55.

Levine, L. S. (1959). The impact of disability. Journal of Rehabilitation, 25(6), 10-12.

Parker, R., & Schaller, J. (1994). Relationships among self-rated and psychometrically determined vocational aptitudes and interests. Educational and Psychological Measurement, 54, 155-159.

Patterson, C. H. (1960). The counselor's responsibility in rehabilitation. In C. H. Patterson (Ed.), Readings in rehabilitation counseling (113-116). Champaign, IL, Stipes.

Patterson, J. B., & Woodrich, F. (1986). The client assistance program (CAP), 1978-1984. Journal of Rehabilitation, 520), 49-52.

Rehabilitation Act of 1973, 29 U.S.C. § 701 et seq.

Rehabilitation Act Amendments of 1992, 106 Star. 4344.

Rehabilitation Act Amendments of 1998, 29 U.S.C. § 2801 et seq.

Salomone, P. (1988). Career counseling: Steps and stages beyond Parsons. Career Development Quarterly, 36, 218-221.

Salomone, P. (1996). Career counseling and job placement: Theory and practice. In E. Szymanski & R. Parker (Eds.), Work and disability: Issues and strategies in career development and job placement (pp. 365- 420). Austin, TX PRO-ED.

The State Vocational Rehabilitation Services Program, Final Rules, 34 C.F.R. § 361 et seq. (1997).
Stoddard, S., Hanson, S., & Temkin, T (1999a). An evaluation of the choice demonstration projects: Final report. Washington, DC: U.S. Rehabilitation Services Administration.

Stoddard, S., Hanson, S., & Temkin, T (1999b). Promising practices in the choice demonstration projects: An operations manual. Washington, DC: U.S. Rehabilitation Services Administration.

Super, D. (1990). A life-span, life-space approach to career development. In D. Brown, L. Brooks, & Associates (Eds.), Career choice and development (2nd ed., pp. 197-261). San Francisco: Jossey-Bass.

U.S. Department of Labor. (1998). Occupational outlook handbook, 1998-1999 edition. Washington, DC: U.S. Government Printing Office.

Van de Ven, A. H., & Delbecq, A. L. (1972). The nominal group as a research instrument for exploratory health issues. American Journal of Public Health, 337-342.

Webster's ninth new collegiate dictionary. (1985). Springfield, MA:Merriam-Webster.