While reading a book titled Redeeming time: endowing your church with the power of covenant, edited by Walter P. Herz, (1999, Boston, MA, Skinner House Books), it struck me that health care professionals enter into a covenant with their clients or patients, particularly if practicing client/patient-based care. Covenants, also, may be an application of professional ethics, the subject of the previous Resource Note. Would I find "covenant" in OT SEARCH?

According to the glossary in Redeeming Time, the definition for covenant is: "The common understandings, agreements, and promises made by members of a congregation that define their mutual obligations and commitments to each other as they try to live their faith and vision." (p. xiv).

The most generic definition from the unabridged second edition of The Random House Dictionary of the English Language is "an agreement, usually formal, between two or more persons to do or not to do something specified." (p. 465).

Perhaps it is because I most often think of a covenant in the context of a religious setting, that I sense a covenant to be more spiritual, more important to the individuals involved. I rush to say that I do take seriously any agreement or contract in which I am a party. A covenant seems to include either tangible and intangible obligations or promises. Perhaps temporal and spiritual are more apt, as we do speak of the "spirit" of an agreement or contract that the parties may assume are present along with the actual words.

For this note, I ask that you consider a covenant between you and your clients/patients as different than a contract with them and that you think of the mutual commitments, responsibilities and obligations that you have to support or challenge one another.

I was disappointed to get zero retrieval when searching with the key word "covenant" in OT SEARCH. Within five days of my beginning this Resource Note, a historian from Yale University called and asked for the date of the first Code of Ethics adopted by the American Occupational Therapy Association. I gave 1977, the year the Delegate Assembly adopted the "Principles of Occupational Therapy." The 1980 revision of the Principles of Occupational Therapy Ethics was published in the American Journal of Occupational Therapy, 34(13), 896-89. Penny Kyler, MA, OTR, FAOTA, current Director on the AOTA Board and former AOTA Ethics Program Manager, reminded me about the "Pledge and Creed for Occupational Therapists." The Boston School of Occupational Therapy (BSOT) adopted the creed, based on that of the American Hospital Association in 1925. Marjorie Green, Director of the BSOT program suggested that AOTA consider adopting which it did at its 10th Annual Meeting in 1926. (_______. (1926). Tenth
annual meeting of the American Occupational Therapy Association. Occupational Therapy and Rehabilitation, 5(6), 441-449.)

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Pledge and creed for occupational therapists

Reverently and earnestly do I pledge my whole-hearted service in aiding those crippled in mind and body.

To this end that my work for the sick may be successful. I will ever strive for greater knowledge, skill and understanding in the discharge of my duties in whatsoever position I may find myself.

I solemnly declare that I will hold and keep inviolate whatever I may learn of the lives of the sick.

I acknowledge the dignity of the cure of disease and the safeguarding of health in which no act is menial or inglorious.

I will walk in upright faithfulness and obedience to those under whose guidance I am to work and I pray for patience, kindliness and strength in the holy ministry to broken minds and bodies. (pp. 448-449).

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Within a day of my sending this additional information to the historian, I received a call from an OT faculty member who in working on a lesson on ethics thought again of the Pledge and Creed and wondered if I had any additional information. It seemed then that the Pledge and creed needed to be included in this discussion of covenants, as it is the closest thing to what I regard as a covenant that I found in the OT literature.

There are, of course, many references in our literature that speak to ethical caring and mutual professional-patient relationships, and here are just a few.


The Guidelines Impact Study investigated use and usefulness of the guidelines for client-centered practice produced in the 1980’s by the Department of National Health and Welfare and the Canadian Association of Occupational Therapists. This paper outlines the study, summarizes findings, and discusses implications for revising and updating the Guidelines. Qualitative interview data from key informants across Canada were incorporated into a quantitative survey of a 5% sample of CAOT members. Data reveal variable use of the Guidelines, with greatest use in acute care and rehabilitation services; and mixed interpretations of the Model of Occupational Performance, particularly 'environment' and 'spiritual component'. Recommendations include: clarification of the purpose and audience of revised Guidelines; national consultation during updating to include diverse forms of practice; and rethinking the Model of Occupational Performance as a dynamic model. Updated Guidelines should include both generic concepts and specific applications for different types of occupational therapy practice.

Health care professionals encounter many ethical issues in the care of persons who are HIV positive or who have been diagnosed as having AIDS. Such issues include the allocation of scarce resources for research and health care; the use of various methods of disease control, including mandatory testing, forced isolation, informing of sexual partners, and education, and the determination of the responsibility to treat infected patients. These issues are presented as a stimulus to readers to examine their own attitudes regarding HIV and AIDS. The usefulness and limitations of occupational therapy's professional code in resolving ethical dilemmas are discussed, followed by the description of a process that can be used.


Home care has been valued as a relevant context for the provision of occupational therapy since the inception of the field. The setting provides rich opportunities to restore meaningfulness in living for clients whose lives have been disrupted by illness or untoward events. Additionally, the home care setting allows practitioners to exercise professional commitments and to meet ethical obligations congruent with the field of occupational therapy. Nevertheless, the home care arena is not exempt from the pressures that pervade the health care industry. To thrive in the provision of home care, occupational therapy practitioners must prepare themselves to deal with the philosophic, economic, and moral challenges inherent in the setting. This article explores the moral obligations of occupational therapy practitioners who provide home care. More specifically, it addresses obligations to self, to patients, to caregivers, to society, to the profession, to fellow health care providers, and to agencies and payers. Ethical principles associated with each are highlighted, and issues are raised. Home care practitioners who are attuned to the moral commitments imbedded in occupational therapy philosophy will most likely incorporate these tenets into their clinical decisions.


The results of a previous inquiry suggest that three images of occupational therapists dominate patients' stories about them: the images of technician, parent, and collaborator or friend. These ways of being in practice can be said to reflect the various understandings that therapists have about how to enact the profession's commitment to both competence and caring. When therapists act as technicians or authoritarian parents, patients register their disappointment over a valuation of competence that excludes caring actions. In a more current inquiry into the climate of caring, patients and caregivers reflect about the current health care system and identify three societal constructs that shape a preference for competence over caring: (a) emphasis on the rational fixing of the health care problem, (b) over reliance on methods and protocols, and (c) a health care system driven by business, efficiency, and profit. Occupational therapists who are concerned about complaints that the health system is increasingly in caring might benefit from a consideration of the extent to which societal beliefs shape the manner in which they care.

In this study, we examine the nature and meaning of therapist-patient interactions from the perspective of the therapist. Qualitative analysis of phenomenological data from interviews with occupational therapists affirmed the importance of a sense of 'connecting' in these relationships, and the predominance of 'helping' and 'working together' in forging those connections. The nature of helping, the nature of working together, and the personal nature of these experiences in occupational therapy are examined. Findings enhance our understanding of collaboration in occupational therapy and underscore the importance of considering the personal contexts of practice.


With world-wide deregulation of mental health services, occupational therapy services are being decentralized with growing importance placed on community based interventions. The present article proposes a model of community development for child and adolescent mental health as one way of encompassing change. The model has five steps (developmental casework, mutual support, coalitions of mutual interest, pro-active community participation, and social movements), each facilitating change for subsequent stages of mental health. In combination with the theories of occupational behavior, role acquisition, developmental and psychosocial theories and the use of coping resources and theories of community development, the model offers an occupation-specific approach that empowers clients to take control of events that influence their health and lives.


RESEARCH QUESTION: The therapeutic relationship has been described as one that is personal, meaningful and intimate (Mosey, 1981a). It is a complex relationship that can be played out in diverse ways depending on the therapist's competence, understanding and ability to communicate caring in a way that is meaningful to the client (Peloquin, 1989, 1990). The researcher explored the complex nature and meaning of the therapeutic relationship between an occupational therapist and clients in psychosocial treatment settings by investigating the following questions: 1) how does a therapist construct a practice that embodies artfulness? 2) What is the nature of the interpersonal relationship between therapist and client in an artful practice? a. What is the therapist's experience? b. What is the client's experience? 3) How does the use of specific activities impact: a. the therapeutic relationship? b. the healing process? 4) How does the environmental context influence: a. the therapeutic relationship? b. the healing process?

Covenants do need to have mutual obligations and responsibilities, I believe. Just as successful patient-professional relationships will have. The following articles include interesting discussions about caring relationships or perhaps, covenants.

In enabling disabled persons to gain increased function and independence, rehabilitation practitioners try to emphasize the patient’s goals by providing the patient with some control over the process. As the patient enters the active rehabilitation phase, the patient actively becomes involved with the design of the treatment plan. If the patient does not fully participate in this plan, his/her motivation may be questioned. Rehabilitation professionals prefer patients who comply with the original treatment plan. Conflicts arise when patients do not comply, and the war between patient autonomy and medical paternalism ensues. When the disabled person becomes an outpatient, we must learn to measure the quality of life, not just the functional outcome. Rehabilitation professionals have become masters of inpatient rehabilitation but are less prepared to facilitate comprehensive rehabilitation care in the outpatient setting. Outpatient rehabilitation also needs to measure community reintegration. In the continuum of chronic disability, the care-giver and the disabled person develop an intermittent interdependence with an alternating relationship between autonomy and paternalism. Mutual respect such as that experienced in friendship provides a useful model for this idealized patient-care enabler team. To understand more of the essence of the disabled person’s life is the responsibility of the rehabilitation provider.


Our culture has a difficult time with caring. The guidelines seem contradictory: "take care of yourself," but "it is more blessed to give." The ambiguity of the caring role, coupled with a lack of preparation or education, may result in codependent or provider-dependent patterns in which one person plays solely the provider role and the other exclusively the dependent role. As a result of this imbalance, each person experiences a diminished sense of self, that is, he or she finds it difficult to think or behave independently. This article assists occupational therapists in examining their own care giving patterns and those of family caregivers so that dysfunctional patterns can be recognized and changed.

In MEDLINE/PubMed, PsychInfo, and CINAHL, I selected the following references dating from 1998 and including abstracts.

Blake, C.L. (1996). Nurses’ reflections on ethical decision-making. Fordham University. (Dissertation.)

Historically, nurses have engaged in moral conduct and adherence to various codes of ethics, which specify expected behaviors and a covenant with society. However, advances in technology, complexity in health care delivery, and the changing environment in the health care industry present nurses with recurring situations in which basic human values and needs pose ethical problems. This requires nurses to exercise ongoing moral judgment in decision making. Because each situation is unique, the task of decision making is further complicated by the changing values and expectations of other health care professionals, patients and their families, and society. This study described and documented nurses’ reflections on ethical decision making. The study also attempted to identify the type of ethical dilemmas encountered and the personal and external factors associated with ethical decision making by nurses. Interviews were used to document the stories of 11 nurses, 10 females and 1 male, working in acute care hospitals in New York City. Through the process of recalling past experiences, the nurses were able to explain cause and effect in terms of ethical decision making. The dilemmas encountered
focused on patients' rights versus institution policy, care versus pain and suffering, and truth telling versus silence about professional misconduct. Factors affecting decision making included the ethical principles of veracity, autonomy, and beneficence; ethical decision models; caring; personal and professional values and interpersonal relationships. Nurses also identified feelings of powerlessness, anger, and the silence that accompanies some decisions. The results of this study indicate that schools of nursing must reach out to students and hospitals must reach out to nurses to help them clarify and understand the ethical standards of the nursing profession in a changing health care environment; to seek and develop insights into personal values and beliefs; to develop sensitivity to diversity; and to maintain a caring attitude toward peers and patients.


It is argued that the current confusion about the role and purpose of the British nurse is a consequence of the modern rejection and consequent fragmentation of the inherited nursing tradition. The nature of this tradition, in which nurses were inducted into the moral virtues of care, is examined and its relevance to patient welfare is demonstrated. Practical suggestions are made as to how this moral tradition might be reappropriated and reinvigorated for modern nursing.


Medicine is, at its center, a moral enterprise grounded in a covenant of trust. This covenant obliges physicians to be competent and to use their competence in the patient's best interests. Physicians, therefore, are both intellectually and morally obliged to act as advocates for the sick wherever their welfare is threatened and for their health at all times. Today, this covenant of trust is significantly threatened. From within, there is growing legitimization of the physician's materialistic self-interest; from without, for-profit forces press the physician into the role of commercial agent to enhance the profitability of health care organizations. Such distortions of the physician's responsibility degrade the physician-patient relationship that is the central element and structure of clinical care. To capitulate to these alterations of the trust relationship is to significantly alter the physician's role as healer, career, helper, and advocate for the sick and for the health of all. By its traditions and very nature, medicine is a special kind of human activity—one that cannot be pursued effectively without the virtues of humility, honesty, intellectual integrity, compassion, and effacement of excessive self-interest. These traits mark physicians as members of a moral community dedicated to something other than its own self-interest. Our first obligation must be to serve the good of those persons who seek our help and trust us to provide it. Physicians, as physicians, are not, and must never be, commercial entrepreneurs, gate closers, or agents of fiscal policy that runs counter to our trust. Any defection from primacy of the patient's well-being places the patient at risk by treatment that may compromise quality of or access to medical care. We believe the medical profession must reaffirm the primacy of its obligation to the patient through national, state, and local professional societies; our academic, research, and hospital organizations; and especially through personal behavior. As advocates for the promotion of health and support of the sick, we are called upon to discuss, defend, and promulgate medical care by every ethical means available. Only by caring and advocating for the patient can the integrity of our profession be affirmed. Thus we honor our covenant of trust with patients.

The goals of medicine as a profession dedicated to healing and caring of the sick in a dignified manner depend very much on a stable and trusting doctor-patient relationship. In the last decade, rapid changes in the healthcare delivery system and socio-political climate have resulted in considerable strain on this relationship. What is needed is a reiteration of the fiduciary obligation of the physician and the central role of the patient in the relationship. Concrete steps and changes at the institutional and individual levels need to be taken to preserve the element of trust in the patient-physician covenant. Only then can the medical profession retain the moral dimension of its role in society.


The physician-patient relationship has changed over the last several decades, requiring a systematic reevaluation of the competing demands of patients, physicians, and families. In the era of genetic testing, using a model of patient care known as the family covenant may prove effective in accounting for these demands. The family covenant articulates the roles of the physician, patient, and the family prior to genetic testing, as the participants consensually define them. The initial agreement defines the boundaries of autonomy and benefit for all participating family members. The physician may then serve as a facilitator in the relationship, working with all parties in resolving potential conflicts regarding genetic information. The family covenant promotes a fuller discussion of the competing ethical claims that may come to bear after genetic test results are received.


Discusses a therapeutic "ethics of covenant" in relation to the question of whether a counselor should breach therapeutic confidence when clients who are infected with the HIV continue to engage in sexual activity or injectable substance-using activity without informing their partners of their positive sero-status. It is suggested that a therapist needs to help clients make the sort of life changes that will enable them to be honest with their partners. Breaching confidence should be avoided, however, except as a last resort.


While some ethical and value issues are unique to the care of the elderly, many are shared with other age groups in medical practice. Efforts at cost containment and the rationing of medical services are impinging deeply on the elderly and placing physicians in roles that may interfere with the covenant of faithfulness that exists between physician and patient. Physicians must examine negative societal images that may influence the care of the elderly and hold firm to the commitment to respond to the needs, values, and best interests of the elderly in the face of changing health care policies and constraints of one kind or another. Further, a major ethical imperative for physicians relates to making themselves available for the treatment of the elderly in the context of an appreciation of these patients’ tasks in the final stage of development.

The author explores the social identity of older persons and their potential for taking leadership roles in their families and communities as mentors to young persons with disability. Dealt with is the powerlessness of both these groups within society and the way in which they may be able to empower each other. It is posited that serious and active grandparenting and mentoring have the potential of filling a large gap in the continuum of meaningful and productive activities for older adults and provide highly valuable support and human resource to young persons with disabilities.


This study examined the association between the therapeutic bond - an element of the therapeutic alliance - and treatment effectiveness. Psychotherapy clients (n = 114) completed self-report questionnaires at intake and throughout open-ended, psychodynamically oriented psychotherapy. Three bond scales, role investment (RI), empathic resonance (ER), and mutual affirmation (MA), were contrasted to session quality and the three phases of outcome (remoralization, remediation, and rehabilitation). Results indicated that different aspects of the bond predicted session quality and treatment outcome. Clients who felt motivated and invested in therapy (relatively high RI) and who reported that the therapeutic environment was friendly and affirmative (relatively high MA) were likely to rate the session as being helpful and productive. Clients who had a relatively high sense of understanding and of being understood (ER) experienced greater remoralization and remediation (but not rehabilitation). The results are placed within the context of recent research into the therapeutic alliance.


Unique among professional codes of ethics is the Texas & New Mexico Hospice Organization's Code of Ethics. Where other codes concentrate only on principles-based ethics, this new code identifies five models of bioethics currently used in resolving ethical dilemmas. This report's primary purpose analyzes the code's four precepts in the context of (1) principles-based ethics, (2) casuistic-based ethics, (3) covenant-based ethics, (4) evidence-based ethics and narrative-based ethics. The second purpose is to present the practicality of these often esoteric concepts in the day-to-day work of palliative care providers. Indications are that this code of ethics, because of its broad scope, is more useful than other principles-based-only codes.


Catholic healthcare should establish comprehensive compliance strategies, beyond following Medicare reimbursement laws that reflect mission and ethics. A covenant model of business ethics--rather than a self-interest emphasis on contracts--can help organizations develop a creed to focus on obligations and trust in their relationships. The corporate integrity program (CIP) of Mercy Health System Oklahoma promotes its mission and interests, educates and motivates its employees, provides assurance of system wide commitment, and enforces CIP policies and procedures. Mercy's creed, based on its mission statement and core values,
articulates responsibilities regarding patients and providers, business partners, society and the environment, and internal relationships. The CIP is carried out through an integrated network of committees, advocacy teams, and an expanded institutional review board. Two documents set standards for how Mercy conducts external affairs and clarify employee codes of conduct.

Do you have information to share about covenants? If so, please send it to me, and I'll share it with the over 800 individuals who receive the Resource Note.

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