ETHICAL DECISION-MAKING IN OCCUPATIONAL THERAPY PRACTICE

ETHICAL DECISION-MAKING IN OCCUPATIONAL THERAPY PRACTICE IN CANADA

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Lay Abstract

"Doing what's right", or ethical decision-making, is an important part of being an occupational therapist in Canada. To help occupational therapists build knowledge and skills it is important to understand how they make ethical decisions in day-to-day practice. This PhD describes three studies that look at three different aspects of ethical decision-making. The first study presents a theoretical explanation of how occupational therapists decide what's right to do. The second study uses the same data to look at supports that occupational therapists feel they need to build knowledge and skills about ethical decision-making. The third study measures the value of an on-line education course in helping occupational therapy educators teach students about ethical decision-making. Results of these studies can be used to support occupational therapists in doing what's right. Results also highlight areas for additional study to further support ethical occupational therapy practice in Canada.

Abstract

Introduction: Ethical decision-making is an important component of occupational therapy practice in Canada. Research is needed to understand ethical decision-making and how to build occupational therapists' competency to make ethical decisions. **Purpose:** The aim of this thesis was to study ethical decision-making in occupational therapy practice in order to contribute to epistemological development regarding ethics in occupational therapy and to support continuing competency in ethical decision-making. **Method:** Three studies comprise this thesis. A *constructivist grounded theory study* was conducted involving in-depth semi-structured interviews with 18 occupational therapists from a range of practice settings to explore the process of ethical decision-making. An *interpretive description study* using secondary analysis of grounded theory data was conducted to explore gaps related to continuing competency in ethical decision-making from the participants' perspective and to generate recommendations for future directions to support continuing competency. Finally, a *non-randomized, single-group, pre- and post-test study* (n=33) was conducted to evaluate an on-line education module developed to support competency for clinician-educators. **Findings:** The grounded theory study led to development of an ethical decision-making prism capturing three processes: *Considering the Fundamental Checklist*, *Consulting Others*, and *Doing What's Right*. The interpretive description study highlighted two gaps related to continuing competency in ethical decision-making: lack of knowledge and lack of supports. Education, tool development, and ethics mentorship were identified directions for development. The third evaluation study found that an on-line education module led to improvements in ethics knowledge and intent to change practice but not to actual practice change. **Implications:** This thesis advances a theoretical understanding of ethical decision-making in occupational therapy practice and an applied understanding of occupational therapists' needs related to competent ethical decision-making. Findings also provide preliminary data regarding on-line ethics education to advance knowledge and skills of clinician-educators who are involved in cultivating ethical decision-making among student occupational therapists.

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List of Abbreviations and Symbols

Association of Canadian Occupational Therapy Regulatory Bodies   ACOTRO

Canadian Association of Occupational Therapists   CAOT

Canadian Institute for Health Information   CIHI

Canadian Rehabilitation Ethics Teaching Workshop   CREW

Evidence-Based Practice   EBP

Hamilton Integrated Research Ethics Board   HiREB

Knowledge-to-Action Process   KTA

Knowledge Translation   KT

Knowledge Translation Planning Template-R™   KTPT-R™

Master of Science Occupational Therapy   MSc OT

Ontario Society of Occupational Therapists   OSOT

Occupational Therapy   OT

Problem-Based Learning   PBL

Research Ethics Board   REB

Declaration of Academic Achievement

This PhD thesis is composed of an introductory and conclusion chapter centred with three distinct manuscripts. I, Sandra VanderKaay, am the first author on all chapters and the manuscripts contained herein are largely my own work. However, the entirety of this work has been generously guided and supported by my current and previous PhD supervisory committee and others. My PhD supervisory committee was initially comprised of Dr. Joyce Tryssenaar as my supervisor and Drs. Sandra Moll and Lori Letts as committee members. Dr. Sandra Moll became my supervisor in September 2015 upon Dr. Tryssenaar's retirement. At that time Dr. Bonny Jung joined as members of the supervisory committee. Contributions are outlined as follows:

Chapter 2: Doing What's Right: A Grounded Theory of Ethical Decision-Making in Occupational Therapy. Drs. Tryssenaar and Moll contributed to the conceptual development of this study including reviewing and approving the *Proposed Plan for Doctoral Thesis* contained in my PhD Comprehensive Examination Portfolio Proposal. All current supervisory committee members provided input into all other stages of the research process including planning and carrying out the research and providing critical input on data analysis and interpretation. All current supervisory committee members also contributed to revising and editing the manuscript presented in this chapter. Drs. Letts, Jung, and Moll are listed as co-authors on this manuscript published in *Scandinavian Journal of Occupational Therapy*.

Chapter 3: Continuing Competency in Ethical Decision-Making: Current Gaps and Future Directions. Dr. Sandra Moll contributed to the conceptual development of the study presented in this chapter and provided input into all stages of the research process including data analysis and interpretation and the iterative process of manuscript revision. Drs. Letts and Jung also provided input into all stages of the research process including providing editorial support. Drs. Jung, Letts, and Moll are listed as co-authors on this manuscript submitted for publication to *Canadian Journal of Occupational Therapy*.

Chapter 4: **On-Line Ethics Education for Occupational Therapy Clinician-Educators: A Single-Group Pre- Post Test Study.** Dr. Joy MacDermid and Dr. Tryssenaar contributed to the conceptual development of this study as part of both RS 725* (Effective Knowledge Transfer for Rehabilitation Science) and my PhD Comprehensive Examination Portfolio. Dr. Lori Letts was instrumental in supporting this study in her role as Assistant Dean of the Occupational Therapy Program by liaising with MacPherson Institute personnel and other relevant stakeholders and by initiating a grant proposal to access the McMaster School of Rehabilitation Science Technology Innovation Pilot Fund. MacPherson Institute provided technical support for development of the on-line module and Rachel Morris (Brock University) provided support with statistical analyses. All current supervisory committee members provided input into all stages of the research process including reviewing drafts and suggesting revisions. Drs. Letts, Jung, and Moll are listed as co-authors on this manuscript published in *Disability and Rehabilitation*.

Chapter 1: Introduction

Every day, in hospitals, rehabilitation centres, homes, schools, and other settings across Canada, occupational therapists set out to accomplish the potentially life-changing work of helping people of all ages, abilities, and sociocultural backgrounds to engage in the day-to-day activities that are meaningful to them (Canadian Association of Occupational Therapists [CAOT], 2012; Canadian Institute for Health Information [CIHI], 2018). Canadians often come to occupational therapy at very difficult times in their lives, when illness or disability is affecting their mental or physical well-being (CIHI, 2018). Occupational therapists help people to reconstruct their lives using engagement in occupation as both the therapeutic medium and the goal of intervention (Townsend & Polatajko, 2007). In *The Philosophy of Occupational Therapy* Adolph Meyer (1977/1922, p. 641) stated:

> It takes rare gifts and talents and rare personalities to be real pathfinders in this work. There are no royal roads; it is all a problem of being true to one's nature and opportunities and of teaching others to do the same with themselves.

For occupational therapists, the work of occupational therapy can be rewarding yet challenging (Edwards & Dirette, 2010; Penny & You, 2011; Townsend & Polatajko, 2007). Occupational therapy is rewarding in the sense that it provides an opportunity to help people: to enable them, at a compromised time in their lives to regain their sense of well-being (Townsend & Polatajko, 2007). However, because of a confluence of several factors related to service delivery in Canada, occupational therapy is often challenging and difficult work. Caseloads may be quite large, cases can be complicated, professional relationships can be complicated, funding is scarce, waiting lists for services are long, the number of allowable visits is short, and evidence may not be readily accessible in some practice situations (Brockett, 1996; Canadian Medical Association,

2016; Dewan & Cohen, 2013; Durocher, Kinsella, McCorquodale, & Phelan, 2016; Grilli et al., 2007; Passalent, Landry, & Cott, 2009; Thomas & Law, 2014). Within this complex context, issues of deep significance to clients persist and occupational therapists face the difficult task of discerning the right or wrong course of action given these professional challenges (Purtilo, 2005). This is precisely the concern of ethics: the systematic consideration of right and wrong in order to determine "right" action (Cheyney-Brandt & Yarett-Slater, 2011).

Ethics and Occupational Therapy

Ethics is a philosophical discipline which has been defined in many ways across centuries of literature. Merriam-Webster (2018) defined ethics as an area of study that addresses ideas regarding what is good and bad behaviour: a branch of philosophy dealing with what is morally right or wrong. Seedhouse (1991, p. 281) however, defined ethics more simply as consideration of "how best to conduct one's life in the presence of other lives". In many contexts, the words ethics and morals are distinguished from each other with morality referring to moral conduct and ethics pertaining to intellectual thought regarding moral conduct (Doherty, 2014; Keniston, 1965; Royo-Bordonada & Román-Maestre, 2015). However, the *Concise Oxford Dictionary of English Etymology* (1996) indicates consistency in etymology of both ethics (Latin origin *ethica* meaning character or personal disposition) and morals (Latin origin *morales* meaning character or conduct) and in many contexts the words morality, morals, and ethics are used interchangeably with little to no distinction made between them (Keniston, 1965; Seedhouse, 2009). Ultimately, the consideration of both ethics and morals is meant to guide critical reflection regarding how one *ought to conduct oneself* and the term *ethics* will primarily be used for the remainder of this PhD thesis.

While the study of ethics is within the domain of philosophy, many prominent ethical theories have their origins in other disciplines including theology, psychology, and anthropology. Greek philosophers such as Plato and Aristotle are commonly associated with ethical thought, but consideration of ethics can be traced back to earlier ancient civilizations. Some ethical theories have emerged in more recent centuries such as feminist ethics (Sherwin, 1992). Several taxonomies of ethics appear within the literature. Although there are variations, there appear to be four main branches of ethics: (a) meta-ethics, which considers the existence and meaning of ethical concepts, (b) normative ethics, which is the study of ethical theories that seek to propose and guide "right" action, (c) applied ethics, which is the application of ethics to real-life situations, and (d) descriptive ethics (non-normative), which seek to describe the actual ethical practice of individuals or groups (Kornblau & Burkhardt, 2012; Purtilo, 2005; Valdez-Martinez, Turnbull, Garduno-Espinosa, & Porter, 2006).

Consideration of ethics is relevant to all aspects of health care including informing the thinking and decision-making of individual practitioners (Purtilo, 2005). Meta-ethical thought in health care is centred on becoming aware of beliefs and assumptions about right and wrong that may underlie thinking and decision-making in clinical contexts (Purtilo, 2005). Normative ethical theories in health care provide guidance to practitioners regarding determining right or wrong courses of action (Purtilo, 2005; Seedhouse, 2009). Some prominent normative ethical theories that are commonly applied to health care include virtue ethics, deontology, consequentialism (including utilitarianism), ethics of care, and the principles approach (including autonomy/beneficence/non-maleficence/justice) (Ferrie, 2006; Purtilo, 2005; Seedhouse, 2009). Professional codes of ethics and casuistry (decision-making based on previous exemplar cases) are examples of applied ethics in health care (Edwards & Delany, 2008; Ferrie, 2006; Kornblau

& Burkhardt, 2012; Purtilo, 2005). Finally, descriptive ethics, although less commonly applied in health care, have been used to describe how health care practitioners negotiate ethics in practice (Durocher & Gibson, 2010; Gremmen, 1999; Lauxen, 2009).

Only one definition of ethics in occupational therapy was located within the literature. In their chapter titled *Ethical Dimensions of Occupational Therapy*, Cheyney-Brandt and Yarett-Slater (2011, p. 469) defined ethics in occupational therapy as "a systematic view of rules of conduct that is grounded in philosophical principles and theory". The authors also describe several ethical theories including ethics of care, teleology (including utilitarianism), deontology, and principles of bio-medical ethics. However, Cheyney-Brandt and Yarett-Slater (2011) did not explicate why the ethical theories described were chosen and they did not provide any substantial level of critical examination of the applicability of these theories to the theory and practice of occupational therapy. In the chapter titled *Ethical Practice* in the seminal introductory occupational therapy textbook *Willard and Spackman's Occupational Therapy* Doherty (2014) does not define ethics or situate occupational therapy within the philosophical discipline of ethics. Furthermore Doherty (2014) devotes less than one page to discussing four major ethical theories (principles-based, virtue/character based, utilitarianism, deontology) and did not provide any level of critical examination of the theories through the lens of occupational therapy. It remains unclear why particular ethical theories were chosen by each author, why there is a discrepancy in which ethical theories were presented, and how the ethical theories relate to the practice of occupational therapy (Cheyney-Brandt & Yarett-Slater, 2011; Doherty, 2014). For example, why did Doherty (2014) not mention the ethic of care? For many thinkers in occupational therapy, the concept of caring is believed to be a central component of ethical practice (Crepeau & Garren, 2011; Peloquin, 2005; Wright-St. Clair, 2001; Yerxa, 1980). Does

the omission of feminist ethics from these textbooks imply that feminist ethics is not relevant to occupational therapy despite a predominant concern for exposing and eliminating oppression of those with diminished power within health care (Brockett, 1996; Sherwin, 1992)? Brockett (1996, p. 197) argued that a feminist perspective of ethics "is especially appropriate to the practice of occupational therapy." Does the ethic of reciprocity, colloquially referred to as the "Golden Rule", apply to occupational therapy? If so, from which philosophical or religious context should this idea of "treating others as one wishes to be treated" be cited and how should it apply? Friend (2012) argued that the Golden Rule "can bring health care providers much needed guidance in complicated ethical situations" (p. 253).

In addition to the ethical theories referenced above, other concepts related to ethics appear within the occupational therapy literature, again, with limited definition or guidance regarding the applicability to occupational therapy practice. For example, in a single paragraph Kanny and Slater (2008) introduced terms such as moral sensitivity, moral judgment, and moral motivation. Definitions are brief, and it is unclear how occupational therapists are to operationalize these concepts in practice. Brockett (1996, p. 204) highlighted the importance of "professional virtue" in occupational therapy practice, but the definition is unclear as is its applicability to practice. What is professional virtue in occupational therapy practice? Should professional virtue be enacted in practice and how? Two authors referred to occupational therapists as moral agents but neither define the term or describe moral agency in the context of occupational therapy (Barnitt, 1998; Penny, Ewing, Hamid, Shutt, & Walter, 2014). Moral agency is a complex concept deeply rooted in the study of philosophy (Skalko & Cherry, 2016). Edwards, Delany, Townsend, and Swisher (2011) described moral agency in physiotherapy as the capacity of an individual or group of physiotherapists or patients to act morally for change within their context. Does moral

agency have similar meaning in occupational therapy practice and to what extent does moral agency parallel other concepts in occupational therapy? These questions are only a few of a myriad of possible unanswered questions that arise when considering the current occupational therapy literature vis-à-vis the philosophical discipline of ethics.

Despite the lack of clarity noted within the literature regarding ethics in occupational therapy, engaging in ethical practice is a key competency for occupational therapy practice in Canada (Association of Canadian Occupational Therapy Regulatory Organizations [ACOTRO], 2012b; CAOT, 2012). The CAOT (2012) and ACOTRO (2012b) indicate that ethical practice involves adhering to codes of ethics, applying ethical frameworks to facilitate ethical decision-making, and responding appropriately to ethical issues encountered in practice. However, Kinsella, Phelan, Park-Lala, and Mom (2015) suggested that the meaning of ethical practice in occupational therapy remains unclear as does an understanding of how ethical practice is enacted and identified. To address this gap, Kinsella et al. (2015) explored the meaning of ethical practice from the perspective of student occupational therapists and put forth seven themes: (a) being faithful to the tenets of practice, (b) being communicative, (c) being in tune with your values, (d) understanding client need, (e) weighing pros and cons, (f) negotiating the grey zones, and (g) taking time to reflect. No similar studies were located which consider other perspectives on ethical practice, including the perspective of occupational therapy scholars or practicing occupational therapists.

Currently there are 10 provincial occupational therapy regulatory bodies in Canada which belong to ACOTRO (2012a). Each regulatory body has an established code of ethics for occupational therapists which reflect several commonly held values. Codes of ethics are the hallmark of autonomous professions (Cheyney-Brandt & Yarett-Slater, 2011). Codes of ethics in

occupational therapy are intended to be regulatory in nature and meant to inform the public of the expected conduct of occupational therapists thereby ensuring public trust in the services provided (Cheyney-Brandt & Yarett-Slater, 2011; Doherty, 2014). The existence of codes of ethics is imperative to professional self-regulation. However, due to this orientation towards professional regulation, codes of ethics are not meant to define or develop the relationship between ethics as a philosophical discipline and the theory and practice of occupational therapy (Cheyney-Brandt & Yarett-Slater, 2011; Purtilo, 2005).

Overall, ethics is considered central to occupational therapy practice but scholarship about applying ethics to day-to-day practice is limited (Jensen, Brasic-Royeen, & Purtilo, 2010; Kinsella et al., 2015; World Federation of Occupational Therapist, 2016). Jensen et al. (2010) called for the establishment of a vision and strategic plan to promote the scholarship of ethics in rehabilitation. Seedhouse (1991) suggested that the focus of ethics within a profession should involve encouraging and enhancing critical thinking about ethics that is linked to its origins within philosophy. In other words, the goal is not to develop "occupational therapy ethics" but to advance the profession through scholarship that includes critical reflection on the relevance and application of ethical theory to the theory and practice of occupational therapy.

Ethical Tensions in Occupational Therapy

Research indicates that occupational therapists experience ethical tensions in day-to-day practice (Bushby, Chan, Druif, Ho, & Kinsella, 2015; Durocher et al., 2016). Currently, in the occupational therapy literature ethical tension is understood as a broad term encompassing *ethical uncertainty*, *ethical distress*, and *ethical dilemmas* (Opacich, 2003). Ethical uncertainty refers to ambiguity or lack of clarity regarding the very existence of ethical issues and/or which ethical concepts apply. Ethical distress results from feeling compelled to respond to clinical

scenarios in ways that are incongruent with the most appropriate course of action. Finally, ethical

dilemmas result when potential responses to ethical problems are in conflict. In their scoping

review of existing literature on ethical tensions in occupational therapy Bushby et al. (2015, p.

212) stated that ethical tensions "have become an unavoidable part of practice". Seven themes

were put forth which summarize areas of ethical tensions in practice: (a) resource and systemic

issues, (b) upholding ethical principles and values, (c) client safety, (d) working with vulnerable

clients, (e) interpersonal conflicts, (f) upholding professional standards, and (g) practice

management. Furthermore, several negative consequences resulting from the experience of

ethical tension were reviewed including practitioner burnout, decreased quality of care, and poor

client outcomes (Bushby et al., 2015). More recently, Durocher et al. (2016) explored ethical

tension among occupational therapists related to systemic constraints. Findings indicated that

occupational therapists were precluded from enacting ethical decision-making consistent with

professional values and goals due to systemic constraints on practice, thereby creating ethical

tension. Systemic constraints included (a) imposed practice, (b) ineffective processes, (c)

resource limitations, and (d) lack of services (Durocher et al., 2016, p. 219). Findings outlined by

both Bushby et al. (2015) and Durocher et al. (2016) focused on factors external to the

occupational therapist which precipitated the experience of ethical tension in practice, including

several characteristics of the complex practice environment.

   Research related to individual factors that may lead to or exacerbate the experience of ethical

tension is limited. However, three research studies suggested that gaps in ethics knowledge and

skill led to feelings of stress, frustration, and anger when addressing ethical issues in day-to-day

practice (Atwal & Caldwell, 2003; Barnitt & Partridge, 1997; Kalantari, Kamali, Joolaee,

Shafarodi, & Rassafiani, 2015). Barnitt and Partridge (1997) indicated that the experience of

these emotions further interfered with decision-making and practitioners' sense of competence. The need for research exploring the professional development needs of occupational therapist regarding continuing competency in ethical decision-making has been highlighted within the literature (Kanny & Slater, 2008).

Ethical Decision-Making in Occupational Therapy

Engaging in sound ethical decision-making is one component of the key competency of ethical practice in Canada (ACOTRO, 2012; CAOT, 2012). Ethical decision-making is conceptualized as one of several reasoning strategies within the broader process of clinical reasoning. Boyt-Schell and Schell (2008, p. 7) defined ethical decision-making as "reasoning directed to analyzing an ethical dilemma, generating alternative solutions, and determining actions to be taken" This definition is centred on ethical decision-making as a response to an ethical dilemma. Boyt-Schell (2014) later reinforced this idea, explaining that ethical decision-making is utilized to balance benefits and risks when faced with conflicting interests. Kanny and Slater (2008, p. 195) also described ethical decision-making as a response to being "confronted with an ethical dilemma or ethical stress". All these definitions emphasize some type of conflict or dilemma as a pre-condition for ethical decision-making. These current definitions of ethical decision-making depart significantly from the original conceptualization put forth by Rogers (1983) in her seminal Eleanor Clark Slagle Lecture titled *Clinical Reasoning: The Ethics, Science, and Art.* Rogers (1983) stated that the "…ethical nature of the goal of clinical reasoning projects itself over the entire sequence" (p. 428). She described the consideration of ethics as "inextricably intertwined" with all aspects of clinical reasoning (p. 438). In *Clinical Reasoning in Occupational Therapy*, Chapparo and Ranka (2008) also described ethical decision-making as influencing clinical reasoning throughout occupational therapy intervention. These authors

posited that ethical decision-making may "frame" the entire clinical reasoning process but acknowledge that current understanding is incomplete (Chapparo & Ranka, 2008, p. 274).

Little is known about how occupational therapists go about making ethical decisions in day-to-day practice. Only two published studies explicitly describe the process of ethical decision-making of occupational therapists (Delany & Galvin, 2014; Durocher & Gibson, 2010). However, both studies were based on single case examples and were specific to one practice area and one aspect of the rehabilitation process. As a result, findings are not necessarily reflective of ethical decision-making in all areas of occupational therapy. No published studies have been located which explore the process of ethical decision-making as an integral component of reasoning in occupational therapy. However, a small number of research studies in occupational therapy indicate that professional codes of ethics may be insufficient in guiding ethical decision-making (Barnitt & Partridge, 1997; Dieruf, 2004; Kinsella, 2006; Wright-St Clair & Newcombe, 2014). Codes may be too general or poorly understood, the principles outlined may be vague or conflicting, or codes may be perceived by practitioners as tools to promote professional autonomy (Barnitt, Warbey, & Rawlins, 1998; Dige, 2009; Kinsella, 2006). Furthermore, professional codes of ethics in occupational therapy often reflect a reductionist approach to ethical decision-making which may require detachment of the practitioner and decontextualization of clients (Barnitt et al., 1998). Brockett (1996, p. 199) stated that:

> When occupational therapists call their professional organizations looking for answers to their ethical problems, they are likely to be disappointed because ethical relationships are not built solely on rules and contracts or professional guidelines…occupational therapists need to be firmly committed to reasoning that reflects the professional's moral ideals or virtue as well as its professional theory.

Another gap in the literature relates to the professional development needs among occupational therapists regarding continuing competency in ethical decision-making. Research indicates that both education needs of individual occupational therapists as well as contextual and systemic constraints on ethical decision-making must be addressed in order to facilitate continuing competency (Barnitt, 1998; Durocher et al., 2016; Myers, Schaefer, & Coudron, 2017). Overall, a need for further research to understand ethical-decision making has been identified in the occupational therapy literature, including explicating its relationship to clinical reasoning, exploring how occupational therapists negotiate ethical decision-making in day-to-day practice, and exploring the professional development needs of occupational therapists regarding continuing competency in ethical decision-making (Bushby et al., 2015; Hudon et al., 2014; Kanny & Slater, 2008; Kinsella et al., 2015; Unsworth & Baker, 2016).

Ethics Education in Occupational Therapy

Ethics education is believed to be integral to ethical practice in occupational therapy including competent ethical decision-making (Hudon et al., 2014; Laliberté et al., 2015). Formal ethics education can facilitate the development of ethical reasoning, allow for an integrated understanding of ethical concepts and theories, and increase confidence to make and enact ethical decisions (Edwards, van Kessel, Jones, Beckstead, & Swisher, 2013; Grady et al., 2008; Stolt, Leino-Kilpi, Ruokonen, Repo, & Suhonen, 2017). Without this formal ethics education, there may be little improvement in ethical reasoning (Dieruf, 2004; Penny & You, 2011). Higher levels of ethical decision-making have been linked to better clinical performance among rehabilitation students and practitioners as measured by standardized and non-standardized assessment tools (Grady et al., 2008; Sisola, 2000). For example, Sisola (2000) found that physical therapy students who scored higher on a test of moral reasoning (Defining Issues Test)

(Rest, 1979) were also rated higher on clinical performance on their first clinical placement. Grady et al. (2008) noted that social workers who had received ethics education in pre-licensure programs or via professional development reported feeling more confident in ethical decision-making and were more likely to enact ethical decisions in practice. Participants were also more likely to utilize ethics resources (e.g. ethics committees) to support ethical practice.

In 2003, in the United States, three influential scholars in the field of ethics education in rehabilitation convened leaders in ethics education in physiotherapy and occupational therapy for a 3-day conference (Jensen et al., 2010). This "dreamcatchers" initiative was influential in promoting scholarship in ethics education in rehabilitation (Jensen et al., 2010; Purtilo, Jensen, & Royeen, 2005). However, debates persist regarding the ideal quantity, content, or pedagogical approach to ethics education in rehabilitation (Hudon et al., 2014; Hudon et al., 2016; Kinsella et al., 2015; Laliberté et al., 2015). As such, continued development of a body of literature and knowledge regarding ethics teaching has been called for within occupational therapy (Bushby et al., 2015; Laliberté et al., 2015).

Laliberté et al. (2015) and Hudon et al. (2014) reviewed ethics teaching across Canadian pre-licensure rehabilitation programs including occupational therapy programs. Results of these studies indicated that time devoted to teaching ethics varied widely across occupational therapy programs (from 5 to 65 hours), the format of ethics education varied widely but primarily involved use of traditional teaching methods including directed readings and lectures, and the content of ethics teaching was primarily narrowly focused on rules (deontology), regulations, and professional standards of practice. Several studies have called for an improved ethics curriculum which extends beyond ethics as standards of practice (Hudon et al., 2014; Hudon et al., 2016; Kinsella et al., 2015). In May 2014, ethics educators from 14 occupational therapy and

physiotherapy programs in Canada attended a workshop titled Canadian Rehabilitation Ethics

Teaching Workshop (CREW) Day (Hudon et al., 2016). The purpose of the CREW day was to

convene ethics educators to discuss and exchange knowledge and ideas regarding teaching

ethics. Two priority objectives for ethics education in Canada were identified: determining

content and developing teaching and evaluation methods (Hudon et al., 2016). Subsequently

published research studies have contributed to the literature in these areas (Kinsella & Bidinosti,

2016; Kinsella et al., 2015). In the first study, Kinsella et al. (2015) put forth seven conceptual

areas to be considered in ethics education: responsibility, ethical communication, integrity and

values, ethical relationship, ethical deliberation, ethical uncertainty, and reflecting on ethically

important moments. The authors recommended consideration of these seven areas as

supplemental to teaching codes of ethics and standards of practice. In a second study, Kinsella

and Bidinosti (2016) reported on an arts-informed approach to teaching and evaluation regarding

ethics in one occupational therapy program in Canada. Student occupational therapists were

charged with the task of using an artistic medium (e.g. painting/poetry/dance) and a reflective

paper to explore the construct of ethical practice. Study findings highlighted this potential

pedagogical approach to teaching ethics in occupational therapy. Taken together, these two

studies advance the literature regarding ethics education in occupational therapy in unique ways.

However, the authors indicated that ongoing pedagogical development is required as is further

research to evaluate ethics education in occupational therapy (Kinsella & Bidinosti, 2016;

Kinsella et al., 2015).

One major barrier to ethics education in rehabilitation is the lack of ethics training among

academic faculty as well as clinician-educators (Avci, 2017; Hudon et al., 2016; Laliberté et al.,

2015). Most faculty members and clinician-educators involved in teaching ethics in Canadian

physiotherapy and occupational therapy programs do not have any formal training in ethics (Hudon et al., 2016; Laliberté et al., 2015). As previously stated, research in occupational therapy also highlighted significant gaps in practitioner knowledge regarding ethics and indicated that many occupational therapists felt that they did not possess adequate knowledge to engage in sound ethical decision-making (Barnitt & Partridge, 1997; Brockett, 1996; Delany, Edwards, Jensen, & Skinner, 2010; Kinsella, Park, Appiagyei, Chang, & Chow, 2008; Kyler, 1998). A more recent study cited "educational insufficiency" regarding ethics as a factor influencing occupational therapists in pediatrics to engage in practice that was considered potentially unethical (Kalantari et al., 2015). Seedhouse (2009, p. 25) stated that "even now many [health care workers] receive very limited, or even no formal training in ethical reasoning, even though their daily work involves direct and often crucial intervention in other people's lives."

In summary, ethics is a broad philosophical discipline and consideration of ethics is relevant to informing thinking and decision-making in occupational therapy practice. Relevant literature in ethics and occupational therapy has been summarized to set the context for this PhD thesis including specific consideration of ethical tensions, ethical decision-making, and ethics education.

Locating the Researcher and the Research

As stated in the Declaration of Academic Achievement this PhD thesis is largely my own work and has been shaped by my knowledge, experiences, and thinking. Thoughtfully acknowledging my location within this research is important information for those engaging with this document and imperative to the integrity of the findings contained herein (Thorne, 2016). My PhD journey began as a registered occupational therapist. For 15 years I provided

occupational therapy services in both adult home care settings and in pediatric rehabilitation, including school health support services. I have always felt a strong affinity for and alignment with the profession of occupational therapy, its core values and beliefs, and its potential to support others in transforming their lives through engagement in occupation. All the occupational therapy services that I provided were publicly funded by provincial ministries within Ontario. At various points throughout my career, I became disenfranchised with the work of occupational therapy. I left my position in home care, for example, because I felt that I could no longer practice occupational therapy in people's homes in the three visits or less that was typically allowed. I also became increasingly uncomfortable with the clinical directives being mandated by case managers who often prioritized organizational policy over the clinical decision-making of practitioners who were interacting directly with clients. In pediatric rehabilitation, the children with disabilities and their families often required a level of care and concern that I feared might be outside of what was allowable according to professional regulations. I also feared that actions that were important to me, such as donating clothes, books, and therapy supplies to clients in need, might conflict with professional regulations. Now, it is clear to me that what I found disenfranchising was the experience of ethical tensions in practice including: (a) the tension of being an autonomous, evidence-based professional within a climate of managerialism and other systemic constraints, (b) the tension between enacting care and virtue within a context of professional regulations that limits and even prohibits these values, and (c) the tension of basing decisions on *something* that I felt was "right" but not having sufficient ethics knowledge to explicate or defend my decision-making. My experience resonates with reports in the literature related to ethical tensions in occupational therapy and the shortcomings of ethics education.

In addition to being an occupational therapist, I am also an emerging rehabilitation scientist. In this role I hope to advance knowledge regarding practice through research and knowledge translation. My PhD training has informed me that research methodology and methods are underpinned with unique ontological and epistemological assumptions. Ontology refers to the study of being and ontological assumptions concern the nature of reality and what constitutes reality (Crotty, 1989). Epistemology is concerned with the nature of knowledge and how it is constructed, known, and communicated (Scotland, 2012). Throughout my tenure as a PhD candidate I have been prompted to consider my own ontological and epistemological worldview and its implications for my program of research. I have considered these topics extensively and sought a wide variety of resources to inform my thinking and support my understanding of ontology and epistemology. I have come to acknowledge that stories largely inform my understanding of reality and my way of knowing. Stories are subjective and socially constructed and influenced by context. As such I acknowledge that I am situated within this PhD thesis as a researcher with a bias towards a relativist ontology and a subjectivist epistemology. I typically do not seek to discover one true reality but to explore multiple subjective realities and I do not purport to produce objective findings but instead acknowledge that any knowledge created has been influenced by my involvement. However, it is also important to acknowledge that my extensive engagement with the literature regarding ontology and epistemology has exposed ongoing gaps in knowledge and understanding that could not be fulfilled with this PhD alone. Albert Einstein is quoted as saying "the more I learn the more I realize how much I don't know" and I have absolutely experienced this phenomenon as it relates to seeking to understand the nature of reality and knowledge. For me to more comprehensively understand ontological and epistemological worldviews would require extensive additional knowledge of philosophy,

theology, physics, and other related disciplines beyond the scope of this PhD. However, my PhD training at McMaster University has taught me that there are many methodological approaches that are relevant and meaningful to addressing research questions in rehabilitation, each with varying ontological and epistemological assumptions. Most importantly, I understand that there is a continuum of a clinical problem, a research question to appropriately address the clinical problem, a methodology to appropriately address the research question, methods that are consistent with the methodology, and a research product which answers to each of these. I understand the benefit of ontological and epistemological congruency across this continuum. At the end of this PhD journey I am satisfied knowing that as a rehabilitation scientist I understand the need to engage research methodologies and methods to best answer the research questions that matter in the lives of the people that we serve.

Finally, I have outlined that I am an occupational therapist and a rehabilitation scientist, but it is also imperative to highlight that I am not an ethicist, nor do I possess formal training in ethics. Benatar (2006, p. 17) stated that "a problem arises when scientists…slip from doing what they are trained to do into doing moral philosophy. Although some do a reasonable job with the latter, very many do not." I have, however, engaged in an intense and ongoing process of self-directed learning to improve ethical competence. This self-directed learning has been motivated by my own practice experience and a desire to contribute epistemologically to ethics in occupational therapy. Lack of formal training in ethics did not preclude "working independently to answer questions that are crucial to ethical decision-making" (Benatar, 2006, p. 20). However, my level of knowledge and understanding of ethics most certainly shaped the work put forth in this PhD thesis.

Objectives of Thesis

The overall aim of this thesis is to study ethical decision-making in occupational therapy practice in Canada in order to contribute to epistemological development regarding ethics and occupational therapy and to support occupational therapy practice. The specific objectives are:

1. To advance a theoretical understanding of the process by which occupational therapists make ethical decisions in day-to-day practice.

2. To explore potential gaps related to competency in ethical decision-making in occupational therapy and to generate recommendations for competency development.

3. To develop and evaluate a theoretically and empirically based on-line ethics education module to build competency among clinician-educators in the Master of Science Occupational Therapy (MSc OT) program at McMaster University.

Composition of Thesis

This thesis is comprised of five chapters. Chapter 1, the *Introduction*, has set the overall context for the research by providing an overview of the literature, explicating my position within the PhD research, and outlining the overall aim and objectives of the research. Given that this introductory chapter is intended as a broad overview, the literature cited within the introduction is addressed and applied in more detail in subsequent chapters. Chapter 2 presents a constructivist grounded theory study titled *Doing What's Right: A Grounded Theory of Ethical Decision-Making in Occupational Therapy* that was conducted to develop a descriptive theoretical model of ethical decision-making in occupational therapy. Ethical decision-making is represented as a prism, whereby participants engage in an inductive and dialectical process of considering a checklist of various personal, client, family, regulatory, and organizational factors and potentially consulting with others in order to do what they feel is right. Chapter 3 is titled

Continuing Competency in Ethical Decision-Making: Current Gaps and Future Directions and it

presents a secondary analysis of data gathered via the constructivist grounded theory study,

viewed through the lens of interpretive description. More specifically, interpretive description

was employed to explore potential gaps related to continuing competency development in ethical

decision-making and to generate recommendations for future directions to support continuing

competency. Chapter 4 is titled *On-Line Ethics Education for Occupational Therapy Clinician-*

Educators: A Single-Group Pre- Post Test Study. This chapter presents the final study for this

thesis which employs a non-randomized, single-group, pre- and post-test to evaluate the utility of

an on-line ethics education module. The module was aimed at improving ethics competency

among occupational therapy clinician-educators (problem-based learning tutors/clinical

placement preceptors/evidence-based practice facilitators) in the MSc OT program at McMaster

University. The *Knowledge-to-Action Process* informed development and evaluation of the

module (Graham et al., 2006). Finally, Chapter 5, *Conclusion and Implications,* summarizes

findings of the PhD thesis and discusses two main themes drawn together from across this body

of work. Implications of the research are also highlighted using the S*cholarship of Practice*

Model which was developed within occupational therapy to couple knowledge generation and

practice enhancement (Hammel, Finlayson, Kielhofner, Helfrich, & Peterson, 2002).

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Chapter 2: Doing What's Right: A Grounded Theory of Ethical Decision-Making in Occupational Therapy

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Abstract

Background: Ethical decision-making is an important aspect of reasoning in occupational therapy practice. However, the process of ethical decision-making within the broader context of reasoning is yet to be clearly explicated. **Objective:** The purpose of this study was to advance a theoretical understanding of the process by which occupational therapists make ethical decisions in day-to-day practice. **Method:** A constructivist grounded theory approach was adopted, incorporating in-depth semi-structured interviews with 18 occupational therapists from a range of practice settings and years of experience. Initially, participants nominated as key informants who were able to reflect on their decision-making processes were recruited. Theoretical sampling informed subsequent stages of data collection. Participants were asked to describe their process of ethical decision-making using scenarios from clinical practice. Interview transcripts were analyzed using a systematic process of initial then focused coding, and theoretical categorization to construct a theory regarding the process of ethical decision-making. **Findings:** An ethical decision-making prism was developed to capture three main processes: *Considering the Fundamental Checklist*, *Consulting Others*, and *Doing What's Right*. Ethical decision-making appeared to be an inductive and dialectical process with the occupational therapist at its core. **Conclusion:** Study findings advance our understanding of ethical decision-making in day-to-day clinical practice.

Keywords: clinical decision-making, ethics, professional practice, qualitative research, rehabilitation research

Introduction

"The time is always right to do right."
~Martin Luther King Jr.

In her 1983 Eleanor Clark Slagle Lecture, Joan Rogers [1] proposed a process of clinical reasoning whereby occupational therapists could determine "right" action in a clinical setting, acknowledging "what is right for one patient is not necessarily right for another" [1,p.602]. In this seminal lecture, she highlighted the need for occupational therapists to be able to elucidate their reasoning. In doing so, Rogers [1] situated the topic of ethical decision-making within the broader context of reasoning noting that "the clinical reasoning process terminates in an ethical decision…and the ethical nature of the goal of clinical reasoning projects itself over the entire sequence" [1,p.602]. Building on Rogers' important work, Fleming [2] conducted a clinical reasoning study of 14 occupational therapists working in a large acute-care teaching hospital. Study findings suggested that occupational therapists have a "three-track mind" and subtly utilize three reasoning strategies (procedural, interactive, and conditional) to address distinct facets of a clinical problem [2,p.1007].

Since these seminal works were published, the construct of clinical reasoning in occupational therapy has been the focus of much research and discussion [3]. Clinical reasoning is defined as the sum of the thinking and decision-making processes that are required to guide practice [4]. Alternate terms such as *professional* or *therapeutic* reasoning have been proposed in favour of clinical reasoning to broaden its scope [5]. For clarity, the term *reasoning* will be used in this manuscript to refer to the broad concept of clinical reasoning and *ethical decision-making* will be used to refer to the specific process of ethical reasoning. Reasoning involves the use of several strategies or foci of thinking that can be employed simultaneously or separately to address various facets of the reasoning process (e.g. scientific, collaborative, pragmatic, enablement) [5].

Ethical decision-making is currently conceptualized as one of these many reasoning strategies: defined as "reasoning directed to analyzing an ethical dilemma, generating alternative solutions, and determining actions to be taken" [6,p.7]. This definition is centred on ethical decision-making as a response to an ethical dilemma. Kanny and Slater [7,p.195] later reinforced this idea, explaining ethical decision-making as a response to being "confronted with an ethical dilemma or ethical stress". These descriptions emphasize some type of conflict or dilemma as a pre-condition for ethical decision-making, rather than the original emphasis by Rogers [1,p.438] who understood ethical decision-making as "inextricably intertwined" with all aspects of reasoning.

In the seminal text titled *Ethics: The Heart of Health Care*, Seedhouse described ethics in the health care context as consideration of "how best to conduct one's life in the presence of other lives" [8,p.281]. Ethics in occupational therapy has been defined as "a systematic view of rules of conduct that is grounded in philosophical principles and theory" [9,p.469]. Ethics is a broad philosophical discipline and consideration of ethics is relevant to all aspects of health care including informing the thinking and decision-making of individual practitioners [10]. Some prominent ethical theories that are commonly applied to decision-making in health care include virtue ethics, deontology, consequentialism (including utilitarianism), ethics of care, the four-component model of moral behavior, and the principles approach (autonomy/beneficence/non-maleficence/justice) [7,9-12]. In 2003, 25 influential scholars in the field of ethics in physiotherapy and occupational therapy convened for a 3-day conference regarding ethics in rehabilitation [13]. This "dreamcatchers" initiative was instrumental in promoting scholarship in ethics in rehabilitation which has continued to evolve in occupational therapy since that time [14-20]. Despite this burgeoning body of knowledge related to ethics in occupational therapy, only

two published studies explicitly described the process of ethical decision-making for occupational therapists. In one study, Durocher and Gibson [21] conducted an ethical analysis of an 87-year-old client with various occupational performance issues and outlined the decision-making process which led to the ethical decision (discharge home). In a similar study, Delany and Galvin [22] interviewed parents of a five-year-old girl with upper extremity motor impairment to explore the ethical challenges of information-sharing and decision-making in a pediatric context. Their analysis summarized the process and outcomes of engaging clients in decision-making using ethics-based questions [22]. Both studies outlined the processes related to ethical decision-making in occupational therapy. However, it should be noted that they were both based on single case examples and were specific to one practice area and one aspect of the rehabilitation process. As a result, findings are not necessarily reflective of ethical decision-making in all areas of occupational therapy. No published studies were located which address or explore the process of ethical decision-making as an integral component of reasoning in occupational therapy. In a systematic review of the reasoning literature in occupational therapy, Unsworth and Baker [3] foregrounded the need for further research to address current gaps including research that describes or models reasoning processes. The call for further research in reasoning has been explicitly extended to understanding ethical decision-making in occupational therapy practice [16,23,24]. In their scoping review of ethical tensions in practice, Bushby et al. [16,p.219] stated that understanding how occupational therapists negotiate ethical decision-making is "of pressing concern" since no research on this topic was found. The purpose of this study was to advance a theoretical understanding of the process by which occupational therapists make ethical decisions in day-to-day practice. The overarching research question that was used

to guide this study was "When faced with an ethical issue in practice how do occupational therapists come to an ethical decision that can be enacted within their practice context?"

Method

Constructivist grounded theory was used to guide this research since it is well-suited to developing explanatory theories about processes which unfold within particular contexts, such as clinical settings [25,26]. In constructivist grounded theory, reality is believed to be socially negotiated (ontology) and knowledge is socially constructed (epistemology). Knowledge construction incorporates the researcher's perspective yet keeps participants' accounts central to theory development [25,26]. Grounded theories emerge inductively through stories told by study participants [25]. As such, existing literature was reviewed to inform development of the research question but not to guide theory development [25]. Ethics approval was granted by the institutional Research Ethics Board (REB Project #0670- see Appendix A).

Recruitment and sampling

Participants had to be (a) practicing occupational therapists registered in their province/territory of practice, (b) willing to participate as per signed consent, and (c) fluent in English. Recruitment began in March 2016. Initially, participants were recruited through members of the research team who nominated "key informants" [27,28]. The research team was comprised of the principal investigator (a doctoral candidate) and members of the supervisory committee (faculty members at the study institution). Characteristics of key informants, determined a priori, included practicing occupational therapists that (a) possessed advanced reasoning skills, (b) possessed the ability to reflect on and explain their reasoning, and (c) were comfortable answering potentially sensitive questions about decision-making. Following analysis of initial interviews with key informants, theoretical sampling informed subsequent stages of

data collection (further described in ***Data Analysis***) [25]. Eighteen people (n=18) participated in the study.

Data Collection

Potential participants were contacted by the principal investigator by e-mail to arrange individual in-depth interviews (see Appendices B and C for e-mail script and consent document). Interviews involved open-ended yet directed questions to explore participants' experiences and insights on ethical decision-making (see Appendix D for interview guide) [25]. Table 1 provides examples of open-ended interview questions. Face-to-face interviews were conducted when possible (7 out of 18 participant interviews). All face-to-face interviews were held at the location of participant choice to increase participant convenience and to minimize potential power differential between participant and researcher [29]. Other means of conducting interviews were telephone (n=9) and Skype (n=2) which allowed engagement of geographically dispersed participants. Interviews were audio recorded and transcribed. A decision was made to discontinue data collection following 18 participant interviews since the principal investigator determined that theoretical sufficiency had been reached [25,30].

Table 1

Examples of Open-Ended Interview Questions

Question	Specific Probes
When I say the words "ethical decision-making in occupational therapy practice" what does that mean to you?	
Tell me about your current practice environment.	a) What is your current role? b) How much interaction do you have with other professionals? c) What is your caseload type/size? d) Who funds your current position/
Keeping your definition of ethical decision-making in mind, tell me about a time in your current practice environment where you made what you would define as an ethical decision. .	a) Any background information? b) Describe the clinical scenario? c) Who were the people involved? d) What potential decisions were considered? e) Ultimately what decision that was made?
Please describe how you ultimately came to the decision you made.	a) Were there any tools used (e.g. ethical frameworks) and how were they employed? b) Which factors/components of the clinical case were most prominent in informing your decision-making? c) What might have helped you in coming to the decision?

Data Analysis

In grounded theory, data analysis occurs throughout the data collection phase using a process of constant comparative analysis [25,26]. Data analysis consisted of four major stages: initial coding, focused coding; theoretical categorization/sorting; and theory construction [25]. Dedoose software was used to facilitate data analysis [31]. Initially, line-by-line coding was utilized to deconstruct interview data and to expose patterns and/or gaps. The second phase, focused coding, allowed for review and reorganization of initial coding to condense and sharpen codes and to begin creating theoretical categories. Theoretical sampling was integral to the development of categories by allowing for exploration of variations in participant characteristics (including gender, geographical location, practice area, and practice context) [25,32]. Theoretical sampling allowed for the development of robust theoretical categories which were "saturated with data" [25,p.213]. Data analysis proceeded from theoretical categorization to a process of theoretical sorting which served to refine and integrate theoretical categories and subsume categories into broader themes. The process of theoretical sorting which led to theory development involved deep and constant consideration of the extent to which the emergent theory and its processes reflected the data, was cohesive and coherent, and held explanatory value. Memo-writing supplemented each stage of data analysis and supported theme development. Analytic memos were written about various topics including thoughts about interviews, noted similarities and differences in data, emerging categories and themes, and relationships between categories. Extensive diagramming and visual mapping also supported data analysis.

Quality

Several strategies for ensuring quality were employed throughout the research process [33]. Ongoing researcher reflexivity and analytical debriefing with peers and study co-investigators supported confirmability of findings and promoted triangulation of research perspectives [25,34]. Through a process of reflexive memoing the principal investigator examined personal assumptions and beliefs that may have influenced the research. The principal investigator is an occupational therapist with 15 years of clinical experience (home care/school health support/pediatric rehabilitation) and advanced knowledge regarding ethics. To ensure dependability, all analytical decisions were detailed and justified in a research journal [35]. To improve credibility, two member-checking focus group sessions were held (one face-to-face and one via web conferencing). Three participants attended each focus group where the emergent theory was discussed, and input provided. Input led to further refinement of the theory. Member-checking focus groups were integral to ensuring that theoretical interpretations adequately captured participant experience [36].

Findings

All 18 participants (15 female/3 male) were occupational therapists registered in their respective provinces of practice including British Columbia (2), Alberta (1), Ontario (11), Quebec (2), and Nova Scotia (2). All participants described their role as primarily clinical except one (primarily administrative). Years of practice experience ranged from approximately two years to 37 years. Practice area also ranged significantly and included paediatric rehabilitation, private practice, acute care, in-patient/out-patient rehabilitation, home care, primary care, community mental health, and out-patient mental health. Two participants had a diploma in

occupational therapy and all other participants possessed either a bachelor (n=7) or masters

degree (n=9) in occupational therapy.

   Ethical decision-making in occupational therapy practice is represented in this study as a

prism with the occupational therapist at its core and several points surrounding the occupational

therapist (see Figure 1 and Appendix E). Three main processes comprise ethical decision-

making. The first process, *Considering the Fundamental Checklist*, relates to a fundamental

checklist of up to 6 intersecting and sometimes competing contributing factors that may

influence decision-making. The next process, *Consulting Others*, may or may not be utilized but

is often initiated when *Considering the Fundamental Checklist* is inadequate in leading to an

ethical decision. The final process, *Doing What's Right*, involves making and enacting ethical

decisions.

Figure 1   The Prism Model of Ethical Decision-Making
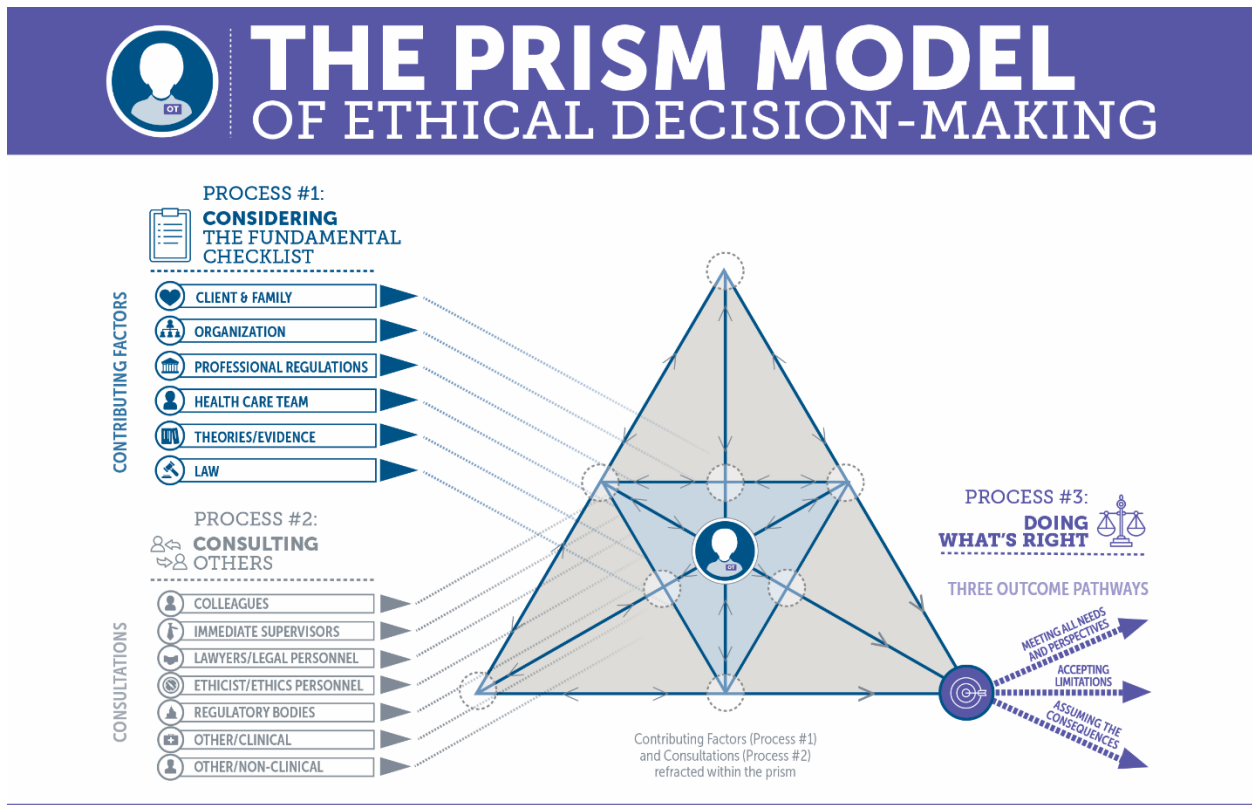
The Occupational Therapist

   Participants were at the core of ethical decision-making and the decision-making process proceeded inductively from this individual level. Two main participant characteristics influenced this core dimension of the ethical decision-making process: a dominant personal ethical foundation and personal values. The dominant personal ethical foundation was not something that participants were necessarily aware of or able to explicitly name. Instead it appeared to be an implicit and underlying ethical lens which influenced how participants approached ethic decision-making in practice. The dominant personal ethical foundation seemed to provide an ethical "home base" that participants could *"always go back to"* (P #17). For example, Participant #3 explained:

> I try to live by "doing unto others what you would have done unto you"…quite often put myself in the position of the client to say, "if that was me, how would I want this therapist to deal with me, or what decisions or what priorities or what approach would I like to see if that was me?"

Other participant quotes reflecting a dominant personal ethical foundation include "I always go back to autonomy" (P #17), "my lens is anti-oppression" (P #6), "I think I'm probably one of the 'greatest good for the greatest number of people' kind of gals when it comes down to it" (P #18) The dominant personal ethical foundation was not the only perspective considered, but it was a way of approaching ethical decision-making that participants could consistently rely upon. Participants also reported that they drew on personal values in ethical decision-making. Several participants stated that their personal values were generally consistent with professional and regulatory body values. One participant stated, "I was probably a person with a lot of the same values as OT….and that's why I went into OT because it was in line with what I believed and my

strengths and my values." (P #3). When personal values were compatible with professional values, ethical decision-making was not impeded. However, when personal and professional values were not compatible, ethical decision-making was more challenging. Participant #1, for example, described a conflict between her personal values about being thrifty with money and the significant financial resources available in private practice:

> There's a money aspect tied to it and I know for me that is a personal value because I'm a single mom of three kids…So, from a personal perspective, money means a lot to me and, so I feel bad about-if there's wasting money. And that idea for me personally leads to a lot of ethical dilemmas…this idea of money and being accountable.

Most participants explicitly acknowledged that they do consider personal values in ethical decision-making. Participant # 9 expressed uncertainty in how to engage "objectively" in ethical decision-making particularly when there is a desire to remain true to personal values:

> It would be a lie to assume that people simply practice by being very objectively OTs only and not their own self. I don't think you come in in the morning and put your identity aside and just be that person at work…I think an example I have about that is the whole debate on assisted dying…. it's personal, religious…values that have nothing to do with what a professional would do in that context.

Considering the Fundamental Checklist

When faced with an ethical decision, participants (armed with their dominant personal ethical foundation and personal values) began the inductive process of decision-making by considering a contributing factor from the "fundamental checklist" (P #1), metaphorically represented as an icon being placed at one of the points within the prism. Participants typically indicated that clients were considered first. Participant #8 emphasized that "client-centeredness is huge".

Another contributing factor was then considered in light of participants' thinking about the first in a "push and pull" process (P #8). Additional contributing factors were considered in light of the previous two and so on. Contributing factors were considered in the sequence that individual participants interpreted as most relevant to the clinical situation. Contributing factors that were more relevant were considered earlier in the process (corresponding icon placed more proximally to the occupational therapist at the centre of the prism) while others were considered later (corresponding icon placed more distally). Some contributing factors were not considered at all. Participant #7 described *Considering the Fundamental Checklist* as "thinking of…the different levels of things that influence me as an OT…So, listening to, paying attention to, understanding what's important at all those different levels." One participant stated that "there's not always kind of a prescriptive approach…you can do this, you can do this…because there's so many dynamic factors in place" (P #4).

Six main contributing factors were identified as key elements of the fundamental checklist: client and family considerations, organizational-level forces, theories and evidence, professional regulations, the healthcare team, and the law. A brief overview of each factor is now provided, highlighting the push and pull process of *Considering the Fundamental Checklist.*

Client and family considerations in ethical decision-making focused on ensuring autonomy and safety. Participants explained that respecting client autonomy meant seeking to understand client goals, perspectives, lived experiences, beliefs, and values. Ensuring autonomy reportedly involved engaging clients and their families in open and transparent dialogue and clearly providing all necessary information in an understandable way. If safety risks to clients were perceived as high (physical/emotional/financial), then decision-making to mitigate risks was

imperative. Participant #6, for example, described a process of balancing client autonomy with concern for client safety:

> I tried upside down and backwards to talk about the benefits of it, why it [hospital bed] would be a great option and she still didn't want it. So anyway, after all of that I had to honor her decision because she was capable of making that decision in spite of my recommendations and just support her with that.

Organizational considerations included policies, resources, implicit expectations, cultural context/values, and the needs of other clients within organizations. These organizational considerations involved the macro level context such as "the healthcare system" broadly (P #5) and the micro level context related to "my place of work" (P #17). Participant #13 explained a process of considering organizational polices and minimizing risk to the client:

> …from a health authority's perspective, they're looking at statistics, length of stay, the cost of having the patient and [I'm] sort of weighing that with the time that a patient needs to stay in hospital to get stronger or for the healthcare team to be able to you know, make plans so that we can facilitate a safe discharge.

Theories and evidence were another important contributing factor influencing the ethical decision-making process. Participants considered (a) theories and evidence from occupational therapy, (b) theories and evidence from related disciplines including ethics, (c) clinical/medical information gathered through assessment and treatment, referral information, and (e) past clinical experience. Participant #9 spoke about weighing organizational demands with professional values reflected in theories and evidence:

> Are we choosing to run superficial examinations and evaluations for the sake of seeing 15 patients and running the risk of giving a very shallow and incomplete analysis or do we

want to remain unique in the sense of being the professionals that really value the details

that make the difference?

Considering *professional regulations* included codes of ethics, standards of practice, and

practice guidelines. For example, Participant #8 described considering regulatory body policies

regarding transparency stating "I have the College that helps inform me. Like saying I have to be

transparent to the client about who I am, why I'm there…what I'm doing and each section that I

assess."

Health care teams were another important contributing factor for some participants. For those

who worked on large in-patient teams input was integral to decision-making. Participant #17

stated that "we're a multi-disciplinary team…and we talk about these cases to process this all out

loud". In contrast, other participants worked in private practice where decision-making was more

independent. Participant #1 stated "We're in a private practice situation. Like there's me and I'm

an OT then there's my boss and that's it".

A final consideration reported by some participants was explicit consideration of federal

and/or provincial *law*. Examples of laws reported by participants that were considered include

Child and Family Services Act (P #4), Highway Traffic Act (driving safety) (P #8), Ontario

Mental Health Act (Form 1) (P #8), Criminal Code of Canada (P #3). Participant #1 described

the push and pull process of considering client factors (autonomy) versus the law:

> He basically admitted to me that he was dealing drugs….you know he's selling drugs for
>
> money…so I didn't report him to the police but then I feel like "…am I an accomplice to a
>
> drug dealer"?...What do I do?

Considering the Fundamental Checklist continued iteratively until, as described by Participant

#13, "all parties involved and the impacts…the decisions would have on everybody" had been

considered. In some cases, participants then made an ethical decision to enact in practice (*Doing What's Right*)*.* In other cases, however, the process of *Considering the Fundamental Checklist* was inadequate in leading to *Doing What's Right*, prompting participants to engage in the process of *Consulting Others.*

Consulting Others

The trigger for *Consulting Others* was described in several ways. At times, the trigger appeared to be intellectual such as "that little red flag in your head" (P #1). However, most often the trigger appeared to be a visceral or emotional response. Participant #4 referred to this emotional response as "that kind of gut feeling" and Participant #6 described the emotional response as "Spidey senses are going off". *Consulting Others* involved considering contributing factors on the fundamental checklist together with the other people with whom participants were consulting. Participants engaged in consultations for several reasons including broadening their clinical perspective, brainstorming, accessing support (venting/frustration), protecting self, and accessing expertise (clinical and/or ethical). Participant #13 explained that consulting provided an opportunity to "bounce ideas and get sort of different perspectives as well." No defined order to consulting was identified. However, several participants stated that colleagues (other occupational therapists and/or other team members) were the first consultation and that this typically involved informal discussions. Participant #4 stated "If I can't get a resolution on my own then I will kind of go to…a colleague". Immediate supervisors were consulted both from a managerial perspective (bosses/managers) and clinical perspective (practice leaders). Participant #7 described "if you can't figure it out yourself, you go to your peers and if you're still not sure amongst your peers, then you can go to manager." Legal resources were consulted from both within and outside of the organization as were ethicists/ethics personnel. Several participants

reported that provincial regulatory bodies were explicitly consulted. This was often done to double check and affirm course of action vis-à-vis regulatory standards. Participant #8 stated "I have called the [regulatory body] on several occasions and…they're good at asking more questions or saying you think about this, weigh this or weigh that…they've been very helpful." Finally, consultation sometimes included other clinical personnel outside of the healthcare team (e.g. expert physicians), and/or consultation with others that might have insight/influence (e.g. university professors). Participant #11 described how consultation with the Rabbi assisted in ethical decision-making:

> There was this Rabbi that had great influence on these families because it was a very small community with a Rabbi that was known by our organization. And that was our solution finally. So, when the Rabbi came, and we had this case discussion with the Rabbi and then the Rabbi went to the family and we had the discussion of what would give the solution…

A small number of participants reported that the process of *Consulting Others* led to a transfer of the case to those who were being consulted with. However, most often *Consulting Others* led participants to the process of *Doing What's Right*.

Doing What's Right

The final step in the process of ethical decision-making was *Doing What's Right*. This idea was reported by several participants. For example, Participant #1 stated that "ethical decision-making conjures up the feeling of doing what's right, doing the right thing". Participant #9 described ethical decision-making as making "the right decision for and with the patient". *Doing What's Right* involved identifying all contributing factors related to the decision and thoroughly considering them. Participant #4 described this process as "making a well-rounded well-informed decision….to kind of weigh all the factors…" Participants expressed a concern for

doing what's right in all clinical decisions. Participant #1 described ethical decision-making "like an umbrella that's like overarching our practice". *Doing What's Right* occurred on a continuum from "small decisions" to "really big dilemmas" (P #16). Participant #16 stated "We make ethical decisions every day, I think it only becomes part of our awareness that we're actually making those decisions when you get to a situation where it is very challenging."

Once all needs and perspectives have been considered, participants sought to enact an ethical decision with which they were comfortable. Participant #3 stated "At the end of the day…what can I live with" (P #3). Participant #16 eloquently summarized "Can I say I did the best I could in that situation?" The process of *Doing What's Right* is represented by three possible outcome pathways: *meeting all needs and perspectives*, *accepting limitations*, and *assuming the consequences*.

Meeting all needs and perspectives.

A straightforward outcome pathway to ethical decision-making occurred when congruency existed among all contributing factors considered. Participant #2 stated "there are just some things that you know it's just sort of straightforward and you're guided by your essential competencies and you just do your thing."

Accepting limitations.

Not all decisions were straightforward. Participants often spoke about accepting limitations in order to make and enact ethical decisions. Limitations could stem from any contributing factor considered in the fundamental checklist and could persist following consultation. On this outcome pathway participants emphasised the need for documentation of their decision and how the process of engaging in documentation facilitated acceptance of limitations. Participant #18,

for example, described the process of accepting limitations in a situation where client safety with feeding and swallowing were compromised because resources were not available:

> You kind of do have to get to a place where you need to accept what is or you'll drive yourself crazy. I think when you're fresh out of grad school, you're still kind of wet behind the ears and the sky is the limit….And then the cold slap of reality comes. When you realize that the real world is so different…So I think, over time, it becomes a little easier to accept that…there are only certain things that you can do, and you can only do your very best and there are things that are chronically going to be problems and there's not a lot we can do about [it]….

Engaging in advocacy activities, regardless of the outcome, also facilitated acceptance even when advocacy represented a "false sense" of accomplishment (P #18). Participant #9 described advocating in a situation where an organizational policy regarding number of visits was perceived to limit decision-making regarding client care:

> On a day-to-day basis you have to make choices and decide how you're going to work and how you're going to…combine those expectations with what you think is the right thing to do for that particular patient at that particular time at that particular clinic…So, it's been tough because there's always…information that is generated through our statistics that kind of shows how many patients you saw and how many you know, what did you do, and you know, how come you only saw 3 patients…And you are trying to kind of advocate because what makes this clinic great is because we do take time to do this, this, this and that…So, this constant battle between what you think is right to do at that particular moment because you have a person in front of you, because you have family and you have, just the whole

reality of the clinical setting that sometimes is ignored or underestimated or forgotten by

the managers.

Assuming the consequences.

This third outcome pathway to *Doing What's Right* involved choosing to knowingly disregard

one or more contributing factors in order to make and enact a decision that participants felt was

right and was something that they could live with. In doing so, participants acknowledged a

willingness to accept risks and assume potential consequences. Participants were careful to state

that the potential risks and consequences affected only them and never compromised the safety

of others. Potential consequences included warnings, employment termination, or being reported

to provincial regulatory bodies. Participant # 9, for example, described a decision to ignore

organizational policy:

> Just because you're going against what somebody is telling you [you're] not necessarily
>
> doing the wrong thing. You might have to…assume the consequences. Maybe your
>
> position is going to be threatened, maybe you're going to be given a warning or something
>
> like that, but it's just wrong from their perspective: it doesn't mean that's its wrong from
>
> an ethical perspective. And that gives me the confidence to keep doing what I'm doing.

On this pathway, client factors are prioritized. Participant #9 described this trajectory as

"respecting the moral contract you have with patients". Participants emphasized the need to (a)

build and maintain trust and therapeutic rapport, (b) consider the best interest of the client, (c)

acknowledge equality with clients (reducing power differential), and (d) conduct oneself

humanely. Some circumstances which prompted engagement in this pathway included receiving

gifts, engaging in self-disclosure, disregarding organizational and/or regulatory body policies and

procedures, hugging or showing affection, and sharing confidential information about clients.

Participant #4 described a decision to disregard employer and regulatory body polices (regarding recommending and accessing equipment for a client) stating:

> I'm going to get in trouble for this from either [employer] or [regulatory body]. Someone is going to have an issue with this because it's not actually legally okay anymore because…[they] don't want someone to get hurt or sued because a piece of equipment or whatever…knowing that with a client having zero equipment in place they're going to have this risk of safety and if they have this equipment in place, their risk of harm is less. Like, I think it's just trying to protect and make them safe and easier to manage. I think these [clients] just go through so much. I'm like "how can I help them?" Which is why we go into therapy-we want to help people. So, how can I help? How can I make the situation better? I might not be able to fix it, but I'm going to lessen their risk, or I'm going to help them with the situation to be better…

Discussion

The purpose of this article was to address the following research question: When faced with an ethical issue in practice how do occupational therapists come to an ethical decision that can be enacted within their practice context? The resulting theory of ethical decision-making in occupational therapy practice put forth in this paper is represented as an ethical decision-making prism with the occupational therapist at the core. Occupational therapists, who were central to ethical decision-making, actively engaged in considering various elements of the ethical decision-making prism in their day-to-day work with clients. Contributing factors associated with *Considering the Fundamental Checklist* and *Consulting Others* are metaphorically represented as icons which can be placed into the prism at points surrounding the occupational therapist. Icons that represent more relevant contributing factors may be situated proximally to

the occupational therapist. Less relevant contributing factors may be situated more distally in the ethical decision-making prism. Participants considered information about the clinical scenario from various angles, like light being refracted within a prism, thereby altering interpretations of information associated with the factors and the decision to be made. Depending upon how the factors are arranged within the decision-making prism, the participants' perspective may be different. Just as light is dispersed from a prism into its constituent parts, so are the three possible outcome pathways of *Doing What's Right*.

The prism metaphor allowed for representation of the rich and complex characteristics of ethical decision-making identified in this study. The first characteristic is that ethical decision-making is primarily inductive and responsive. The occupational therapist is at the core of decision-making and builds a decision-making model based on the unique characteristics of the ethical decision to be made in response to their understanding and interpretation of the clinical scenario. Second, participants in this study described their thinking as going back and forth between all contributing factors within the prism in a process of 'checks and balances' or 'pushing and pulling'. Participants described a process of considering their own ideas as well as the perspectives of others (e.g. clients) when *Considering the Fundamental Checklist*, and at times they actively sought input into the ethical decision-making process via *Consulting Others*. The various thoughts and ideas can be conceptualized as refracting light within a prism. Participants' descriptions of their process of ethical decision-making in occupational therapy practice are consistent with a dialectical process for ethical thinking, in the Aristotelian sense, where the thinker considers "the same, the different, the like, the unlike, contrariety, and prior and posterior" among known factors, beliefs, and opinions [Aristotle as cited in 37]. Furthermore, in an Aristotelean dialectic, factors can be considered as equal without one factor

necessarily holding more truth than another and the thinker can examine both a thought and its negation [38]. In the physiotherapy literature, Edwards, Delany, Townsend, and Swisher [39] put forth a theoretical framework for ethical decision-making referred to as "The Ethical Reasoning Bridge". These authors also described the ethical decision-making process (guided by the reasoning bridge) as dialectical in nature. More specifically, they asserted that practitioners are meant to amass both inductive knowledge (e.g. patient values) and deductive knowledge (e.g. regulatory codes of conduct) related to the ethical decision with neither "regarded as intrinsically truer than the other and where each contributes to an understanding of the other" [39,p.1658]. Although physiotherapy is distinct from occupational therapy, findings of this study support the theoretical claim [39] that the process of ethical decision-making is dialectical in nature.

Findings of this study inform the long-identified need for better understanding of the relationship between ethical decision-making and reasoning [40-42]. Findings indicate that contributing factors considered in ethical decision-making parallel those considered in clinical reasoning broadly and that all clinical decisions involve consideration of what is right [5,43]. Clinical reasoning is an ongoing and constructivist process [4] and study findings suggest that ethical decision-making parallels reasoning throughout this process from decisions that are largely tacit and routine to those that are complex and explicit. Ethical decision-making is also employed to address discreet ethical dilemmas. Boyt-Schell [5,p.391] describes ethical decision-making as "yet another component of reasoning" to address explicit ethical dilemmas. However, these study findings support Rogers' [1,p.616] original conceptualization that ethical decision-making is "inextricably intertwined" with all aspects of reasoning. In their discussion of reasoning in occupational therapy, Chapparo and Ranka [44] suggested that ethical decision-making may frame the broader process of reasoning but acknowledge that this explanation may

be incomplete. Edwards and Delany [40] provided two compelling reasons to better understand ethical decision-making within the broader context of reasoning: to improve the rigour of ethical decision-making by aligning it with the broader process of reasoning and better elucidate the rationale behind ethical decision-making. This study advances current literature by elucidating the processes involved in ethical decision-making and thereby explicating the relationship of ethical decision-making and reasoning. However, given that this study is the first known to explore the process of ethical decision-making in occupational therapy practice, additional studies are required to further define the construct of ethical decision-making and further interrogate and clarify the relationship of ethical decision-making within the reasoning process broadly.

Another key finding was the presence of a dominant personal ethical foundation. The dominant personal ethical foundation appears to be a personal prioritization of one approach to ethics over others that served as a "home base" or "primary lens" informing ethical decision-making but that remained largely tacit. Although the exact influence of the dominant personal ethical foundation was not elucidated, it was clear that this taken-for-granted ethical foundation did influence participants' consideration of contributing factors within the fundamental checklist. This finding is consistent with Edwards and Delany [40] who stated that physiotherapists may have an intrinsically-motivated and personally-derived orientation towards one approach to ethics without having critical awareness or understanding of its influence on decision-making. The influence of tacit assumptions about ethics on ethical decision-making has not been explicitly discussed within the occupational therapy literature. However, the reasoning process is believed to be influenced by personal assumptions [3,45-47]. Mattingly [48] first labelled these tacit assumptions as personal beliefs. Hooper [46,p.329] later referred to assumptions as

worldview or "pretheoretical foundation". Some personal assumptions found in the literature that are thought to influence decision-making include assumptions about God, the nature of being, assumptions about others, and/or function and disability [46,48-50]. Results of this study suggest that tacitly-held assumptions about ethics and the primacy of particular ethical theories are central to ethical decision-making. This finding is also consistent with evidence from the field of behavioral ethics which indicates that ethical decision-making is most often intuitive and largely based on a preconscious basic moral sense [51-53]. Furthermore, research has shown that explicit problem-solving rarely overrules ethical decisions that are made preconsciously or intuitively [53]. One of the dangers, however, of a tacit yet dominant personal ethical foundation is that these un-interrogated assumptions could distort how clinical scenarios are perceived and understood and may actually preclude a client-centred approach to ethical decision-making [9,40,47,54]. Becoming aware of personal assumptions is imperative to ensuring that ethical decision-making is not based on the personal moral orientation of the occupational therapist but on client factors (values/goals/perspectives) and broad consideration of a variety of ethical perspectives [7,9,40,47]. Additional research is required that further explores the dominant personal ethical foundation and its influence on decision-making. More research is also needed to identify ways to support occupational therapists in exposing tacitly-held beliefs about ethical theory in order that they can make well-rationalized and defensible decisions that can be enacted in practice.

Another important finding of this study is the noted role of personal values in the process of ethical decision-making. Purtilo [10] defined values in ethical decision-making in health care as those objects or ideas that a person regards as important. Personal values are acknowledged to impact reasoning within health care including occupational therapy [11,44,55]. Such values

include physical items such as money, intangible items such as friendship or creativity, ideologies such as independence, and aesthetic items such as appearance [11]. Participants clearly indicated that personal values were considered in ethical decision-making. Several participants reported their values to be consistent with the values of occupational therapy thus facilitating ethical decision-making. One participant indicated that similarity of values may have influenced the decision to pursue occupational therapy. However, in other instances the consideration of personal values led to ethical dilemmas. In these cases, participants were unsure of how to honour personal values within the decision-making process. Findings regarding personal values are consistent with a phenomenological study conducted by Mekkes [49] who found that participants chose occupational therapy because it was consistent with personal values but at the same time experienced discomfort about incorporating personal values into decision-making. As a result, participants emphasized that they attempted to avoid allowing personal values to bias decision-making [49]. Kinsella et al. [14] reported that conflicting values between occupational therapists and clients, colleagues, and students was of a source of ethical tension. There is a paucity of research and resources in occupational therapy aimed at cogently defining the construct of personal values [56,57] and understanding the interface of personal values and ethical decision-making thereby creating a milieu of uncertainty [17]. One mixed-methods study in occupational therapy highlighted the benefit of making personal values explicit in decision-making and suggested that considering personal values can contribute to a more robust consideration of ethical issues [17]. Further understanding of the intended role of personal values in ethical decision-making is required in occupational therapy as are resources to support occupational therapists in navigating this complex issue.

Findings of this study indicate that occupational therapists consider theories and evidence when making ethical decisions and this finding is consistent with reasoning in occupational therapy [2,5,44]. Participants in this study reported that theories and evidence were drawn from various sources including the occupational therapy literature and literature from cognate disciplines. Consideration of ethics theories and knowledge was reported by very few participants and thus subsumed into the broad category of *theories and evidence*. However, it seems axiomatic that ethical theories should, at least in part, inform ethical decision-making in occupational therapy [7,58]. As a result, a parallel interpretive description study involving secondary analysis of data gathered via this grounded theory study was conducted to further explore this finding and to identify potential avenues for professional development to support ethical decision-making [59]. Findings of the interpretive description identified two main gaps: one gaps related to ethics knowledge and another gap related to support for ethical decision-making. Ethics education, tool development, and formal ethics mentorship were identified as strategies to address noted gaps. Additional research and training within occupational therapy is required to address competency needs of occupational therapists to minimize reliance on a potentially uninterrogated dominant personal ethical foundation or personal values and to promote the application of ethics knowledge to ethical decision-making [59].

Finally, results of this study indicate that, at times, *Doing What's Right* meant assuming risks and consequences including potential job loss. In most cases, these decisions were justified as benevolent for the client. Several recent publications have examined tensions in ethical decision-making involving occupational therapists in a variety of clinical contexts, however, this issue of assuming consequences was not noted [15,21,22]. In a personal account of inner conflict and tension, Kinsella [19] described a circumstance of ethical decision-making where a decision was

enacted that could have been perceived to disregard policy but was determined to be in the best interest of the client and the therapeutic relationship. The trajectory of *Assuming the Consequences* may represent the "underground practice" where a chasm exists between what occupational therapists do and what they feel they can report [60] or what is referred to in constructivist grounded theory as a "hidden topic" [25,61]. Durocher et al. [15] highlighted the need for ongoing consideration of how to enable occupational therapists to make ethical decisions that reflect their desire to prioritize client need. Results of this study not only support the finding by Durocher et al. [15] but extend the rationale for this recommendation to include reducing fear of repercussion and potential job loss.

Limitations

Participants recruited during initial sampling were identified as expert clinicians and as such their reflective skills and decision-making processes may be different from those who may be less adept in articulating their reasoning processes. Although these key informants provided insight into the potential complexities of ethical decision-making and its various dimensions, recruiting a more diverse sample may have improved the transferability of study findings. The principal investigator was an occupational therapist with several years of clinical experience as well as advanced training in ethics. This insider perspective and theoretical expertise likely shaped the data collection and data analysis process. All participants in this study except one described their role as primarily clinical. Additional exploration of ethical decision-making among occupational therapists with other roles (e.g. clinical and managerial or clinical and academic) may be worthwhile in future studies. This study was conducted in Canada with Canadian occupational therapists thereby potentially limiting transferability of findings to other geographical contexts. Finally, while there are several advantages of using metaphors in

qualitative research, the risk of misrepresenting data is one potential disadvantage [62]. Potential risks and benefits were thoughtfully considered. Ultimately, the principal investigator and co-investigators felt that use of a prism metaphor allowed for an understandable representation of the findings of this study.

Conclusion

This paper presents a theoretical model of ethical decision-making in occupational therapy which emerged from inductive analysis of data from interviews and focus groups conducted with Canadian occupational therapists. Ethical decision-making in occupational therapy practice is represented as a prism, whereby participants engage in an inductive and dialectical process of considering a checklist of various personal, client, family, regulatory, organizational and other contributing factors and potentially consulting with others in order to do what they feel is right. Study findings advance our understanding of ethical decision-making as occurring in day-to-day clinical practice in response to a broad range of clinical scenarios rather than as a discrete response to an ethical dilemma. Further epistemological development is required within occupational therapy regarding ethics broadly and ethical decision-making specifically. Based on the findings of this study, epistemological inquiry (including scholarly discussion, critical thinking, and research) is recommended to cogently define ethical decision-making and to further explicate the relationship of ethical decision-making within the broader context of reasoning. Additional inquiry is also required to explore the dominant personal ethical perspective and its impact on decision-making, to seek to elucidate the relationship of personal values and ethical decision-making, and to further investigate how and why occupational therapists engage in alternate pathways in order to do what they feel is right.

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Chapter 3: Continuing Competency in Ethical Decision-Making: Current Gaps and Future Directions

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Abstract

Background: Competency in ethical decision-making is a criterion for ethical practice and it is expected to advance with ongoing professional development. However, research aimed at exploring continuing competency needs of occupational therapists regarding ethical decision-making is limited. **Purpose:** The purpose of this study was to explore potential gaps and directions for development related to continuing competency in ethical decision-making from the perspective of practicing occupational therapists. **Method:** Interpretive description informed secondary data analysis of professional narratives regarding ethical decision making. In-depth interviews were conducted with a purposive sample of 18 occupational therapists. Data analysis focused on identifying gaps and future directions regarding continuing competency. **Findings:** Two main themes regarding potential gaps were identified: *I Didn't Have the Knowledge* and *I Don't Have Anybody*. Education, tool development, and ethics mentorship were identified as directions for development. **Implications:** Findings advance understanding of continuing competency needs of occupational therapists related to ethical decision-making.

Keywords: education, ethics, mentors, occupational therapy, professional practice

Introduction

In the *Profile of Practice of Occupational Therapists in Canada*, The Canadian Association of Occupational Therapists (CAOT, 2012) put forth a continuum which outlines a broad range of knowledge, skills, and abilities that are required for occupational therapy practice. Competency refers to an individual occupational therapist's capacity to employ such knowledge, skills, and abilities to engage in professional practice (Moyers, 2008; Moyers-Cleveland & Hinojosa, 2011; Verma, Paterson, & Medves, 2006). Minimum competency requirements are met at entry-to-practice, however, competency is expected to advance over time (CAOT, 2012; Moyers, 2008). Gaps in competency can occur when there is a discrepancy between competency requirements and individual skill in meeting those requirements (Peres, Ezeagu, Sade, de Souza, & Gómez-Torres, 2017). Engaging in continuing professional development is imperative throughout an occupational therapist's career to address potential gaps and to enhance knowledge and skills (CAOT, 2012; Moyers-Cleveland & Hinojosa, 2011; Myers, Schaefer, & Coudron, 2017; Sargeant et al., 2011; Wallace & May, 2016). Ultimately, advancing competency through engaging in continuing professional development, such as attending workshops and maintaining professional portfolios, is intended to improve client care and promote better client outcomes (Myers et al., 2017; Sargeant et al., 2011; Tompkins & Paquette-Frenette, 2010; Vachon et al., 2018; Van Hoof & Meehan, 2011).

Engaging in ethical practice is considered one key competency for occupational therapists. Ethical competency includes adhering to codes of ethics, applying ethical frameworks to facilitate decision-making, and recognizing and responding appropriately to ethical issues encountered in practice (Association of Canadian Occupational Therapy Regulatory Organizations [ACOTRO], 2012; CAOT, 2012). Three research studies indicated that practicing

occupational therapists may feel that they do not possess adequate knowledge or skills to engage in competent ethical decision-making in day-to-day practice (Atwal & Caldwell, 2003; Barnitt & Partridge, 1997; Kalantari, Kamali, Joolaee, Shafarodi, & Rassafiani, 2015). Occupational therapists in these studies reported feelings of uncertainty, stress, pressure, frustration, and anger when addressing ethical issues. Barnitt and Partridge (1997) indicated that the experience of these emotions further interfered with decision-making and practitioners' sense of competence. Furthermore, a recently published study exploring ethical decision-making in occupational therapy practice indicated that very few occupational therapists considered ethics theories or knowledge when engaging in ethical decision-making (VanderKaay, Letts, Jung, & Moll, 2018a). In such times of uncertainty, occupational therapists are encouraged to consult professional codes of ethics (Barnitt & Partridge, 1997; Cheyney-Brandt & Yarett-Slater, 2011). However, research indicates that professional codes may have limited utility in supporting competent ethical decision-making (Atwal & Caldwell, 2003; Barnitt & Partridge, 1997; Kinsella, 2006; Wright-St Clair & Newcombe, 2014). The principles outlined in these codes of ethics may suggest conflicting courses of action and individual occupational therapists may not have sufficient ethics knowledge to effectively negotiate conflicting principles (Atwal & Caldwell, 2003; Barnitt, Warbey, & Rawlins, 1998; Kinsella, 2006; Snelling, 2016). Furthermore, the role of codes of ethics may be poorly understood and may be perceived by some practitioners as tools used by organizations to promote professional status (Lee, Cripps, Malloy, & Cox, 2011; Sansom, 2013; Snelling, 2016).

Consideration of ethical competency extends beyond assessment of individual knowledge and skill to include critical examination of the broader systems within which occupational therapy is delivered (Moyers-Cleveland & Hinojosa, 2011; Myers et al., 2017). The current environment

for occupational therapy services in Canada is complex. Resource limitations, extensive waiting lists for services, excessively large caseloads, and complexity of medical needs are common scenarios faced by occupational therapists (Durocher & Gibson, 2010; Durocher, Kinsella, McCorquodale, & Phelan, 2016; Hudon et al., 2014; Kinsella, Park, Appiagyei, Chang, & Chow, 2008; Laliberté et al., 2015). These practice environments heighten the demand for competency in ethical decision-making and can precipitate the experience of ethical tension among occupational therapists (Bushby, Chan, Druif, Ho, & Kinsella, 2015; Durocher et al., 2016; Myers et al., 2017). In a recent study, Durocher et al. (2016) found that systemic constraints on practice precluded occupational therapists from making and enacting ethical decisions that were consistent with professional values and goals. Systemic constraints included (a) imposed practice, (b) ineffective processes, (c) resource limitations, and (d) lack of services (Durocher et al., 2016, p. 219).

Literature relating to continuing professional development regarding ethical decision-making is limited. Barnitt et al. (1998, p. 56) suggested that individual occupational therapists may be better equipped to engage in competent ethical decision-making by "gaining an understanding of the theories and principles that underpin health care ethics". However, Durocher et al. (2016) stated that considering individual learning is not sufficient in addressing ethical decision-making. The authors suggested that organizations and regulatory bodies must consider structural and contextual barriers to competent ethical decision-making and advocate for the removal of systemic constraints. In their scoping review of continuing competency in occupational therapy, Myers et al. (2017) highlighted the need for further research related to continuing competency development considering both noted gaps in knowledge among occupational therapists and the complexity of the occupational therapy practice context. This call has been specifically applied

to research that addresses professional development needs of occupational therapist regarding

competent ethical decision-making (Kanny & Slater, 2008). The purpose of this study was

twofold: to explore potential gaps related to continuing competency development in ethical

decision-making in occupational therapy practice and to identify potential avenues for

professional development to support continuing competency.

Method

This study was conducted as a secondary analysis of data from a broader constructivist

grounded theory study examining ethical decision-making in occupational therapy in Canada

(VanderKaay et al., 2018a). An interpretive description approach was adopted since the goal was

to answer questions specific to clinical practice (Thorne, 2016). This secondary analysis

addressed a different research question than the original grounded theory study, considered

related but distinct literature, and allowed for exploration of data that was not fully utilized in the

original research (Fine & Kurdek, 1994; Long-Sutehall, Sque, & Addington-Hall, 2012; Thorne,

2012, 2016). Interpretive description explores patterns and generates interpretations from

professional narratives that can inform new directions for clinical practice (Thorne, 2016;

Thorne, Reimer-Kirkham, & O'Flynn-Magee, 2004). Ethics approval was granted by the

institutional Research Ethics Board (REB Project #0670-see Appendix A).

Recruitment/Sampling

All participants were practicing occupational therapists registered in their province/territory of

practice who consented to participate and were fluent in English. Purposeful sampling was

conducted through nomination of key informants and theoretical sampling (Fetterman, 2008;

Thorne, 2016; Thorne et al., 2004). Initially, recruitment of key informants involved nomination

of practicing occupational therapists that were professional associates known to the principal

investigator and co-investigators and who (a) had advanced clinical reasoning skills, (b) were able to reflect on and explain their reasoning, and (c) were comfortable answering potentially sensitive questions about decision-making. Data gathered during this initial phase informed the subsequent phase of theoretical sampling (Gentles & Vilches, 2017). Theoretical sampling facilitated the inclusion of perspectives considered to be important to informing the analysis including variations in gender, geographical location, practice area, and practice context (Thorne, 2016). Eighteen participants were enrolled in the study.

Data Construction and Analysis

Potential participants were contacted by the principal investigator by e-mail to arrange individual in-depth interviews. Interviews were conducted either face-to-face (n=7), or via telephone (n=9) or Skype (n=2) between March 2016 and January 2017. Individual in-depth qualitative interviews involved the use of open-ended yet directed questions which allowed participants to describe their decision-making processes in day-to-day practice (Thorne, 2016). Data analysis for this study was centred upon a sub-set of data that were not central to the focus of the original study and not utilized to inform its findings (e.g. responses to the question "What kinds of things would help you in making ethical decisions in practice?") Doing so allowed the principal investigator to "do justice to the full scope of [participant] accounts" (Thorne, 2016, p. 271) rather than just those data utilized for the grounded theory study.

All interviews were transcribed verbatim and Dedoose software was used to manage data analysis (SocioCultural Research Consultants LLC., 2016). Data analysis consisted of several stages consistent with interpretive description: preparation, organization, and interpretation. *Preparation* involved an iterative process of reviewing transcripts in detail several times. Thorne (2016, p. 167) described this process as "dwelling in [data] repeatedly and purposefully and

developing a relationship with it." The *organization* stage involved line-by-line coding to

identify basic conceptual units followed by focused coding to reorganize initial codes into new

interpretive categories (Thorne, 2016). *Interpretation* involved further refinement of interpretive

categories to reflect meaningful analytical insight about themes related to potential gaps in

ethical decision-making and future directions for development within occupational therapy

regarding ethical decision-making (Thorne, 2016). The principal investigator wrote memos at

each stage of data analysis to support interpretation.

Quality Strategies

The principal investigator is a PhD candidate and registered occupational therapist with 15

years of clinical experience and advanced ethics knowledge. This disciplinary orientation

supports "interpretive authority" and can therefore improve credibility of findings (Thorne et al.,

2004, p. 6). Other quality strategies included ongoing analytical debriefing with co-investigators

(members of the PhD supervisory committee) to ensure epistemological and methodological

integrity. In addition, two member-checking focus group sessions were conducted (one face-to-

face and one via web conferencing) to provide a forum for interaction and discussion among

participants and further development of interpretive categories (Thorne, 2016). Ongoing

researcher reflexivity was consistently employed and documented via reflexive memoing (Braun

& Clarke, 2006). In addition, all analytical decisions were explicated and justified in a research

journal to promote dependability (Lincoln & Guba, 1985).

<center>**Findings**</center>

Fifteen female and three male occupational therapists participated in this study. Sixteen

participants possessed either a bachelor (n=7) or masters degree (n=9) in occupational therapy.

Two participants had a diploma in occupational therapy. Provinces of practice included British

Columbia (2), Alberta (1), Ontario (11), Quebec (2), and Nova Scotia (2). Seventeen participants described their role as primarily clinical and one was primarily administrative. Years of practice experience ranged from less than 2 years to 37 years. Practice areas included paediatric rehabilitation, private practice, acute care, in-patient/out-patient rehabilitation, home care, primary care, community mental health, and out-patient mental health.

Two main in-vivo themes regarding competency in ethical decision making were identified: *I Didn't Have the Knowledge* and *I Don't Have Anybody.* The first theme, *I Didn't Have the Knowledge* articulates a gap related to ethics knowledge. Directions for development to support competent ethical decision-making associated with this theme were education and tool development. The second theme *I Don't Have Anybody* elucidates a gap in support for ethical decision-making and formal ethics mentorship was identified as a suggested direction for development.

Lack of Knowledge: *I Didn't Have the Knowledge*

I Didn't Have the Knowledge includes three interrelated gaps in ethics knowledge including foundational knowledge upon which to base ethical decision-making, ethical language required to articulate ethical decision-making, and knowledge about tools and resources to support ethical decision-making.

Very few participants reported that they explicitly considered foundational ethics knowledge when engaging in ethical decision-making in practice. In fact, several participants reported having little or no ethics knowledge. For example, when speaking about an ethical situation involving a client's capacity to safely utilize a scooter, Participant #11 stated "I didn't have the knowledge to deal with these kinds of…situations." Similarly, Participant #1 stated "I couldn't name…ethical theory…like all this talking that I've done, I don't know if it subscribes to a

specific theory or not". A small number of participants reported that they had some foundational knowledge which was mostly gained through specific ethics training either in their pre-licensure occupational therapy program or via post-graduate courses in ethics. The participants who had this training reported that they did explicitly draw upon it when making ethical decisions. The reported benefits of having ethics knowledge included (a) being able to perceive and understand ethical issues more readily and from a broader perspective, (b) having a more robust knowledge base upon which to draw for making ethical decisions (c) being comfortable making and enacting a broader range of ethical decisions even when situations are ethically complex and when decisions may violate policy or regulations (d) being better able to cogently articulate ethical decision-making using ethical theory. Participant #9 described the benefits of ethics knowledge:

> So, the fact that I actually went and did a masters in bioethics and we did you know speak extensively about what is the right decision…It's just gaining all that knowledge…So, I feel that now when a manager comes and tells me "This is the reality"…I have the tools to either fight back, because I have arguments, I have knowledge or I have the tools to acknowledge when that manager is right, you know? So, I've kind of built my own I guess professional intelligence….And so, that helped me a lot to gain confidence in making decisions.

Although, as stated above, most participants did not explicitly report considering ethical theories in decision-making, ethical and philosophical theories were reflected in their responses without the use of language related to ethics. For example, Participant #7 described her rationale for engaging in personal disclosure as wanting to let a client who was struggling know that "I feel what you're feeling, I've been there." This statement directly echoes Noddings (1984) ethic

of care which emphasizes the importance of "feeling what he feels as nearly as possible…" when making ethical decisions (p. 16). Participant #18 described considering "How can I support the most amount of people with the limited resources and the best possible way that I can?" which reflects the theory of utilitarianism or the "greatest good" for the "greatest number" (Seedhouse, 2009, p. 92). Additional examples are provided in Table 1.

Table 1
Examples of Participant Responses Reflecting Ethical Theory

Participant Comment	Ethical Theory
"Compassion…care…in the sense of like caring for someone…" (P #9)	Ethics of Care
"My experience of prior ethical decisions and things that I've learned from them…are informing it…" (P #15)	Casuistry
"Is it the greatest good for the greatest number of people. Or is it you provide the most support to one and should you think about providing supports to everyone?" (P #18)	Utilitarian Ethics Principles-Based Approach (Justice)
"What drives how much I advocate for a client is based on…the social determinants of health. So, if they really have a lot of social determinants of health issues, including security, no support, no finances, a lot of systemic barriers or whatever, I think personally, I tend to put that much more effort or energy into obviously supporting them." (P #6)	Feminist Ethics
"I want to support them to live at home but when…is it on me you know that "do no harm" business…like that's their choice and they're making it, but when we're seeing people when they're questionable capacity of making all these decision…I don't know." (P #8)	Principles-Based Approach (Autonomy/Non-Maleficence)
"I try to make sure that I'm doing things the right way, so I don't end up in an ethical or otherwise difficult situation that I shouldn't have gotten myself into." (P #16)	Rule Deontology

In addition to limitations in theoretical knowledge and ethical language to articulate thinking, participants had limited awareness of tools and resources to guide ethical decision-making. For example, when discussing a regulatory body ethical decision-making framework, Participant #1 honestly stated "I don't even know what it is". Similarly, when discussing regulatory body codes of ethics Participant #15 stated "I'm a bit embarrassed to say that I'm not familiar with the document." Other participants were aware of tools and resources but felt they were inadequate in overcoming knowledge gaps. For example, Participant #16 stated "they're not clear enough as a decision-making tool for you to be 'okay, this is what this tells me, this is what I need to do.'" In general, very few participants reported seeking out tools or resources to guide ethical-decision making. Participant #2 expressed concern regarding this gap:

> I feel that people…aren't aware…of the resources….And I worry about that….it's a worry for me…we'll be seeing more ethical dilemmas out there…people involved in ethical issues that they haven't handled well because…they're not aware of those resources, they're not in-tune to them to help them you know work through some of the difficulties at work.

Direction for development: Education and tool development.

Participants identified a desire for formalized and ongoing ethics education. Methods of education and training suggested by several participants included university-based courses devoted specifically to ethics in occupational therapy that would be offered to both student occupational therapists and practicing occupational therapists. Other suggestions included: in-person professional development workshops, on-line self-paced education modules, case-based or clinical research rounds, and newsletters or bulletins describing clinical scenarios and outlining an approach to ethical decision-making. Participant #4 stated:

> It's good to have some formalized training so everyone is coming from a common ground
> or at least have some [common] language [when] they are dealing with things or some
> awareness. If you don't have awareness or…at least an indication of potential things that
> you should be considering, then you are kind of at a disadvantage.

Some participants suggested that training should address several different aspects of ethics and ethical decision-making including (a) foundational knowledge about ethics and ethical theories (b) application of ethics to day-to-day practice, and (c) acknowledgement and discussion of areas of ethical uncertainty or tension.

Several participants expressed a desire for tools and frameworks to both guide thinking regarding ethical decision-making and to facilitate reflection-on-practice. Participant #16, for example, expressed a desire for "…a more clear tool, like an actual working tool that you can use….an ethical decision-making grid or 'Have you considered this? Have you considered this?'" Some participants noted the importance of tools that would be specific and facilitate a process of considering relevant ethics information and weighing various options. Suggested formats included flow charts, decision-making trees, and checklists. It was felt that tools would be particularly helpful for recent graduates who are faced with the complexities of practice often with little support. Participant #2 stated:

> For our newer grads coming out…I worry somehow that they may not know what they
> don't know in terms of…making an ethical decision…so that's my fear and I'm hoping
> that there, there may be some additional tools or directions or things to help them through
> because of the…lessening of the support systems out there.

Lack of Support: *I Don't Have Anybody*

One of the main findings of the broader grounded theory study was that participants engage in a process of actively consulting others (including colleagues and supervisors) to obtain support for ethical decision-making (VanderKaay et al., 2018a). However, several participants lamented that *I Don't Have Anybody.* They elucidated gaps related to support for ethical decision-making in two main areas: ethics experts and regulatory bodies.

Participants with access to ethics experts, such as ethicists or other ethics personnel (e.g. ethics facilitators/risk management team), found this to be very useful to guide decision-making. Participant #4 stated:

> We're lucky having a bioethicist here, so that we can go to and be like "hey, can you give us some perspective?" And sometimes it's totally out of the box. I didn't even think about that…because that's their niche area of expertise. We're quite fortunate to have that…I like knowing that I have somewhere to go….Some of my colleagues I talk to in the community, they're like "It's just me. I have to figure it out on my own." And man, that's tricky.

However, very few participants had access to ethics experts, particularly those working outside of large teaching institutions. Participant #6 stated:

> What's fascinating to me, is that all the hospitals have ethicists that clinicians and staff members can call upon, and in the community we don't have that resource…So, I just find it interesting, that in the hospital system we all have access to that where we can you know, get some support, talk to some, whereas in the community, you're kind of on your own…as sole-charge OT, I don't have anybody. I'm…on my own.

Of the participants that did not have access to ethics personnel, several reported a desire to have access to support for ethical decision-making. Participant #15 stated:

> It would be great…if there were a staff member in the hospital in the ethics department. I
>
> don't think that there is an ethics department here, but if there was someone who could
>
> come and give some clinical support with a scenario…that would be wonderful.

In addition to ethics experts, several participants contacted provincial regulatory bodies to

obtain support for ethical decision-making. In some cases, the support was reported to be useful.

For example, Participant #14 stated:

> They [regulatory body] have been helpful because they've given me the information that
>
> I've needed to continue to do the work in a way that I know is going to adhere to the
>
> [regulatory body]. So, I guess that that helped me have comfort in the decision that I was
>
> making.

In other cases, there were issues in accessing support for ethical decision-making from provincial

regulatory bodies. One issue relates to the timeliness of responses given the immediate demands

of ethical situations in clinical practice. For example, Participant #3 described a decision not to

contact the regulatory body for guidance with a client who was threatening her personal safety

stating, "And timeliness was a big issue here…calling the [regulatory body] and leaving a

message and we'll get back to you within 7 days". Another limitation was the perceived

authoritative approach of regulatory bodies to participants experiencing ethical issues. For

example, Participant #4 described contacting a regulatory body for guidance regarding a

"sensitive scenario" related to potential client neglect and stated that "I accessed you to ask you a

question and you sent me something as if I'm doing something wrong." Other noted issues with

accessing support for ethical decision-making from regulatory bodies include policies perceived

to be "too constraining" (P #7) and not reflective of the realities of practice. Participant #1 stated

"the [regulating body] sets this gold standard from some ivory tower that we're supposed to meet in the frontline trenches."

Direction for development: Ethics mentorship.

Mentorship to support ethical decision-making was identified by participants as a key area for professional development. One participant stated that "I think formalizing the process of mentorship is a good resource to have and not just for new grads…for clinicians regardless of where they practice" (P #17). Several participants named ethicists as potential ethics mentors to guide decision-making. However, potential mentors included managers and other clinicians with advanced training in ethics. Participants indicated that ethics mentors should be formally recognized as such and possess the following qualities (a) available/readily accessible (b) knowledgeable on the topic of ethics/ethical decision-making (c) knowledgeable about specific practice areas. Participant #8 stated "Oh what would be great? If there was a 1-800 number…".

Discussion

The current study advances our understanding of continuing competency development regarding ethical decision-making in day-to-day practice by providing insight into potential gaps and required supports. The first theme, *I Didn't Have the Knowledge*, articulates a gap related to ethics knowledge in three interrelated areas including foundational knowledge, ethical language to articulate decision-making, and knowledge about tools and resources. Education and tool development were identified as strategies to address knowledge gaps. The second theme *I Don't Have Anybody* captures the perceived gaps in support for ethical decision-making from both ethics experts and regulatory bodies. Formal ethics mentorship was identified as a related direction for development to support continuing competency in ethical decision-making. Study findings are consistent with the scoping review conducted by Myers et al. (2017) who noted that

gaps in knowledge and contextual factors can influence continuing competency in occupational therapy. However, findings of this study extend previous work towards understanding continuing competency related specifically to ethical decision-making.

The first important finding is the noted gap in ethics knowledge and the desire expressed by occupational therapists in this study for additional and on-going ethics education to support competent ethical decision-making. Occupational therapists wanted ethics education in a variety of formats and a broad range of topics including foundational knowledge about ethical theories and the application of ethics knowledge to day-to-day practice. Occupational therapists who had received education in ethics outlined several important benefits of this knowledge to ethical decision-making. This finding is consistent with a recommendation by Bushby et al. (2015) who stated that practicing occupational therapists may benefit from education regarding addressing ethical tensions in practice and Myers et al. (2017) who found that continuing education provided through a variety of formats (e.g. workshops/seminars) was an important means of supporting competency among practicing occupational therapists. Furthermore, ethics educators from across Canada also identified foundational ethics knowledge grounded in realistic practice examples as a priority for ethics teaching in occupational therapy (Hudon et al., 2016). However, although ethics education has evolved over the last 15 years, concerns persist regarding the development of relevant content, evidence-based teaching tools, and evaluation methods (Hudon et al., 2016; Jensen, Brasic-Royeen, & Purtilo, 2010; Kinsella & Bidinosti, 2016; Kinsella, Phelan, Park-Lala, & Mom, 2015; Laliberté et al., 2015). A recent study of a new on-line ethics education module for occupational therapy clinician-educators found that ethics knowledge cultivated via viewing the on-line module led to increased confidence in their ability to make, enact, explicate, and defend ethical decisions (VanderKaay, Letts, Jung, & Moll, 2018b).

Although no similar studies of ethics education involving practicing occupational therapists were located, an earlier study conducted by Kinsella and Bidinosti (2016) indicated support for a novel arts-based approach to ethics education among occupational therapy students. Additional and ongoing pedagogical development regarding ethics education for occupational therapists is recommended.

However, as Moyers-Cleveland and Hinojosa (2011) indicated, the acquisition of new knowledge may not translate into increased competency in occupational therapy practice. Limitations in applying new knowledge to clinical practice following continuing education have been well documented within the rehabilitation literature specifically and health care broadly (Menon, Korner-Bitensky, Kastner, McKibbon, & Straus, 2009; Scott et al., 2012; Van Hoof & Meehan, 2011; Wallace & May, 2016). Wallace and May (2016) suggested that improving competency via continuing education in health care is limited because most continuing professional development is "input-based" only i.e. didactic events such as lectures with written notes. Instead, the authors suggested an "outcomes-based" professional development model whereby new learning delivered in a didactic manner must be supplemented with opportunities for participants to engage in ongoing assessment of how new learning has been applied to improving competency (Wallace & May, 2016). This outcomes-based model is consistent with the processes required in professional portfolios including: (a) gap-analysis to determine learning needs, (b) developing a plan to acquire new knowledge and, (c) subsequently measuring application of new knowledge to practice (Vachon et al., 2018; Wallace & May, 2016). Two systematic reviews in rehabilitation highlighted that education was most effective in eliciting practice change when multiple components were added to didactic events (Menon et al., 2009; Scott et al., 2012). More specifically, application of new knowledge to practice can be enhanced

with post-education follow-up discussions, outreach visits, and opportunities for discussion with experts (Menon et al., 2009; Scott et al., 2012). Taken together the literature suggests that ethics education should extend beyond traditional didactic activities, include multiple components, and a focus on identifying and measuring tangible outcomes related to competency in ethical decision-making in day-to-day practice.

A related finding of this study is that existing tools to support ethical decision-making may be underutilized and that occupational therapists in this study requested a clear and specific tool to guide ethical thinking and decision-making. The use of tools to guide reasoning is well-established within occupational therapy (Chapparo & Ranka, 2008). Several tools to guide ethical decision-making in occupational therapy specifically and rehabilitation broadly are currently available including the Guide for Ethical Decision Making put forth by Kanny and Slater (2008) the Patient-Centred Care Ethics Analysis Model for Rehabilitation put forth by Hunt and Ells (2013), and various decision-making tools put forth by regulatory bodies including Conscious Decision-Making in Occupational Therapy Practice (College of Occupational Therapists of Ontario, 2016). However, there is currently no published literature which evaluates the effectiveness of these tools to guide ethical decision-making. The findings from this study highlight the need for increased awareness of tools that are available and increased clarity regarding how they can be used in practice. Hunt and Ells (2013) posited that tools used to guide reasoning in other areas can also be used to guide ethical decision-making if they include specific points of analysis related to ethical issues. A study by Delany and Galvin (2014) illustrated how a model of shared decision-making could be used to inform ethical decision-making in paediatric occupational therapy. This study, however, involved only one single case report in one specific area of practice. The authors called for further research that explores

integrating patient perspectives with ethical theory and professional obligations into a shared decision-making model (Delany & Galvin, 2014). Findings of this interpretive description study combined with literature reviewed indicate that more research is needed which explores the needs of occupational therapists regarding tool development including assessing the utility of currently available tools to guide ethical decision-making.

Finally, findings of this study suggest that occupational therapists desire formal ethics mentorship. The reported limitations to accessing mentorship from regulatory bodies are consistent with published literature indicating that professional codes of ethics may not be sufficient in supporting ethical decision-making. In fact, upholding regulatory practice standards may be a source of ethical tension (Barnitt & Partridge, 1997; Bushby et al., 2015; Edwards, van Kessel, Jones, Beckstead, & Swisher, 2013; Sansom, 2013; Wright-St Clair & Newcombe, 2014). It is important to note that provincial regulatory bodies are mandated to regulate the practice of occupational therapy to protect the public rather than to provide a forum for deep deliberation of ethical issues in practice in the form of ethics mentorship (Cheyney-Brandt & Yarett-Slater, 2011; Doherty, 2013; Government of Ontario, 1991). Mentorship in the health professions is a broad topic (Shaw & Fulton, 2012) and its thorough examination is beyond the scope of this study. However, mentorship has been defined in the occupational therapy literature as a partnership between an experienced occupational therapist (mentor) and someone with less experience (mentee) with a focus on of supporting professional growth (Foss, 2011; Milner & Bossers, 2005). Research indicates that occupational therapists prioritize mentorship as a means of professional development (Myers et al., 2017). Milner and Bossers (2005) reported the results of a quantitative study which evaluated a mentorship program for student occupational therapists at Western University. Findings indicated that the mentorship program was valued by both

mentors and mentees and several strengths and areas for improvement of the program were identified. However, *ethics* mentoring was not specifically addressed (Milner & Bossers, 2005). Occupational therapists in this study identified a desire for mentors with expertise in ethics. The CAOT has recently initiated a Mentorship on Demand program that allows occupational therapist to seek mentorship on an as-needed basis (Baptiste & Canadian Association of Occupational Therapists, 2018). Similarly, the Ontario Society of Occupational Therapists (OSOT) also facilitates mentorship through their Find-a-Mentor On-Line program (OSOT, 2017). Although these mentorship programs can be personalized according to mentees' self-identified needs, they are not specifically targeted to ethics mentorship (Janet Craik, personal communication, February 5, 2018). No published literature was located related specifically to mentoring and ethical decision-making in occupational therapy. However, literature in related disciplines such as nursing, clinical psychology, and medicine indicates that mentorship has been *explicitly* applied to the development of competency in ethical decision-making (American Psychological Association, 2006; Garimella, Wood, & Hultman, 2015). The Canadian Nurses Association put forth the idea of an ethics mentor as someone who helps others to perceive situations explicitly through an ethics lens (Sourani & Storch, 2011). Ethics mentors are required to be proficient in the use of ethics resources and must be able to assist others in identifying and utilizing appropriate ethics resources. Other stated roles of ethics mentors included arranging ongoing education opportunities and seeking to create ethics communities of practice (Sourani & Storch, 2011). It is recommended that organizations that support the practice of occupational therapy including academic institutions, employers, professional associations, and regulatory bodies further explore potential ways to provide formal ethics mentorship specifically to support occupational therapists in continuing to develop competent ethical practice. Doing so may

require capacity-building among occupational therapy mentors with respect to the theory and practice of ethical decision-making (Aulisio, Arnold, & Youngner, 1998; Benatar, 2006).

There are several limitations to this study that should be noted. Key informants were nominated for their ability to reflect on their decision-making and speak about potentially sensitive issues in practice. The struggles that they reported may be different from those experienced by clinicians who do not possess similar characteristics. Data collection consisted primarily of one interview on one occasion. Triangulation of data methods (e.g. participant observation) may have enriched depth of study findings (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014). Finally, secondary analyses may have precluded the researcher from fully exploring the influence of the broader contexts of practice (e.g. institutional structures) on ethical decision-making. Secondary analyses may have also limited opportunities to follow-up on participant responses in a way that specifically addresses the secondary research question (Thorne, 2012). Expanding data collection to include primary sources may have allowed for deeper exploration of the research question potentially identifying additional gaps (Thorne, 2012).

Conclusion

This interpretive description study advances our understanding of competency in ethical decision-making in occupational therapy in Canada by articulating two main gaps in competence in ethical decision making: a gap related to ethics knowledge and a gap in support for ethical decision-making. Furthermore, findings indicate three areas for professional development to support competency in ethical decision-making including education, tool development, and formal ethics mentorship. To address these findings, further pedagogical development regarding ethics education for practicing occupational therapists is required which extends beyond

traditional didactic formats. The utility of current tools to guide ethical decision-making remain unclear and current mentorship opportunities provided by professional organizations do not focus explicitly on ethical decision-making. There appears to be a need for clear and comprehensive tools and formal mentorship regarding ethical decision-making. Despite several noted limitations, it is hoped that the findings of this study will encourage broader-scale rigourous research to further examine of the needs of occupational therapists and promote the development of relevant educational interventions, decision-making tools, and mentorship opportunities to support continuing competency in ethical decision-making in occupational therapy in Canada.

Key Messages

- Canadian occupational therapists practice in complex environments which heighten the demand for competency in ethical decision-making.

- Competency in ethical decision-making is supported by sufficient knowledge in ethics as well as skill in applying knowledge to the complex cases encountered in day-to-day practice.

- Occupational therapists require outcomes-focused ethics education, clear and comprehensive decision-making tools, and readily accessible ethics mentorship to support continuing competency development.

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Acknowledgements

Chapter 4: On-Line Ethics Education for Occupational Therapy Clinician-Educators: A Single-Group Pre-Post Test Study

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Abstract

Purpose: Ethics education is a critical component of training rehabilitation practitioners. There is a need for capacity-building among ethics educators regarding facilitating ethical decision-making among students. The purpose of this study was to evaluate the utility of an on-line ethics education module for occupational therapy clinician-educators (problem-based learning tutors/clinical placement preceptors/evidence-based practice facilitators). **Method:** The *Knowledge-to-Action Process* informed development and evaluation of the module. Clinician-educators (n=33) viewed the module and reported on its impact on knowledge and facilitation practices via pre, post, and follow-up questionnaires. **Results:** Pre- and post-test data indicated improvement in self-reported ethics knowledge (t = 8.275, p < 0.01). Follow-up data indicated knowledge did not decrease over time (t = -1.483, p = 0.075). There was improvement in self-reported intent to change practice (t = 4.93, p < 0.01) however actual practice change was not indicated (t = -1.499, p = 0.072). **Conclusion:** This study provides preliminary data regarding an on-line ethics education module for clinician-educators. Future recommendations include broader consideration of context, adding supplemental knowledge translation components, and further research exploring outcomes with larger samples, longer follow-up, and randomized trial methodology.

Keywords: ethics, on-line module, education, occupational therapy, clinician-educators

Introduction

Ethics education is an integral component of the pre-licensure education of rehabilitation practitioners [1-7]. Formal ethics education can facilitate the development of ethical reasoning, allow for an integrated understanding of ethical concepts and theories, and increase confidence to make and enact ethical decisions [6,8,9]. Without this formal ethics education, there may be little improvement in ethical reasoning [10,11]. Higher levels of ethical decision-making have been linked to better clinical performance among rehabilitation students and practitioners as measured by standardized and non-standardized assessment tools [6,12].

Research in ethics education in rehabilitation, including three recent studies conducted by one Canadian research team published in *Disability and Rehabilitation*, indicated that there is no clear consensus regarding the ideal quantity, content, or pedagogical approach to ethics education [3,5,13]. Laliberté et al. [5] noted wide variations in ethics teaching time across Canadian physiotherapy and occupational therapy curricula. Ethics teaching time ranged from five to 65 hours, with "limited time allotted to ethics" identified as an obstacle to ethics teaching [5,p.2307]. Edwards et al. and Swisher et al. [8,14] reported a significant change in ethical reasoning among student physiotherapists following a 6-week intensive ethics course involving blended learning including on-line modules and face-to-face interactive workshops. Although the number of weeks was stated, the specific number of hours of instruction was not specified or recommended. In addition to issues related to quantity of ethics education, concerns have also been noted regarding content. Ethics teaching often focuses on regulations and professional standards of practice, without sufficient attention to ethical and philosophical theories [3,5]. A more robust ethics curriculum which extends beyond ethics as standards of practice has been recommended [4,6,15]. This includes incorporating ethical theories and frameworks and

focusing on critical thinking and skill development required to address ethical dilemmas in day-to-day practice. However, which specific ethical theories should be included in ethics content remains unclear as does the application of some ethical theories to the rehabilitation context [3,14,16]. Finally, from a pedagogical perspective, there is broad support for ethics teaching that extends beyond traditional lectures and includes small group case-based discussions [2-4,6-8,14,15,17-19]. Although traditional lecture-based approaches are often used in ethics teaching [3,5,8,18] other research has indicated that lectures on ethics are perceived by students to have less value than case-based discussions [15]. Documented benefits to case-based discussions include (a) increased opportunity to practice ethical reasoning, (b) better understanding and integration of ethical knowledge, (c) increased likelihood of exploring a variety of ethical perspectives, and (d) enhanced meaning or relevance to practice [3,15,20,21]. Case-based discussions can occur within small groups of rehabilitation students with a facilitator, and/or individually with clinician-educators (preceptors/supervisors) [3,15,17,18]. Clinical placements and small group discussions provide opportunities for case-based deliberation with ethics educators, including clinician-educators, and can therefore be considered an important platform for ethics education [22].

One of the foremost barriers to ethics education in rehabilitation is the lack of ethics training among academic faculty as well as clinician-educators [3,5,17]. Hudon et al. and Laliberté et al. [3,5] reported that most faculty members and clinician-educators involved in teaching ethics in Canadian physiotherapy and occupational therapy programs did not have any formal training in ethics [3,5]. Additional research in physiotherapy and occupational therapy highlighted significant gaps in practitioner knowledge regarding ethics and indicated that many rehabilitation practitioners felt that they did not possess adequate knowledge or skill to engage in sound ethical

decision-making [23-27]. In a mixed-methods study (survey/interviews) of Canadian

undergraduate social work programs, faculty members reported that they lacked ethics

knowledge particularly related to professional ethics [28]. The author [28] called for further

research to explore faculty member needs regarding learning related to ethics education. Hudon

et al. [3,p.2249] stressed the need for "learning modules and opportunities for continuing

education in ethics" for ethics educators including clinician-educators to improve the ethics

preparation of future rehabilitation practitioners. Avci [17,p.12] echoed this call stating that "the

education of educators must come first because the lack of ethics educators and educators'

experience in ethics are major obstacles". The purpose of this paper is to report the findings of a

non-randomized, single-group, pre- and post-test study conducted to evaluate a theoretically and

empirically based on-line education module developed for clinician-educators (tutorial and

seminar group facilitators/clinical placement preceptors) in the Master of Science Occupational

Therapy (MSc OT) program at one Ontario university. In the context of this study, the term

clinician-educators refers to practicing occupational therapists who also participate in teaching

student occupational therapists. Teaching roles include both small group learning facilitators

(problem-based learning tutors and evidence-based practice facilitators) and clinical placement

preceptors (see *Participants* section for additional details). The overarching research question

that was used to guide this study was: What impact does viewing an on-line ethics education

module have on clinician-educators' self-reported ethics knowledge and teaching practices

related to facilitating ethical decision-making among student occupational therapists?

Module Development

Module development took place from October 2014 to August 2016. The *Knowledge-to-Action Process* (KTA) put forth by Graham et al. [29] was used to guide development and

implementation of this on-line education module within the clinician-educator community. The KTA process is a conceptual framework which guides the utilization of knowledge [29]. It is divided into two processes: the knowledge creation phase and the action phase. Knowledge creation is the central process of the framework through which knowledge becomes increasingly refined. The action cycle serves as a guide to the implementation of the knowledge translation (KT) intervention and is based on multiple planned action theories [29]. For the purposes of this project the *Knowledge Translation Planning Template-R™* (KTPT-R™) developed by Barwick [30] was also used within the action phase to inform module development. The KTA process is outlined in figure 1 (see Appendix F for permission to include). Although the KTA process is depicted as sequential in nature, it is intended to be dynamic and changeable to suit the project [29,31]. A brief description of each step of the action cycle follows in the order intuitive to this manuscript.

Problem identification resulted from a 2013 review of the ethics curriculum at the Ontario university where this research took place. The curriculum review was conducted by the occupational therapy curriculum committee and the corresponding author. The occupational therapy curriculum committee is comprised of occupational therapy faculty members, some of whom carry a clinical caseload and act in the role of clinician-educators. This review revealed that ethics education was restricted to approximately 8 hours and delivered primarily as lectures (one lecture per term in the first three terms of study) with limited opportunity for small and large group discussions. In addition, during the curriculum review it was noted that there was minimal discussion of ethics during other small group learning such as tutorials and seminars despite the noted importance of these learning opportunities in facilitating ethical decision-making. In addition, based on evidence reviewed it was hypothesized that clinician-educators

may not have had the ethics training required to facilitate application. Following this curriculum

review the curriculum committee decided that the next important step in ethics education would

be to provide training to clinician-educators regarding ethics via an on-line education module to

support the extension of ethics teaching to small group learning and clinical placements.

Figure 1   The Knowledge-to-Action Process adapted from Graham et al. [28]
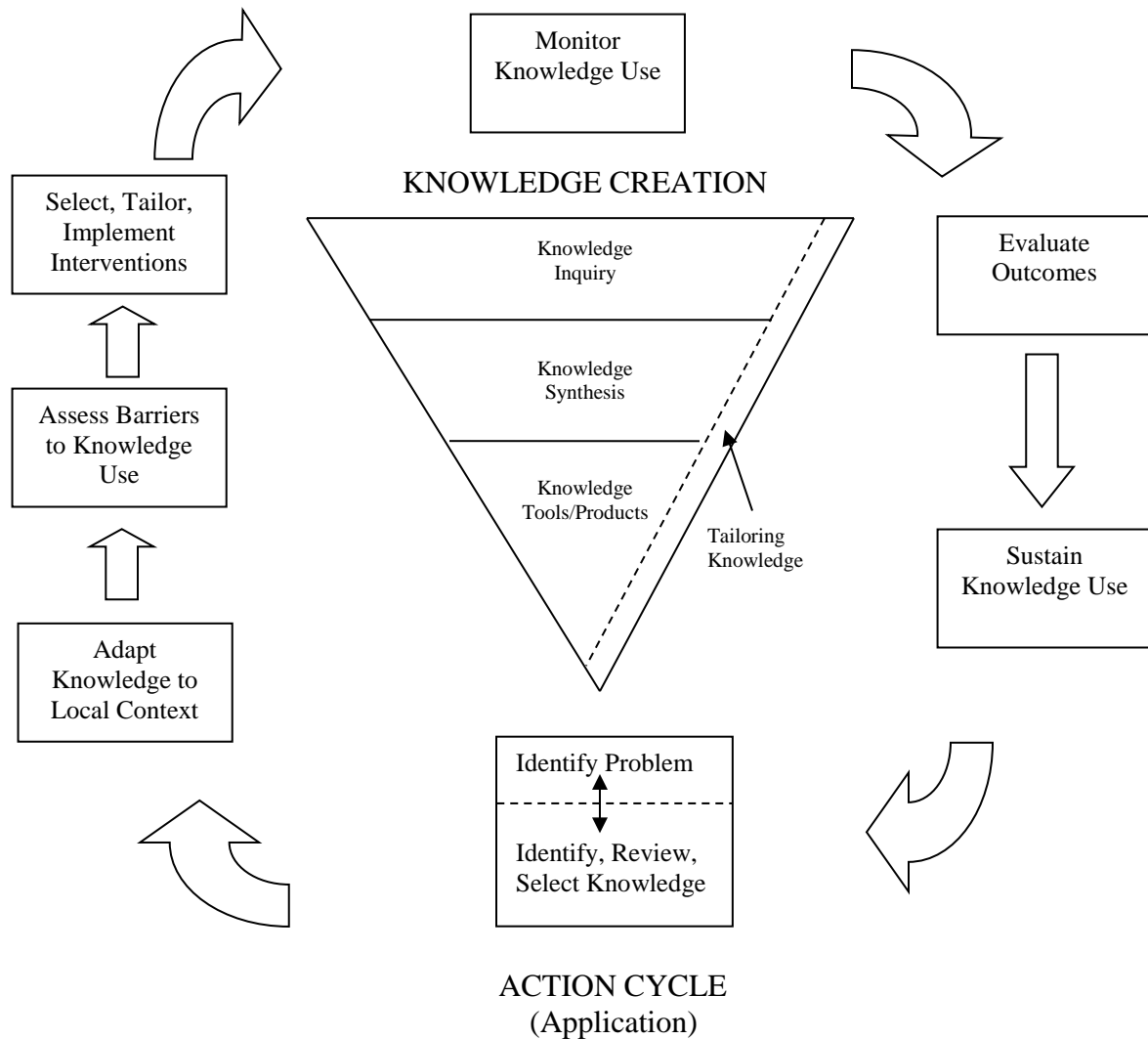
An on-line approach was adopted since it offers (a) flexibility in time, place, and pace of learning, (b) efficient access to knowledge thereby supporting relevant knowledge gain in shorter periods of time, and (c) equal access to learning for practitioners in rural and/or remote practice contexts [32-36]. Research regarding the use of on-line modules specific to ethics education in health care is limited. However, Moses et al. [36] and Hendee et al. [37] supported the use of on-line ethics education for health care professionals and called for ongoing development of such resources and their wider dissemination and utilization. Moses et al. [36,p.21] described on-line ethics training as novel idea that "could be used by…professionals on their own and that could also strengthen the quality of formal ethics teaching in clinical settings."

Identification, review, and selection of knowledge began with a broad review and synthesis of individual research studies relating to ethics education in pre-licensure health care programs followed by a synthesis of knowledge. Through this phase of *knowledge inquiry* and *knowledge synthesis* three main messages for the on-line education module were identified with two distinct goals. The first main message focused on providing basic information regarding ethics including ethical theory, practical application (applied ethics), and information regarding current tools and frameworks to support ethical decision-making. This main message was considered important since review of published research and engagement with intended knowledge users indicated a significant gap in educator and clinician-educator knowledge [3,5,23,24,27]. The second main message focused on the importance of ethics education in preparing student occupational therapists for professional practice [3,25,38,39]. The third main message focused on the pedagogical value of case-based discussions for ethics education and the unique role of clinician-educators in facilitating these case-based discussions [8,15]. The overarching goals of these three main messages were (a) to provide basic information regarding ethics to cultivate knowledge

development and (b) to encourage practice change by providing clinician-educators with training

and tools to support them in explicitly addressing ethical decision-making during case-based

discussions with student OTs. Please refer to table 1 for a summary of content which is further

addressed *in* the *planning and development* section below.

   The extensive process of *planning and developing* the on-line module first involved

establishing content. As previously stated, there is no clear consensus regarding the ideal content

for ethics education in rehabilitation [3,5,13]. The corresponding author is a doctoral researcher

and educator in ethical decision-making in occupational therapy and is extensively engaged in

the study of ethics. In this capacity, the corresponding author participated in a national

conference with ethics educators from occupational therapy and physiotherapy programs across

Canada in May 2014 [3]. At this workshop priority content for ethics teaching in rehabilitation

was discussed including ethical theories and professional codes of ethics. The importance of

using practical examples to situate theories and codes was emphasized and ideas regarding

teaching and evaluation methods were also shared. Development of module content was

informed by conference dialogue [3] and was also rigorously and judiciously based upon a

cogent body of published literature as well as several relevant textbooks [8,15,26,40-48]. Content

was intended to be introductory and paralleled information taught to student occupational

therapists during ethics lectures. Please refer to table 1.

   Planning and development also involved (a) reviewing peer-reviewed scientific journal

articles relating to e-learning; (b) reviewing on-line resources regarding the development of on-

line learning modules and incorporating principles of Universal Design for Learning (UDL); (c)

reviewing documents related to best practices for creating on-line learning modules; (d) viewing

several on-line education modules designed for similar purposes; (e) on-going and iterative

consultation with an instructional designer from the university's institute of teaching and learning [49-54]. The presentation slides and script were created by the corresponding author. Slides and script were uploaded to Articulate® Storyline 2.

Table 1

Summary of Content

Component	Content
Introduction	Goal of On-Line Module Module Organization
Mini-Module #1 *What is Ethics?*	What is ethics? How does it apply to occupational therapy? Three Main Branches of Ethics Ethical Theories • Deontology • Ethic of Consequences • Virtue Ethics • Ethic of Care • Feminist Ethics
Mini-Module #2 *Ethics Applied*	The Four Principles Approach (autonomy/beneficence/non-maleficence/justice) Other Principles • veracity • fidelity • confidentiality • privacy Professional Codes of Ethics College of Occupational Therapists of Ontario Code of Ethics
Mini-Module #3 *Ethical Decision-Making and You*	Research on Ethics Education Importance of Case-Based Discussions Your Role Useful Tools How do I learn more? How to best use this information?

Adapting knowledge to reflect local context included referencing policy documents such as the Canadian Guidelines for Fieldwork Education in Occupational Therapy, Profile of Practice of Occupational Therapists in Canada, and an institution-specific document [22,55,56]. In addition, eleven project partners assisted in knowledge adaptation by evaluating a first draft of the on-line module (March to May 2015). This evaluation was designed to gather feedback regarding all aspects of the module including content relevance and content level, and design including speed, length, and visual appeal. A tool with both Likert response format questions and open-ended questions was developed by the corresponding author for this purpose. The corresponding author and the Director of Clinical Education chose project partners to review the first draft guided by relevant literature [29,57]. Five of the eleven project partners that evaluated the first draft were members of the occupational therapy curriculum committee, the problem-based learning course coordinator, the Director of Clinical Education (MSc Occupational Therapy Program), and the Assistant Dean of the occupational therapy program (some role overlap). Six clinician-educators (intended knowledge users) were also engaged in this process of knowledge adaptation, in part to mitigate anticipated barriers to knowledge use [29,57]. These six clinician-educators did not subsequently also participate in the research study. Please refer to table 2 for a summary of the main issues identified by evaluation of the first draft and the resultant revisions. The finished product is approximately 40 minutes in length (duration dependent upon level of engagement) and, following a brief introduction, is divided into three mini-modules: (1) What is Ethics? (2) Ethics Applied and (3) Ethical Decision-Making and You. Mini-modules contain interactive activities, and each concludes with a summary of key messages. Please refer to figure 2 for a screen shot of the on-line module. A certificate of completion suitable for a professional portfolio is available for printing at the conclusion of the module.

Table 2

Summary of First Draft Evaluation Data and Resultant Revisions

First Draft Evaluation Data	Revision
Module was too long.	Module script was revised/shortened, and module was divided up into three discreet mini-modules which could be viewed independently.
Poor quality audio.	Audio was re-recorded in a studio with appropriate equipment (microphone/reference monitor) and support of a digital media specialist.
Request for more practice-based examples.	Additional practice-based examples were added throughout. In mini-module #3 (Ethical Decision Making and You) the narrator works through a practice-based example using an ethical decision-making tool.
Request for more interactive activities and more challenging interactive activities.	Existing interactive activities were revised to increase interest/challenge. Additional interactive activities were added including an opportunity to apply an ethical decision-making tool to a practice-based example.
Request for notes to be provided.	Complete transcript was incorporated into module. During the introduction, a recommendation is provided for participants to obtain pen/paper to record notes and the presentation is paused.
Module was not visually appealing.	Additional support was obtained from digital-media specialist and instructional designer to improve visual appeal/interest.

Figure 2   Module Screen Shot
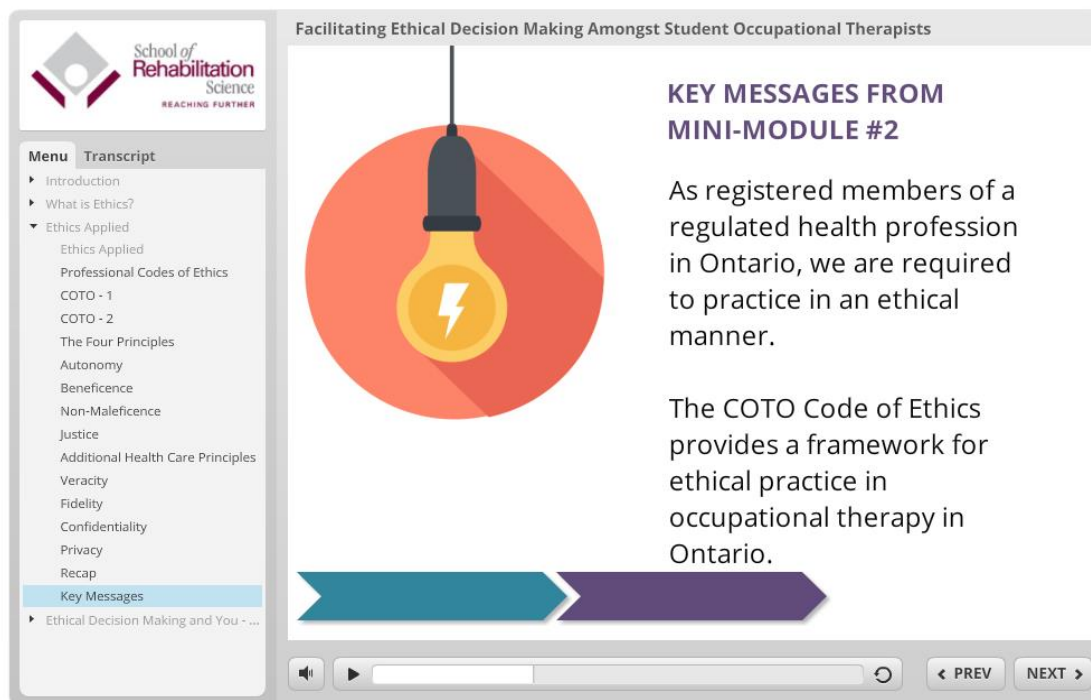
Assessment of potential barriers to knowledge use involved critical reflection on this on-line

education module and review of the literature which revealed two potential barriers. First was

that there was no requirement for clinician-educators to view the on-line module or apply the

principles in their work with students; their participation was dependent upon their self-direction

as adult learners [58]. It was anticipated that clinician-educators would be motivated to complete

the on-line module since they are practicing occupational therapists who commit to acting as role

models for student occupational therapists and to promoting student development regarding the

core competencies of occupational therapy practice [22,55]. Furthermore, clinician-educators

were engaged in evaluation of the first draft of the on-line module. Stakeholder engagement is

considered an important predictor of knowledge use [57]. The second barrier was the lack of

standards or guidelines in the literature regarding how best to provide ethics education to

clinician-educators so that they may, in turn, disseminate ethics knowledge. As a result, it was not possible to base the development of the module on a cogent body of context-specific research. This barrier was managed by judiciously tailoring existing research, including research regarding development of on-line modules, to best suit the context.

Monitoring knowledge use and evaluating outcomes are necessary steps in determining the extent to which the knowledge has been diffused and "whether application of the knowledge actually makes a difference…" [29,p.21]. The degree of knowledge use was measured using reach indicators i.e. tracking the number of completions of the on-line module [30]. The focus of evaluation of the final module is based on principles outlined by Barwick [30]: (a) to measure its usefulness in improving and sustaining self-reported knowledge (evaluation for knowledge generation) and, (b) to measure self-reported intent/commitment to change practice and actual practice change (practice change indicators) [30].

Evaluation Methods

Module evaluation took place from September 2016 to February 2017. The institutional Research Ethics Board (REB) was contacted on two occasions to inquire about REB requirements for module evaluation. On both occasions the Research Ethics Officer confirmed that REB approval was not required since the project was locally-based (within the institution) and module evaluation was considered part of the ongoing process of program development. (J. Sancan, personal e-mail communication, March 24, 2015/January 18, 2016; unreferenced). However, ethical principles outlined in the World Medical Association Declaration of Helsinki were upheld [59]. More specifically, informed consent was obtained from all participants and included explanation of the purpose of the research, the voluntary nature of participation, potential burdens and benefits of the research, how to withdraw from the research, and a

description of how data would be utilized. To protect privacy and confidentiality all personal

information was removed from data and was replaced with an identification number. A list

linking the identification number with participant name was kept in a secure place separate from

the data. Data was stored on a secured web-site and will be safely destroyed following

completion of the study.

Design

A single group, pre- and post-test research design was used for this evaluation. This research

design is generally indicated for program evaluations, such as this on-line ethics education

module, when the purpose is to determine the impact of the intervention and when access to

control/comparison groups may not be feasible [60].

Participants

Clinician-educators were recruited to participate. In the context of this study, clinician-

educators refers to both small group learning facilitators, including problem-based learning

(PBL) tutors and evidence-based practice (EBP) facilitators, and clinical placement preceptors.

Problem-based learning (PBL) refers to small group, self-directed, case-based learning. The PBL

tutor facilitates both the group process and recognition and understanding of important concepts

[22]. PBL tutorials typically occur once or twice weekly over a 9 to 12-week term. The problem-

based tutorials involved in this study occurred with Term 1 students (first year) and Term 4

students (second year). Evidence-based practice seminars (EBP) entail small group learning and

provide an opportunity for critical appraisal, synthesis, and application of evidence to clinical

practice dilemmas [61]. Evidence-based practice seminars are conducted once per week for

seven weeks in Term 4 only (second year students). Clinical placements are full-time fieldwork

education opportunities of varying length (either four or eight weeks). Clinical placements are

supervised by clinicians who commit to offering learning opportunities and the necessary support to student occupational therapists (referred to in this context as *preceptors*) [55]. The clinical placements involved in this study occurred between Term 1 and Term 2 (first year students) and between Term 4 and Term 5 (second year students). PBL tutor, EBP facilitator, and clinical preceptor are three distinct roles but were considered one target audience for this on-line education module because they comprise all educational roles provided by people who are practicing clinicians for this university.

Participant recruitment took place in September and October 2016 in the following two ways. First, for tutors and facilitators, an e-mail was sent several days in advance of their first tutor/facilitator meeting informing them of the project. Then, the corresponding author attended an initial tutors'/facilitators' meeting to further explain the project and request participation. These meetings are typically held on-site at the university thereby facilitating a face-to-face request. Those interested were asked to provide their name/e-mail address and the study was initiated within one week. Second, for preceptors, an e-mail was sent approximately two weeks prior to the start of the study to outline the project and request participation (preceptors typically do not convene prior to clinical placements). Those interested in participating were asked to contact the corresponding author directly by e-mail. The corresponding author is a doctoral student with no regular interaction with clinician-educators and no influence over their role at the university. As such, the risk of perceived power differential resulting in coercion to participate was believed to be minimal. Furthermore, the voluntary nature of participation was emphasised during recruitment. Several clinician-educators act in more than one role. The numbers reported here indicate the role of participants when they were recruited to the study. In total, 157 clinician-educators were invited to participate: 33 tutors (≈ 21%), 10 facilitators (≈ 6%), and 114

preceptors (≈ 73%). A total of 50 clinician-educators indicated interest in participating by sharing contact information. Figure 3 provides a flow chart describing recruitment and participation.

Figure 3   Participant Recruitment and Participation
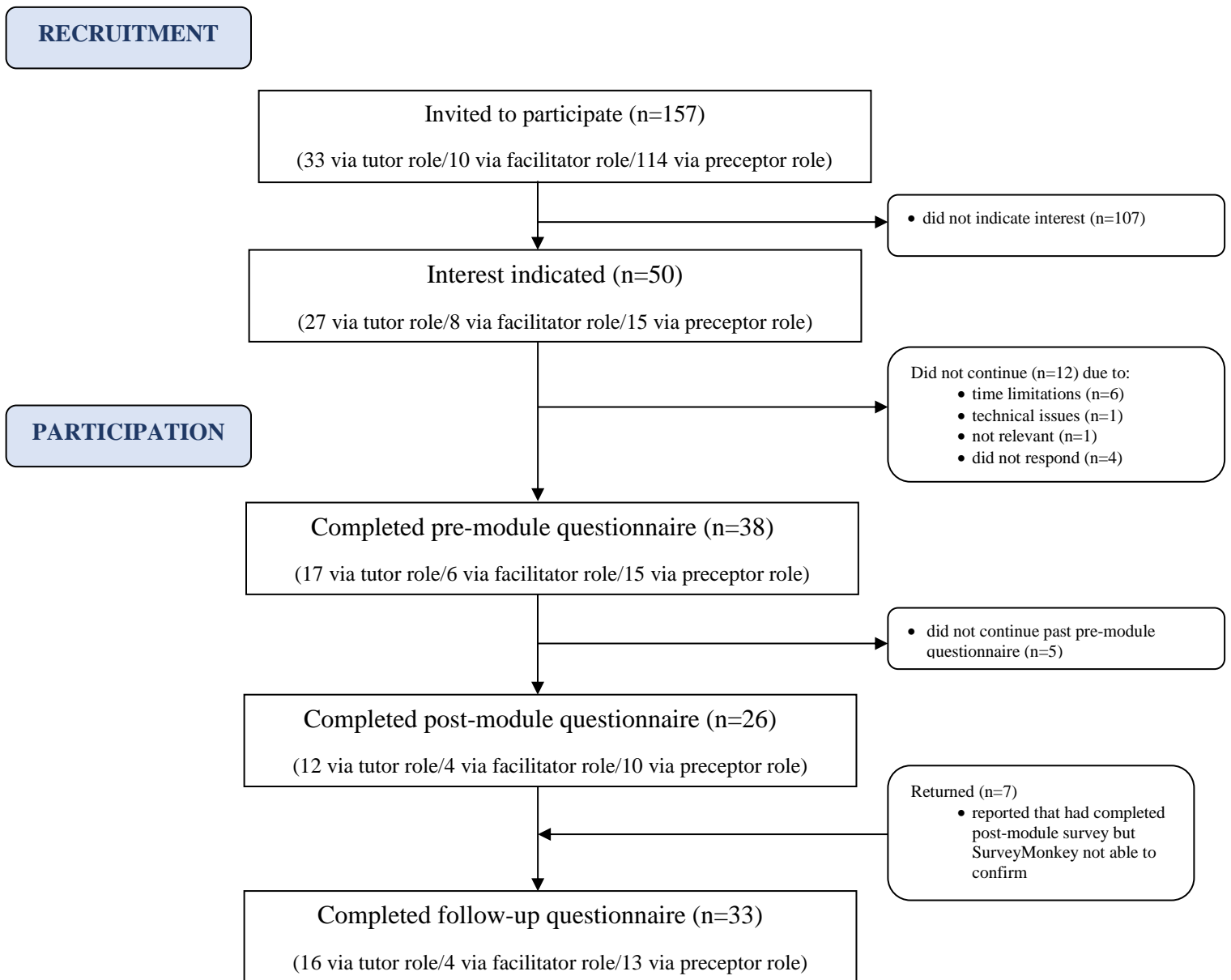
N.B. Please refer to Participant section for a description of tutor, preceptor, and facilitator roles.

Ultimately 33 participants completed the pre-module questionnaire and the follow-up

questionnaire. Of those 33 participants, 8 reported more than one role. However, 16 participated

via their role as tutor (≈ 48% of invited tutors), 4 participated via their role as facilitator (≈ 40%

of invited facilitators), and 13 participated via their role as preceptor (≈ 11% of invited

preceptors). A completed post-module survey was received for 26 of the 33 participants that

completed the study. Although the remaining 7 participants reported that they had completed the

post-module survey, the SurveyMonkey ® technical support team stated that they were unable to

locate these questionnaires. Post-module surveys for these participants is considered missing

data. Statistical analyses were guided by published literature relating to handling missing data

[62,63].

Data Collection

Three parallel questionnaires were developed by the corresponding author for the purposes of

data collection: a pre-module viewing questionnaire (see Appendix G), a post-module viewing

questionnaire (see Appendix H), and a follow-up questionnaire (see Appendix I). Design of

survey questionnaires was based on a review of questionnaires for a similar project in

rehabilitation as well as published literature [35,64-68]. Although the questionnaire was not

piloted before being distributed, all co-authors provided input into questionnaire development

and the questionnaire was revised multiple times before use. Questionnaires were posted on

SurveyMonkey ®. Participants were asked to complete the pre-module questionnaire, view the

module at the hyperlink provided, then complete the post module questionnaire. This was to be

completed prior to or at the start of their work with the students. Then clinician-educators

engaged in their role with students. As previously described, time working with students varied

from once weekly for seven to twelve weeks (for evidence-based practice facilitators and

problem-based learning tutors) to full-time for either four or eight weeks (for clinical placement preceptors). Follow-up questionnaires were sent to participants after their work with students (i.e. within one week following completion). The corresponding author tracked all responses and sent up to two reminder e-mails to participants for each questionnaire (one week/two weeks after questionnaire sent) as required.

Questionnaires had three parts. Part A (General Information) was designed to collect descriptive data and to track participant identifiers. Part B (Self-Assessment of Knowledge and Skill) consisted of 12 questions designed to gather information regarding self-reported ethics knowledge (e.g. *I have a good understanding of ethical decision making in occupational therapy*.) Part C (Role as Tutor/Preceptor/Facilitator) consisted of 7 questions designed to explore the extent to which clinician-educators addressed and/or planned to explicitly address ethics education in their work with student occupational therapists (e.g. *I will explicitly highlight and discuss the ethical dimension of clinical cases in my discussions with student occupational therapists*.). Parts B and C were structured in a 7-point Likert response format where 1 was labelled as "strongly disagree", 4 was labelled as "neutral", and 7 "strongly agree" [64]. Parts B and C remained consistent at all three data collection points. Opportunities to provide qualitative feedback to further expand on responses or to comment on module utility, relevance, content level, and quality were provided throughout in the form of single textboxes. These open-ended questions varied across questionnaires as relevant to each stage of the process. Please refer to table 3 for examples of open-ended questions from each questionnaire.

A composite score was calculated for both Part B (Self-Assessment of Knowledge and Skill) and Part C (Role as Tutor/Preceptor/Facilitator). Two questions in Part B were removed when calculating the composite score. One question was removed due to duplication related to the

essence of the question (as opposed to the exact wording of the question itself) as determined by

the corresponding author. Another question was removed because it related to general awareness

of regulatory body documents regarding ethics not ethics knowledge specifically [69]. The

composite score for Part B consisted of the sum of ordinal response numbers (one to seven as per

Likert response format) of the 10 remaining questions and the composite score for Part C

consisted of the sum of ordinal response numbers to all 7 original questions. Missing values were

imputed using mean substitution [70].

Table 3

Examples of Open-Ended Survey Questions

Survey	Questions
Pre-Module Questionnaire	Please describe any formal ethics training that you may have completed. Please provide any additional relevant information in the box below.
Post-Module Questionnaire	Please comment on the length of the module. Please comment on the relevance of the module to your work as a PBL tutor/clinical placement preceptor/EBP facilitator. Please comment on the content of the module (e.g. too simple/too complex). Please comment on the vignettes and interactive activities.
Post-Module Questionnaire	Have you gone back to review the module since your first viewing? Please explain. Have you had the opportunity to discuss the module with colleagues since viewing e.g. in the context of a tutor's meeting? Please provide any relevant additional information in the box below including specific examples of if/how your practice as a tutor/preceptor/facilitator was adapted or changed as a result of viewing the module.

Data Analysis

Data analysis was completed using the Statistical Analysis System (SAS)© developed by SAS Institute Inc. The Kolmogorov-Smirnov test for normality indicated that all distributions could be assumed normal ($\alpha=0.01$) [71]. Student's t-tests were used to determine whether mean differences between paired data (pairings outlined in Results) significantly differed from zero (H_o: $\mu_o=0$) [72]. These parametric tests were applied given that the ordinal data (from Likert responses) was converted to numerical data via the composite score and treated as continuous data [73,74].

Responses gathered via open-ended questions were collated and analyzed using a conventional content analysis approach [75-77]. Content analysis consisted of three main phases: preparation, organizing, and reporting [77]. Preparation involved becoming familiar with data through a process of immersion. Organizing data involved creating and describing categories. Although open-ended questions can add rich data to survey results [68], text boxes were often left blank and answers provided were generally brief. However, the processes of becoming familiar with data through immersion and organizing data into categories allowed for the development of four categories which were informed by several responses: impact on knowledge, impact on practice, general feedback (e.g. content/relevance/length), and suggestions.

Results

The final analysis sample (n=33) consisted of two males and 31 females. Years of clinical practice experience varied widely from less than one year to 37 years (mean=19.3 years). Practice area spanned a range of diagnostic categories and practice contexts. Number of years in

their role as clinician-educator varied from one participant being in the training phase (tutor-in-training) to three participants reporting at least 30 years of experience (mean=12 years).

Self-Assessment of Knowledge and Skill

Paired t-test compared *pre-module* to *post-module* questionnaire knowledge scores to test for improvement in self-assessment knowledge. Results indicated that viewing the module led to a statistically significant improvement in self-reported ethics knowledge (t = 8.275, p < 0.01). Several participants noted that the module was an effective learning tool to increase ethics knowledge both theoretically and practically. For example, Participant #31 (preceptor/facilitator) stated that viewing the module led to "increased understanding of the theoretical and philosophical underpinnings and how these link to decision-making in practice" and Participant #10 (tutor) stated that "I feel that I now have more tools/resources at my disposal…". Several participants also reported that ethics knowledge acquired through viewing the module would not only be applied to their role as clinician-educator but was also highly relevant/applicable to their clinical role. Participant #14 (tutor) stated that:

> The core concepts introduced are very relevant to my work as an OT. I now feel that I
> actually have the words available to me to express concern when I see something
> happening, rather than trying to convey the feelings of discomfort I may have.

Another finding regarding knowledge was that viewing the module appeared to stimulate a desire for additional and on-going learning regarding ethics. Several participants expressed a desire to share new knowledge with colleagues. One participant, for example, reported: "I will use this experience for my personal development goals and plan for [regulatory body] this year to continue to address my own learning." (P #31, Preceptor/Facilitator)

Paired t-test comparing *post-module* and *follow-up* knowledge scores indicated that there was not a statistically significant decrease in ethics knowledge (t = -1.483, p = 0.075) suggesting that ethics knowledge was at least sustained throughout the clinician-educators' work with student occupational therapists. One participant (P #26, tutor) suggested that clinician-educators be reminded/required to review the module annually to ensure that knowledge is sustained long term.

Role as Tutor/Preceptor/Facilitator

Paired t-tests compared Part C of *pre-module* to *post-module* questionnaires to assess for change in participants' *intent* to change facilitation approach with student occupational therapists regarding ethical decision-making (i.e. making ethics/ethical decision-making more explicit and supporting ethical decision-making in the context of clinical cases). Results of the paired t-test indicated that viewing the module led to a statistically significant improvement in self-reported intent to change practice, including making ethics/ethical decision-making more explicit and supporting ethical decision-making among student occupational therapists (t = 4.93, p < 0.01). Several participants commented that viewing the module increased their awareness of the importance of their role in addressing ethics/ethical decision-making and increased their awareness of when, where, and how ethics and ethical decision-making could be discussed. Participant #30 (tutor), for example, stated "I now realize how important my role is in fostering their ethical decision-making…" Most participants described the module as being very relevant to their role as clinician-educator and reported that the module has encouraged practice change. Participant #7 (tutor) stated:

A very useful learning module. Has inspired me to encourage students to bring ethics to the forefront of their discussions in tutorial and explore ways they can make their ethical

reasoning more explicit-such as through consideration and application of the theories and

tools reviewed. It has also inspired me to reflect my own practice and try to do the same.

Participant #13 (facilitator) reported intent to change practice stating:

I think it is relevant to the application part of the EBP process and therefore useful to

highlight the different ways in which ethics can be approached. I have been doing it from a

typical bio-ethics point of view but might be interesting to review different

approaches…will give thought to how to approach in a timely way.

Finally, a paired t-test was conducted comparing *pre-module* and *follow-up* module change

scores to determine whether viewing the module led to a statistically significant difference in

actual self-reported change in facilitation practice. This was not supported ($t = -1.499$, $p =$

0.072). Some qualitative data speak to this finding. Two participants reported that the clinical

problems used in tutorial sessions were not conducive to highlighting ethics/ethical decision-

making and/or student occupational therapists did not prioritize the ethical component of the

problem (P #22, tutor/facilitator and P #30, tutor). Several participants reported that the module

did not provide sufficient education/preparation to elicit practice change. Participant #11 stated

"I think it would be valuable to do a refresher…there needed to be more exposure to the

information and more time to integrate it…". Additional training resources outside of the

module, increased frequency of module viewing, a more in-depth module, and written

notes/handouts were also listed as recommendations to better support clinician-educators in

facilitating ethical decision-making with student occupational therapists. Participant #19 (tutor)

provided another perspective regarding timing:

Unfortunately, the nature of once weekly tutorials did not provide many opportunities to

take the discussion into more theoretical realms of decision-making-[it] should be easier to

introduce and explore in first year when there are less time constraints and continue with

prompting once the knowledge is more familiar in second year.

Despite this finding regarding barriers to implementing the module teaching, five of the 33

participants provided explicit examples of incorporating changes to their facilitation approach.

Participant #30 (tutor), for example, stated that "I encouraged students to reflect on potential

ethical issues for each problem" and Participant #24 stated that viewing the module "prompted

me to open the door to discuss".

Discussion

This paper describes the development and evaluation of a theoretically and empirically based

on-line education module developed for clinician-educators in the MSc OT program at one

Ontario university. In doing so, this paper furthers the literature by reporting preliminary

findings of how an on-line education module was used to address the gap in ethics training

among clinician-educators. Fifteen years ago (2003) three influential scholars in the field of

ethics in rehabilitation [78] convened leaders in ethics education in physiotherapy and

occupational therapy in the United States for a 3-day conference regarding ethics education in

rehabilitation. This "dreamcatchers" initiative was influential in promoting scholarship in ethics

education in rehabilitation [78,79]. Since that time, research and scholarly discussion within

rehabilitation has continued to evolve providing a basis for development of this on-line education

module [8,15,26,40-48]. However, debates persist regarding the ideal quantity, content, or

pedagogical approach to ethics education in rehabilitation [3,5,13,16]. As such, continued

development of a body of literature and knowledge regarding ethics teaching has been called for

within occupational therapy [5,39]. Although this manuscript furthers the literature by reporting

preliminary findings for an on-line ethics education module in occupational therapy, ongoing

development of additional resources and learning opportunities to promote clinician-educator preparedness regarding facilitating the development of sound ethical decision-making skills among student occupational therapists is recommended.

This is the first known module to address the noted knowledge gap in ethics education among clinician-educators in occupational therapy. Results of this study provide empirical support for the use of an on-line ethics module in imparting basic ethics knowledge, increasing awareness of main messages regarding ethics education, and encouraging commitment to change practice. Results also illustrate the challenge of an on-line module in effecting practice change in how clinician-educators facilitate ethical decision-making with students. Translating knowledge to practice is a common issue in knowledge translation in health care [80]. However, it is imperative to further address this finding of the absence of actual practice change. In a similar study published within this journal, Gross and Lowe [81] reported that a knowledge translation initiative to encourage the uptake of evidence-based information among community physiotherapists ultimately effected little change in clinical practice. To address this challenge in facilitating practice change, Gross and Lowe [81] encouraged a more robust consideration of contextual factors such as lack of time and organizational support [81]. These factors were also evident in feedback gleaned from clinician-educators in this study. For example, the primary reason given for not participating (by those that indicated interest but did not complete the study) was time limitations. Clinician-educators often carry a full clinical caseload and supporting student OTs is supplemental. Time limitations due to existing work burden for practicing clinicians is an understandable and well-documented barrier to participation in research [82,83] that should have been anticipated during the *assessment of potential barriers to knowledge use* phase of this study. Had this barrier been identified then contextual adaptations could have been

employed to mitigate time barriers such as (a) providing more lead time which may have allowed

clinician-educators to plan for and schedule participation in advance (instead of the several days

for tutors/facilitators or two weeks for preceptors given in this study) and/or (b) allotting time

during already scheduled tutor/facilitator meetings to view the on-line education module.

In addition to time barriers identified above, two systematic reviews of studies that evaluated

knowledge translation interventions in rehabilitation identified additional limitations in effecting

practice change. More specifically, results of both systematic reviews indicated that educational

interventions alone were limited in leading to practice change and that multi-component

knowledge translation interventions may be more likely to result in actual practice change

[84,85]. Multi-component knowledge translation interventions included interactive education

sessions, post-intervention follow-up discussions, printed materials such as information sheets,

and outreach visits (both with and without opinion leaders) [84,85]. Levac et al. [34] put forth a

cogent set of best practice recommendations to guide the development, implementation, and

evaluation of e-learning modules in rehabilitation [34]. As part of their fourth recommendation,

Share Results and Disseminate Knowledge, Levac et al. [34] suggested strategies such as

outreach visits at stakeholder meetings, maintaining and updating the on-line module, and/or

continuing to provide information on relevant web-sites. Critical reflection on the literature

reviewed above vis-à-vis this study combined with qualitative data gathered and reported in the

Results section indicate that several contextual barriers and additional educational strategies

could have been considered which may have increased the likelihood of practice change. For

example, explicit opportunities to apply information contained in the on-line module could have

been created within the occupational therapy curriculum so that ethical dimensions of clinical

problems might have been highlighted e.g. revising cases studies used in PBL tutorials and EBP

seminars. Discussion and idea sharing regarding applying the information contained in the module could have been encouraged and facilitated during weekly meetings. Written notes or handouts could have been provided to clinician-educators which summarized information contained in the module thereby increasing accessibility and application of information during interactions with student occupational therapists. Educational outreach activities could have been undertaken by the corresponding author (and main developer of the module) such as attending follow-up tutor/facilitator meetings or providing a contact e-mail to answer questions from clinician-educators (including clinical placement preceptors who are geographically dispersed). Finally, creating subsequent supplemental learning opportunities may have also contributed to practice change given feedback from several participants that viewing the module itself did not provide sufficient preparation. In general, a more thorough assessment of the context of clinician-educators for barriers to practice change and the inclusion of supplemental knowledge translation interventions are recommended for future iterations of this on-line ethics module or for the development of other similar on-line ethics modules. Doing so may address noted limitations of this on-line approach and may further support clinician-educators in effecting practice change [29].

The use of KT frameworks is intended to guide the development of educational programs, including assessment of barriers to practice change in rehabilitation [86,87]. Frameworks must be thoughtfully chosen and intentionally applied to best suit specific projects [86]. However, Hudon et al. [86,p.634] indicated that there is "continuing uncertainty about the relative strengths and limits of different KT frameworks, raising questions about which one would be the best to select for a given KT project." Several frameworks were thoughtfully considered to guide development and implementation of this on-line education module [29,88,89]. Ultimately the

KTA process put forth by Graham et al. [29] was chosen for multiple reasons. One such reason is that the KTA process allows for knowledge creation that becomes increasingly useful, relevant, and ready for implementation as it is filtered through the funnel [29,90,91]. This step was considered fundamental since knowledge regarding the broad field of ethics was to be tailored to the complex paradigm of ethical decision-making in occupational therapy. Furthermore, the KTA process is dynamic and fluid which allowed for various aspects of both the knowledge creation and action phases to be altered to reflect the development of this specific education module [29]. Despite these noted benefits of the KTA process in guiding module development, its utility in facilitating assessment of barriers to knowledge use may have been limited in this context given that several barriers (discussed above) were not considered. As indicated in figure 1, assessment of potential barriers to knowledge use is part of the KTA process [29]. However, limited guidance is provided in doing so (e.g. some potential barriers are not explicitly listed for consideration). Instead barriers to knowledge use were identified through literature review and drawing on the experience of the research team. Given that the KTA process allows for concurrent use of other resources, incorporating determinate frameworks specifically aimed at identifying barriers and planning for behavior change (e.g. Theoretical Domains Framework) may be one useful consideration when employing the KTA process in rehabilitation [92-94].

Although this study was not formally modelled on a train-the-trainer approach to education, one of the main goals of the on-line module is consistent with this approach: providing basic training/tools to clinician-educators about how to more explicitly address ethical reasoning during case-based discussions so that they, in turn, could best educate student OTs [95]. There were several advantages to using this approach, the foremost of which included extending the ethics curriculum beyond classroom ethics lectures to small group learning and clinical

placement contexts via clinician-educators. As previously discussed, research indicates that case-based learning, which occurs in small groups and on clinical placements, can facilitate the integration of ethics knowledge and support the development of ethical decision-making ability [8]. Using an on-line format for this education module allowed for flexibility in access including time, place, and pace of learning, and facilitated reaching a larger audience of clinical preceptors who may be geographically dispersed and not typically able to attend on-site training [34,95]. This flexibility addresses concerns expressed by clinician-educators regarding adequate preparedness, access to necessary resources, and time limitations [96,97]. Despite these significant benefits, some issues with this on-line approach were highlighted through the study. Several participants reported experiencing technological issues related to difficulty accessing the module via certain web-browsers and problems with moving back to previous screens. Several others felt that the on-line format was too limited and expressed a desire for a more in-depth education intervention involving additional resources, refresher courses, and/or opportunity for interactive discussion to better support/integrate new learning. As suggested by participants and previously discussed, supplemental in-person knowledge translation activities may mitigate these noted barriers to an on-line education format.

Several limitations to this study have been identified which foreground potential areas of change/improvement for future research. A response rate of approximately 21% of clinician-educators invited to participate limits the generalizability of study findings [98]. It may be that those clinician-educators who chose to participate were early adopters and possibly more committed to the process of learning and/or practice change thereby reflecting a volunteer bias [99]. Salkind [99] provided several suggestions to reduce volunteer bias which may be relevant to this study/educational intervention including communicating the benefits of the educational

intervention to potential participants in a way that is interesting and that highlights its practical application. Providing compensation/incentives can also be used to mitigate low response rate [83,99] but were not available for this study. In this study, clinical preceptors represented the lowest response rate among those invited ($\approx 11\%$ of invited preceptors participated). It may, therefore, be important to consider how to further engage this sub-group of clinician-educators in the process of ethics education. Clinical preceptors were recruited via an e-mail invitation since they typically do not convene at the university whereas tutors/preceptors were recruited via face-to-face meetings where there was an opportunity for questions/discussion including discussion regarding the relevance of the on-line module to the work of clinician-educators and the potential benefits to student OTs. Evanson et al. [96] reported that opportunities for professional development were ranked as important to clinical preceptors in occupational therapy and that clinical preceptors viewed their role with student OTs as significant. The benefit to viewing the on-line module to both the clinician-educator and student OTs may have been more clearly communicated in face-to-face recruitment meetings with tutors/facilitators than in the e-mail invitation sent to clinical preceptors thereby accounting for higher percentage of participation of tutors/facilitators. Clinical preceptors are highly influential in the development of applied skills and essential competencies for practice [96,100]. As a result, to expand the reach/impact of the on-line module to learning among student occupational therapists, it is recommended that the benefit to viewing the on-line module to professional development and to the role of clinical preceptor be more clearly explicated in e-mail communications. In addition, opportunities for face-to-face discussion with clinical preceptors either in person or via internet (e.g. Skype) could be considered. As previously stated two questions in Part B were removed when calculating the composite score. Pilot testing the questionnaires on a small sample of potential participants could

have prevented this issue [101]. This study utilized a non-randomized study design with no comparison/control group [60,102]. Use of an experimental or quasi-experimental design involving a control group is needed to ensure that noted improvements could be attributed to the educational intervention thereby strengthening the validity and credibility of study findings [60,102]. Furthermore, the use of multiple paired t-tests may have increased the potential for a Type 1 error [103]. More robust statistical analyses with larger sample sizes are also recommended for future research. Text boxes intended to gather supplemental data were often left blank and answers provided were generally brief. Non-response is a common concern when using open-ended survey questions [70,104]. Utilizing a mixed method design is recommended since qualitative data collection methods gather rich and in-depth data that can be useful to informing rehabilitation [105,106]. Sequential or concurrent mixed methods procedures could be considered [106]. Finally, this study was conducted at one Ontario university. Evaluating the on-line module in the contexts of other educational institutions is recommended to facilitate generalizability.

Conclusion

This paper reports findings of a study that examined the impact of viewing an on-line ethics education module on clinician-educators' ethics knowledge and teaching practices related to facilitating ethical decision-making among student occupational therapists. Development of this theoretically and empirically based on-line education module was informed by the *Knowledge-to-Action Process*. Clinician-educators who participated in this research study reported a sustained increase in ethics knowledge and an intent to incorporate strategies to explicitly address ethics within the context of their work with student occupational therapists. However, the study findings indicate that this intent to change was not consistently implemented. Despite

this finding and other noted limitations in sample size and study design, this study provides preliminary data regarding the value of training clinician-educators via on-line ethics education. It is recommended that future iterations of this on-line education module and other similar interventions incorporate multiple components in addition to an on-line module format. This may include supplemental interactive educational sessions, post-intervention follow-up discussions, or outreach visits. A broader consideration of context is also recommended. Furthermore, although this manuscript reports findings for an on-line ethics education module, ongoing development of additional resources and learning opportunities to promote clinician-educator preparedness regarding facilitating the development of sound ethical decision-making skills among student occupational therapists is recommended. Finally, further research which explores outcomes in other university contexts, with larger sample sizes, longer follow-up, and randomized trial methodology is required to address the needs of ethics educators, including clinician-educators, across rehabilitation disciplines to best provide ethics education to future rehabilitation professionals.

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Acknowledgements

Chapter 5: Conclusion and Implications

The overall aim of this PhD thesis was to explore ethical decision-making in occupational therapy practice in Canada in order to advance epistemological development regarding ethical decision-making and ultimately to support practice. After setting the context in Chapter 1 regarding ethics and occupational therapy, the next three chapters provided results of three studies that progressed from building a theoretical understanding of ethical decision-making in occupational therapy, to identifying gaps and directions for development to support continuing competency in ethical decision-making, and finally to an evaluation of an on-line education module designed to build competency among occupational therapy clinician-educators and ultimately student occupational therapists. The first manuscript presented in Chapter 2 titled *Doing What's Right: A Grounded Theory of Ethical Decision-Making in Occupational Therapy* advanced knowledge in occupational therapy by outlining a descriptive ***theory*** of ethical decision-making that was grounded in and emerged from participants' descriptions of their day-to-day clinical practice. The second manuscript presented in Chapter 3 titled *Continuing Competency in Ethical Decision-Making: Current Gaps and Future Directions* advanced disciplinary knowledge related to perceived challenges to continuing competence in ethical decision-making in ***practice*** and identified necessary supports for continuing competency from the perspective of Canadian occupational therapists. Finally, the third manuscript presented in Chapter 4 titled *On-Line Ethics Education for Occupational Therapy Clinician-Educators: A Single-Group Pre- Post Test Study* described the development and evaluation of a theoretically and empirically based on-line ethics ***education*** module that was developed for occupational therapy clinician-educators. Results of this study advanced disciplinary knowledge by providing preliminary data regarding the use of an on-line ethics module to cultivate basic ethics

knowledge and encourage commitment to explicitly address ethical decision-making with student occupational therapists. Thus, the body of work contained in this PhD thesis is consistent with a central dynamic within occupational therapy: that of theory development, research, practice, and education synergistically informing one another (Kielhofner, 2005; Suarez-Balcazar & Hammel, 2015).

Common Themes

There are two common themes in this thesis that warrant further discussion: ethics education and ethics support. I have argued that a more robust program of *ethics education* is required in occupational therapy, including both pre-licensure programs and continuing education for practicing occupational therapists. The study presented in Chapter 2 indicated that very few participants drew on ethics knowledge to inform ethical decision-making despite the importance of this knowledge base noted in the literature (Barnitt, Warbey, & Rawlins, 1998; Kanny & Slater, 2008). If occupational therapists do not possess ethics knowledge, then it cannot be readily applied. In the study presented in Chapter 3, participants who had received ethics education expressed multiple benefits including being able to perceive and understand ethical issues more readily and an increased comfort level in making and enacting a broader range of ethical decisions even when situations were ethically complex. Participants expressed a desire for formalized and ongoing ethics education on a broad range of topics and in a variety of formats. In Chapter 4, one approach to providing ethics education was highlighted. The clinician-educators who participated in the on-line ethics education module reported a sustained increase in ethics knowledge. Participants also expressed multiple benefits to ethics knowledge obtained including having a better understanding of the theoretical and philosophical field of ethics, a greater awareness of how ethical theory can inform ethical decision-making, and increased

awareness of how to approach ethics teaching with student occupational therapists. Several

participants noted that viewing the on-line module stimulated a desire for additional ongoing

learning regarding ethics.

However, as highlighted throughout this PhD thesis, there are several barriers related to ethics

education for occupational therapists. One is the lack of consensus regarding a pedagogical

approach to ethics education including the number of hours or type of education required to

cultivate sufficient and sustained knowledge or to effect practice change. Through this program

of research, I have identified that didactic ethics education alone may not be sufficient in

effecting practice change (Chapter 4). Instead, ethics education for practicing occupational

therapists should extend beyond traditional didactic activities (e.g. lectures and workshops) to

include multiple components such as educational outreach and the maintenance of web-sites and

focus on identifying and measuring tangible outcomes related ethical decision-making in day-to-

day practice (Chapters 3 and 4). Another noted barrier to ethics education is the time

commitment required by therapists to engage in quality education. As noted in Chapter 4, there

were occupational therapists who initially indicated interest in the on-line educational

intervention but who did not subsequently view the module. Lack of time to participate in

educational interventions is a commonly identified barrier to knowledge translation in

occupational therapy which must be addressed when planning educational interventions (Bennett

et al., 2016). Contextual assessment and resulting adaptations can and should be employed to

mitigate time barriers. Lack of awareness regarding current ethics resources may also be a barrier

precluding occupational therapists from engaging in ongoing learning regarding ethical decision-

making (Chapter 3). As a result, I recommended that the utility and availability of current tools

to guide ethical decision-making be further explored as well as mentorship opportunities to

promote ongoing learning regarding ethical decision-making. I do feel, however, that one of the foremost barriers to ethics education as noted in this research is the pressing need for scholarship in occupational therapy to develop a body of ethical knowledge, rooted in philosophy, but critically applied to the theory and practice of occupational therapy. Cruess, Johnston, and Cruess (2004, p. 76) stated that "it seems axiomatic that an educational activity aimed at teaching an abstract concept should begin by first defining the concept." As noted in Chapter 1, research and scholarly discussion regarding ethics in rehabilitation has evolved substantially over the last fifteen years. However, throughout this PhD thesis I have identified several areas where there is a lack of clarity in concepts related to ethics in occupational therapy including: the definition of ethical decision-making and an understanding of its relationship to reasoning (as discussed in Chapter 2), a clear definition and description of ethical practice and ethical competency (as discussed in Chapter 3), and an understanding of ethical theory and its application to ethics education in occupational therapy (as discussed in Chapter 4).

The second common theme across this PhD thesis is *ethics support*. The findings across several studies highlighted the ways in which support regarding ethics and ethical decision-making was sought, requested, and recommended. Finding also highlighted several contextual factors that may support or limit ethical decision-making. In the grounded theory study (Chapter 2), one of the main processes identified was *Consulting Others*. When participants could not come to an ethical decision on their own, they sought support for ethical decision-making from a range of sources including colleagues, supervisors, legal experts, and ethicists. This process of seeking support often facilitated ethical decision-making and this finding suggests that, although ethical decision-making is presented as an individual process, it may involve varying degrees of collaboration. In the interpretive description study outlined in Chapter 3, participants explicitly

identified a gap in support for ethical decision-making and expressed a desire for formal support in the form of ethics mentors. Participants who practiced within a context that provided access to ethics supports (e.g. ethicists and other ethics personnel) found this to be very useful to guide decision-making. Participants expressed a desire for formal ethics mentors who were readily available, knowledgeable about ethics, and knowledgeable about specific practice areas. Due to the method utilized (secondary analysis) and outlined in Chapter 3, the study did not extensively interrogate additional gaps related to supports within practice contexts (e.g. institutional structures). Gaps related specifically to contextual support, including institutional structures, should be examined in future research relating to ethical decision-making. Finally, one of the main findings of the study presented in Chapter 4 was that an ethics education module alone was not sufficient in leading to practice change. Additional support for ethics education was recommended in the form of post-intervention follow-up discussions with other occupational therapists and ongoing discussion via outreach visits with opinion leaders. This recommendation is consistent with the literature relating to both continuing professional development (Chapter 3) and knowledge translation (Chapter 4) (Menon, Korner-Bitensky, Kastner, McKibbon, & Straus, 2009; Sargeant et al., 2011; Scott et al., 2012; Wallace & May, 2016).

This PhD thesis advances disciplinary knowledge by furthering our understanding of ethical decision-making in day-to-day clinical practice, identifying continuing competency needs of occupational therapists related to ethical decision-making, and reporting preliminary findings of how an on-line education module was used to address the gap in ethics training among clinician-educators. However, by highlighting both the common themes identified in this conclusion chapter and the outstanding issues and further recommendations contained within each chapter,

this PhD thesis has broader implications for occupational therapy. The *Scholarship of Practice Model* will now be used to contextualize discussion of potential implications.

Implications

The *Scholarship of Practice Model* was developed within occupational therapy to advance both knowledge generation and practice enhancement (Hammel, Finlayson, Kielhofner, Helfrich, & Peterson, 2002). Scholarship of practice is defined within the model as a dialectical relationship between theoretical and empirical knowledge and issues of practice in occupational therapy. The three main components of the scholarship of practice model are: theory development and research, occupational therapy practice, and external organizations. A key underpinning of the model is that "in a profession such as occupational therapy legitimate scholarship is devoted to improve practice" (Kielhofner, 2005, p. 9). The value of scholarship lies in its ability to support and enhance practice thereby improving practice outcomes. Another key underpinning of scholarship of practice is the importance of synergistic relationships between researchers, practitioners, and external organizations that support research and practice (Braveman, Helfrich, & Fisher, 2002). External organizations must have complementary and theoretically consistent goals for occupational therapy and the nature of their relationship to research and practice must be clear (Braveman et al., 2002). The scholarship of practice model is consistent with the overall aim of this thesis: advancing knowledge in occupational therapy to support ethical practice.

Theory Development and Research

Central to the *Scholarship of Practice Model* is a commitment to *theory development and research* that contributes to the practice of occupational therapy. As stated, this PhD thesis has contributed theory development and research by advancing a theoretical understanding of ethical

decision-making in occupational therapy practice and an applied understanding of occupational therapists' needs related to competent ethical decision-making. In addition, preliminary data was reported regarding on-line ethics education to advance the knowledge and skills of clinician-educators. Furthermore, several important areas where additional epistemological development in the form of theory development and research related to ethics in occupational therapy were identified. I have argued that occupational therapy requires: (a) a general professional consensus about definitions regarding ethical decision-making and its relationship to clinical reasoning, (b) a robust and active ethics discipline that includes scholarly discussion and research regarding ethical theories and concepts and their potential application to occupational therapy practice; (c) further analysis of the influence of the institutional context of practice on ethical decision-making; (d) effective educational interventions to bridge knowledge and clinical practice including tools and resources to support ethical decision-making, and (e) a cogent ethics curriculum for both pre-licensure and practicing occupational therapists to support sustained and ongoing learning regarding ethical practice.

One promising development within the profession is the emergence of forums for ethics educators in rehabilitation to discuss and exchange knowledge and ideas regarding ethics teaching such as the CREW Day held at McGill University (discussed in Chapter 1 and Chapter 4) and the "dreamcatchers" initiative in the United States (discussed in Chapters 1, 3, and 4). Convening ethics scholars as a community of researchers can be highly productive in producing, transforming, and disseminating knowledge (Cheek, Corlis, & Radoslovich, 2009; Hudon et al., 2016; Jensen, Brasic-Royeen, & Purtilo, 2010; Omidvar & Kislov, 2013). More specifically such communities can provide an important opportunity to promote and scholarship in ethics in rehabilitation, identify priority content for teaching ethics, explore effective pedagogical

approaches to ethics education, identify new research directions, and create networks of researchers invested in ethics. Ongoing communities of research and practice regarding ethics and occupational therapy may help to continue to move the field forward but should also include practicing occupational therapists. Consistent with the scholarship of practice model, such communities can provide scholars with the opportunity to obtain input regarding issues encountered in day-to-day practice, both by individual occupational therapists and occupational therapists collectively, and to develop network of researchers who can then conduct research that is responsive to such issues (Kielhofner, 2005).

Occupational Therapy Practice

The role of *practice* in the *Scholarship of Practice Model* is to inform theory and research by bringing forward issues that arise in practice. Collaboration with individuals and organizations to enact change is a key competency for occupational therapy practice (Verma, Paterson, & Medves, 2006). Baptiste (2011, p. 27) reinforced the role of individual occupational therapists in collaborating with scholars and professional organizations in a spirit of "mutual exchange and alliances…framing the practice dilemmas and questions…". Drawing on the work contained in this PhD thesis I have identified several ways in which practitioners can collaborate with scholars and professional organizations. First, in all three studies contained in this PhD thesis I had the opportunity to engage occupational therapists as participants and to gather data that was grounded in their practice experience. Their insightful contributions as study participants were integral to this thesis. Although there are several documented barriers to participating in research among occupational therapists including lack of time and lack of organizational support, one main advantage is that it can provide a forum for occupational therapist to express important

issues to be addressed in research (Birken, Couch, & Morley, 2017; Eriksson, Tham, & Guidetti, 2013).

Results presented in Chapters 3 and 4 of this PhD thesis indicate several benefits for occupational therapy practitioners to engage in ethics education including being able to perceive and understand ethical issues more readily and from a broader perspective, having a more robust knowledge base upon which to draw for making ethical decisions, having more confidence in making and enacting a broader range of ethical decisions even when situations are ethically complex, and being better able to cogently articulate ethical decision-making using ethical theory. Unfortunately, several substantial issues and limitations in ethics education in occupational therapy in Canada (both a pre-licensure and practice level) have also been highlighted throughout this thesis. However, I continue to encourage occupational therapists to engage in any available continuing education regarding ethics. In doing so, occupational therapists may not only benefit from new learning, but they will also have a forum to engage with ethics educators to provide feedback regarding educational interventions and voice ongoing needs related to ethics education.

Finally, I encourage occupational therapist to become involved in occupational therapy organizations including national and provincial associations and regulatory bodies. In doing so, occupational therapists will be positioned to provide input regarding ethical issues in practice and to advocate for education, research, and resources to support ethical decision-making in practice. For example, Chapter 3 elucidated a desire amongst occupational therapists in the study for formal ethics mentorship. Although the Canadian Association of Occupational Therapists (CAOT) and Ontario Society of Occupational Therapists (OSOT) mentorship programs are not centred specifically on ethics, content can be personalized according to mentee's self-identified

needs. If occupational therapists become involved as both mentors and mentees their feedback related to potential needs regarding ethics can inform program development. Occupational therapists who currently possess expertise in ethics are encouraged to consider becoming involved as mentors. Furthermore, it may be helpful to build capacity of occupational therapy mentors with respect to the theory and practice of ethical decision-making through educational and training opportunities since highly complex ethical issues may be involved (Aulisio, Arnold, & Youngner, 1998; Benatar, 2006).

External Organizations

The *Scholarship of Practice Model* emphasizes the role of collaborative partnerships with organizations that shape and support research and practice (Suarez-Balcazar & Hammel, 2015). Based on findings of the PhD thesis such organizations include national occupational therapy organizations including the CAOT, the Canadian Occupational Therapy Foundation (COTF), provincial occupational therapy organizations, and provincial regulatory bodies and their national organization, the Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO). Informed by findings of this PhD thesis, some general implications for organizations can be identified. First, organizations providing funding for research, including the COTF and provincial associations can continue to fund research that explores topics raised in this PhD thesis related to ethics in occupational therapy. The task of accessing funding for research in occupational therapy can be "daunting" and the milieu of competitive funding is discouraging for even highly motivated researchers in occupational therapy (Stoykov, Skarupski, Foucher, & Chubinskaya, 2017, p. 3). The studies presented in Chapter 2 and Chapter 3 were generously supported by COTF via the McMaster Legacy Fund in the amount of $1500.00. The study presented in Chapter 4 was supported by the McMaster School of Rehabilitation Science

Technology Innovation Pilot Fund in the amount of $5000.00. These examples indicate that even modest financial support can be leveraged to produce relevant scholarship in ethics in occupational therapy (Jensen et al., 2010).

Second, as knowledge and research regarding ethics in occupational therapy continues to emerge, organizations that support and regulate occupational therapy practice can consider revising and tailoring policies and documents in a way that both reflects epistemological development in the field and that may address potential barriers to ethical decision-making. Research findings contained herein may, in some small way, be relevant to informing changes at an organizational level. For example, provincial regulatory bodies can consider the issues raised regarding the utility of currently available ethical decision-making tools and allocate resources to further development of tools to promote clarity and usefulness. Academic institutions may consider addressing the professional development needs of ethics educators including clinician-educators. Finally, both national and provincial organizations currently provide a myriad of professional development opportunities in the form of on-line and in-person workshops, conferences, webinars, and symposiums intended to meet members' needs regarding ongoing learning. All participants in the studies presented within this PhD thesis are members of either CAOT and/or provincial occupational therapy associations. This PhD thesis indicates that professional organizations providing education could consider ensuring that ethics education is included in their portfolio of educational offerings. Findings reported in Chapter 3 and Chapter 4 may be applied to developing content and format of ethics education.

In summary, the overall aim of this thesis was to study ethical decision-making in occupational therapy practice in Canada in order to contribute to epistemological development regarding ethics and occupational therapy and to support occupational therapy practice. In order

to achieve this aim ethical decision-making was examined from the perspective of occupational therapists in day-to-day practice. A descriptive ethical theory was put forth regarding the process of ethical decision-making which advanced current literature in several ways including clarifying the relationship between ethical decision-making and clinical reasoning. From that point the potential needs of occupational therapists regarding continuing competency in ethical decision-making were elucidated and one educational intervention to support competency was developed and evaluated. Occupational therapy is a rewarding yet challenging profession that "makes considerable demands on the ethical awareness of the occupational therapists" (World Federation of Occupational Therapists, 2016, p. 1). The findings of this PhD thesis can be utilized in light of these demands to support occupational therapists in doing what's right when helping people restore their quality of life through engagement in occupation.

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Appendix A
Hamilton Integrated Research Ethics Board (HiREB) Approval Letter: Project #0670

Hamilton Integrated Research Ethics Board

December 3, 2015

Project Number: 0670

Project Title: Ethical Decision Making in Occupational Therapy Practice in Canada

Principal Investigator: Dr. Sandra Moll

This will acknowledge receipt of your letters dated November 24, 2015 and December 1, 2015 which enclosed revised copies of the Information/Consent Form, Email Script and the Application Form along with a response to the additional queries of the Board for the above-named study. These issues were raised by the Hamilton Integrated Research Ethics Board at their meeting held on November 4, 2015. Based on this additional information, we wish to advise your study had been given *final* approval from the full HiREB.

The following documents have been approved on both ethical and scientific grounds:

Document Name	Document Date	Document Version
Study Protocol	10/13/2015	#1
Information/Consent Form for Participation in Research	12/01/2015	#3
E-Mail Script	12/01/2015	#3
Interview Guide	11/24/2015	#2

The following documents have been acknowledged:

Document Name	Document Date	Document Version
SVanderkaay tcps2_core_certificate	09/29/2015	TCPS2

Please Note: All consent forms and recruitment materials used in this study must be copies of the above referenced documented.

We are pleased to issue final approval for the above-named study for a period of 12 months from the date of the HiREB meeting on November 4, 2015. Continuation beyond that date will require further review and renewal of HiREB approval. Any changes or revisions to the original submission must be submitted on a HiREB amendment form for review and approval by the Hamilton Integrated Research Ethics Board.

PLEASE QUOTE THE ABOVE REFERENCED PROJECT NUMBER ON ALL FUTURE CORRESPONDENCE

Sincerely,

Dr. Raelene Rathbone, MB BS, MD, PhD
Chair, Hamilton Integrated Research Ethics Board

Appendix B
Script for E-Mail Invitation to Participate: HiREB Project #0670

Title of Study: Ethical Decision Making in Occupational Therapy Practice in Canada

Local Principal Investigator: Dr. Sandra Moll
Assistant Professor
School of Rehabilitation Science
McMaster University
Hamilton, Ontario
Canada
(905) 525-9140 extension 23523
molls@mcmaster.ca

Student Principal Investigator: Sandra VanderKaay
PhD Candidate
School of Rehabilitation Science
McMaster University
Hamilton, Ontario
Canada
(905) 933-5934
sandyvdk@gmail.com

Co-Investigators: Dr. Sandra Moll, Assistant Professor, McMaster University School of
Rehabilitation Science

Dr. Lori Letts, Associate Professor, McMaster University School of
Rehabilitation Science

Dr. Joyce Tryssenaar, Associate Professor, McMaster University School of
Rehabilitation Science

Dear (insert name of occupational therapist here)

My name is Sandra VanderKaay and I am a PhD Candidate from the School of Rehabilitation
Science at McMaster University and a registered occupational therapist in Ontario. For my PhD
thesis I am conducting a research study titled *Ethical Decision Making in Occupational Therapy
Practice in Canada.* For this research study I am aiming to interview approximately 25 to 30
practicing occupational therapists from across Canada who represent a broad spectrum of practice

characteristics including: (a) practice contexts, (b) years of experience, (c) education background, and (d) type of positions held. You have been recommended as a possible study participant.

As you may know ethical practice is an essential aspect of occupational therapy. Given the increasingly complex context of health care in Canada, occupational therapists are often faced with ethical decisions in day-to-day practice and may struggle with deciding how to respond. Research that explores ethical decision making among practicing occupational therapists is extremely limited and as a result very little is known about how occupational therapists make ethical decisions in day-to-day practice. The purpose of my study is to develop and describe a theory regarding the ways in which occupational therapists make ethical decisions. My goal is that the resulting theoretical framework will support practicing occupational therapists in engaging in ethical decision making. It is anticipated that this research will also promote increased professional awareness regarding ethical decision making and highlight a need for ongoing knowledge development within occupational therapy regarding this topic.

If you agree to participate in this research you will be asked to do one to two interviews with me and possibly one follow-up session. Interviews are expected to be no more than one hour and a half in duration but may be less. I will contact you to arrange a convenient interview time and method e.g. face-to-face/telephone/Skype. There are no known risks to participating in the research study and you can choose to end your involvement with the research at any time. The main drawback is that you may be asked to share sensitive information regarding your experience of an ethical dilemma. However, this potential drawback would be no more difficult than discussing these cases with colleagues in daily clinical practice.

Although there will be no direct benefit to you for participating in this study, your participation will assist in providing valuable information about ethical decision making in occupational therapy which will hopefully contribute to the advancement of the body of knowledge within occupational therapy. All personal information such as your name, address, telephone number, and e-mail address will be will be safely stored on a computer with advanced encryption technologies and will be kept strictly confidential.

I would be happy to provide you with additional information that may assist you in deciding on your participation in this study. Please feel free to contact me if you have any questions. I look forward to your response.

Thank you.
Sandra VanderKaay
(905) 933-5934
sandyvdk@gmail.com

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HIREB). The HIREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the Chair, Hamilton Integrated Research Ethics Board at 905-521-2100 extension 42013.

Appendix C
Participant Information Sheet and Consent Document: HiREB Project #0670

Title of Study: Ethical Decision Making in Occupational Therapy Practice in Canada

Local Principal Investigator: Dr. Sandra Moll
Assistant Professor
School of Rehabilitation Science
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molls@mcmaster.ca

Student Principal Investigator: Sandra VanderKaay
PhD Candidate
School of Rehabilitation Science
McMaster University
Hamilton, Ontario
Canada
(905) 933-5934
sandyvdk@gmail.com

Co-Investigators: Dr. Sandra Moll, Assistant Professor, McMaster University School of
Rehabilitation Science

Dr. Lori Letts, Associate Professor, McMaster University School of
Rehabilitation Science

Dr. Joyce Tryssenaar, Associate Professor, McMaster University School of
Rehabilitation Science

Sponsor: No funding has been received to support this study.

**You are being invited to participate in a research study conducted by Sandra VanderKaay,
PhD candidate in the School of Rehabilitation Science at McMaster University because you
are an occupational therapist practicing in Canada. In order to decide whether or not you
want to be a part of this research study it is important that you understand the research
purpose and the potential risks and benefits. This form gives detailed information about the
research study. This information will be discussed with you. Once you have reviewed and**

discussed the information you will be asked to sign this form if you agree to participate. Please take time to make your decision. Feel free to discuss this decision with those that may assist you in deciding on your participation.

WHY IS THIS RESEARCH BEING DONE?

Ethical practice is an essential aspect of occupational therapy. Given the increasingly complex context of health care in Canada, occupational therapists are often faced with ethical decisions in day-to-day practice which require coherent and defensible ethical reasoning. Research that explores ethical decision making among practicing occupational therapists is extremely limited and as a result very little is known about how occupational therapists make ethical decisions in day-to-day practice.

WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this study is to develop and describe a theory regarding the ways in which occupational therapists make ethical decisions. The resulting theoretical framework will assist practicing occupational therapists engage in ethical decision making. It is anticipated that this research will also promote increased professional awareness regarding ethical decision making and highlight a need for ongoing knowledge development within occupational therapy regarding this topic.

WHAT WILL MY RESPONSIBILITES BE IF I TAKE PART IN THE STUDY?

If you agree to participate in this research you will be asked to participate in up to three interviews possibly including one follow-up session up to 18 months following your first interview(s). Interviews are expected to be no more than one hour and a half in duration but may be less. Interviews will consist of a series of questions and informal discussions regarding your experience with ethical decision making. Interviews will be audio recorded to assist the Principal Investigator in gathering accurate information. You will be contacted to arrange a convenient interview time, location and/or method e.g. face-to-face/telephone/Skype.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

There are no known risks to participating in the research study. However, the main discomfort is that you may be asked to share sensitive information regarding your experience of an ethical dilemma. However, this potential discomfort would be no more difficult than discussing these cases with colleagues in daily clinical practice. You have the right to refuse to answer any of the questions in this study for any reason.

WHAT ARE THE POSSIBLE BENEFITS FOR ME AND FOR SOCIETY?

Although there will likely be no direct benefit to you for participating in this study, your participation will assist in providing valuable information about ethical decision making in occupational therapy practice which will contribute to the development of a theoretical framework regarding ethical decision making within occupational therapy.

HOW MANY PEOPLE WILL BE IN THE STUDY?

Approximately 25 practicing occupational therapists will participate in this study. Occupational therapists will be selected to represent a broad spectrum of practice characteristics including: (a) practice contexts, (b) years of experience, (c) education background, (d) type of positions held.

WHAT INFORMATION WILL BE KEPT PRIVATE?
All personal information such as your name, address, telephone number, and e-mail address will be removed from the transcribed data and will be replaced with an ID number. A list linking the number with your name will be kept in a secure place separate from your data. All written and audio recorded responses provided by you will become study data. This data will be organized by the number assigned to you so that your identity will be available only to investigators and will remain completely confidential. The audio files and transcribed data will be safely stored in a secure cloud-based computer program with advanced encryption technologies. Data will be retained for approximately five years following the completion of the project. The data will then be destroyed. If results of the study are published, your name will not be used and no information that discloses your identity will be released or published.

IS PARTICIPATION IN THE STUDY VOLUNTARY?
Your participation in this study is completely voluntary. By choosing not to participate you will not experience any penalty or reprisal.

CAN PARTICIPATION IN THE STUDY END EARLY?
You may elect to withdraw from this study at any time by contacting the principal investigator. You can choose to withdraw either some or all of and the information we have collected which will then be destroyed.

WILL I BE COMPENSATED FOR PARTICIPATING IN THE STUDY?
Due to the limited budget for this research compensation/honariums will not be provided for research participation.

WILL THERE BE ANY COST INVOLVED IN PARTICIPATING IN THE STUDY?
There are no known costs to participating in this study. Every effort will be made to ensure that you will not incur any costs associate with your participation in this research.

HOW DO I FIND OUT ABOUT RESULTS OF THE STUDY?
If you are interested in the results of this study, you may leave your name and email with the principal investigator and we will contact you with a summary of the results. If you leave your contact information, it will be kept in a separate location than your responses and participant code in order to maintain confidentiality. Alternatively, you may contact the principal investigator at sandyvdk@gmail.com

IF YOU HAVE ANY QUESTIONS OR PROBLEMS, WHOM CAN YOU CALL?
If you have any questions about this study, you can contact Sandra VanderKaay at (905) 933-5934 or e-mail sandyvdk@gmail.com. Alternatively, you could contact Dr. Sandra Moll at (905) 525-9140 extension 23523 or molls@mcmaster.ca

Thank you very much.

Sandra VanderKaay
PhD Candidate
School of Rehabilitation Science
McMaster University
Institute for Applied Health Sciences
1400 Main Street West
Hamilton ON
L8S 1C7

<div align="center">CONSENT STATEMENT</div>

PARTICIPANT:

I have read the preceding information thoroughly. I have had an opportunity to ask questions and all of my questions have been answered to my satisfaction. I agree to participate in this study. I understand that I will receive a signed copy of this form.

Name	**Signature**	**Date**

PERSON OBTAINING CONSENT (PRINCIPAL INVESTIGATOR):

I have discussed this study in detail with the participant. I believe the participant understands what is involved in this study.

Name, Role in Study	**Signature**	**Date**

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HIREB). The HIREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the Chair, Hamilton Integrated Research Ethics Board at 905-5211-2100 extension 42013.

Appendix D
Interview Guide: HiREB Project #0670

INTERVIEW GUIDE

Title of Study: Ethical Decision Making in Occupational Therapy Practice in Canada

Local Principal Investigator: Dr. Sandra Moll
Assistant Professor
School of Rehabilitation Science
McMaster University
Hamilton, Ontario
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(905) 525-9140 extension 23523
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sandyvdk@gmail.com

Co-Investigators: Dr. Sandra Moll, Assistant Professor, McMaster University School of Rehabilitation Science

Dr. Lori Letts, Associate Professor, McMaster University School of Rehabilitation Science

Dr. Joyce Tryssenaar, Associate Professor, McMaster University School of Rehabilitation Science

---

DEMOGRAPHIC INFORMATION

1. Gender: _____Female _____Male

2. Age/Year of Birth: _____

3. From which university did you receive your OT degree? _____

4.   In what year did you receive your OT degree? _____

5.   How many years have your practiced in occupational therapy? _____

6.   In which province/territory do you currently practice? _____

7.   Describe your current role/position: _____

_____

IN DEPTH QUESTIONS

There are no right or wrong answers to my questions. They are intended to explore your views and experiences of making ethical decisions in your occupational therapy practice and to gain a sense of the range of views and experiences that occupational therapists have. Nothing that you say in this interview will be reported to anyone beyond this interview. You have the right to refuse to answer any of the questions in this study for any reason.

1.   When I say the words "ethical decision making in occupational therapy practice" what does that mean to you?

2.   Tell me about your current practice environment.
     e) Current role.
     f) Involvement/interaction with other professionals.
     g) Caseload type/size.
     h) Any administrative/managerial components.
     i) Funding for current position.

3.   When I say the words "ethical decision making in occupational therapy practice" what does that mean to you as it relates to your practice which you have just described?
     a) Is this different than your previous answer?
     b) If so, then how and why is it different?

4.   Keeping your definition of ethical decision making in mind, tell me about a time in your current practice environment where you made what you would define as an ethical decision.
     f)   Background information.
     g)   Clinical scenario.
     h)   People involved.
     i)   Potential decisions that were considered.
     j)   Ultimately the decision that was made.

5.   Describe how you ultimately came to the decision you made.
     a)   Were there any tools used (e.g. ethical frameworks) and how were they employed?
     b)   Which factors/components of the clinical case were most prominent in informing your decision making?
     c)   What might have helped you in coming to the decision?

6. Research shows that professional codes of ethics are extremely limited in their ability to guide ethical decision making. Can you comment on this research from your practice experience?
   a) Does the professional code of ethics inform your decision making?
   b) If so, then how?
   c) If not, then why?

7. Research also indicates that because of the limitations of professional codes of ethics many practitioners draw on other means to inform their ethical decision making such as personal values and personal experiences. Can you comment on this from your practice experience?
   a) Can you identify any other means that can/have been used in order to come to support ethical decision making?

8. Research shows that student occupational therapists on clinical placement do perceive ethical dilemmas. If you take on a student occupational therapist on clinical placement do you explicitly teach them about ethical decision making?
   a) If so how do you teach them about ethical decision making?
   b) If not, then why not? What are the barriers to teaching students about ethical decision making?

9. Describe what kinds of things you do, if any, to learn more about the ethical issues in practice and how to deal with them.

10. What kinds of things might help you in making ethical decisions in practice?

11. While we have been talking about ethical decision making have any new thoughts come up?

12. Is there anything else you would like to add that you have not yet said?

13. Is there anything that you would like to ask me?

Appendix E
The Prism Model of Ethical Decision-Making
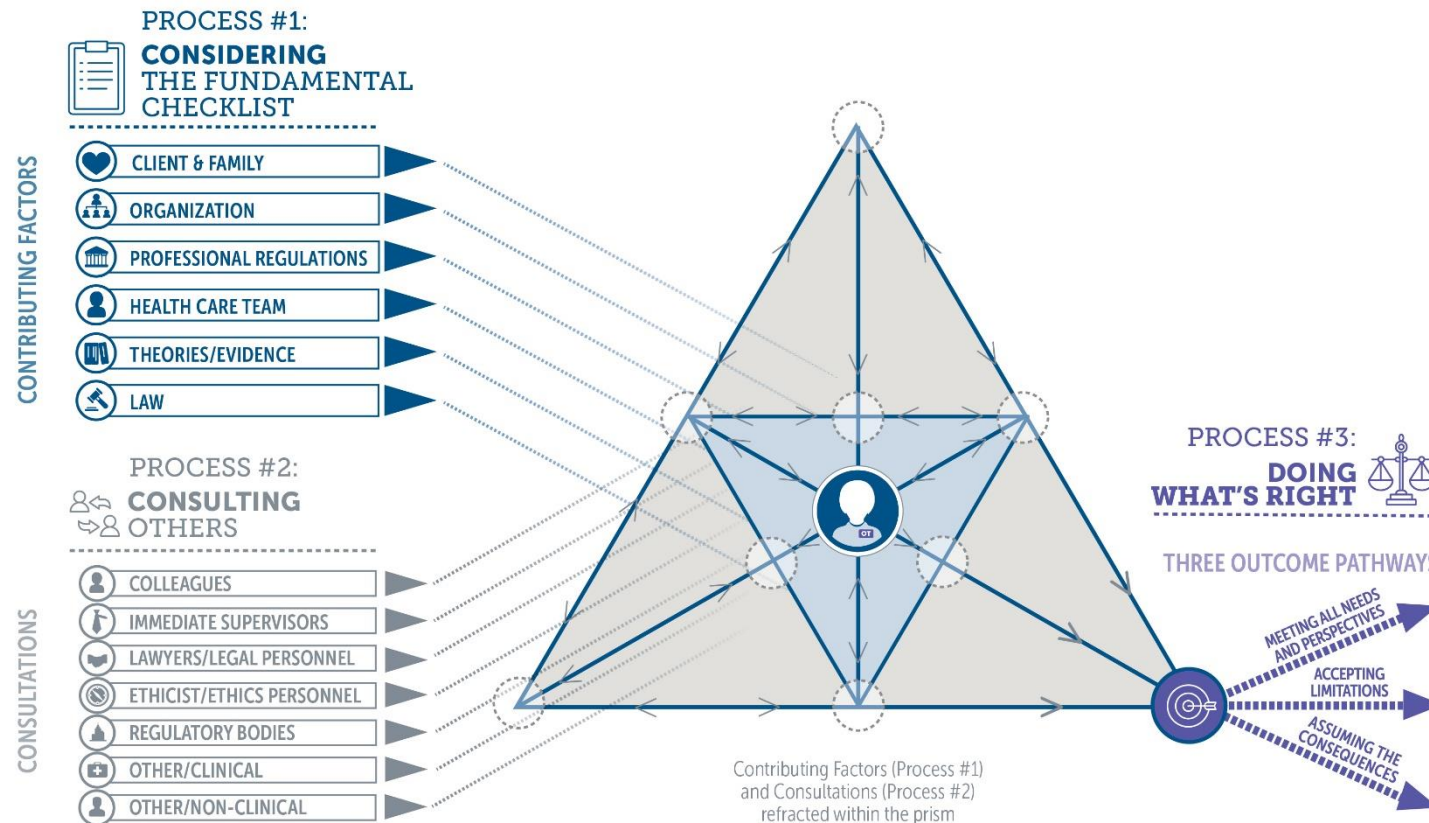
Appendix F
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CCC Federal ID:	13-2922432
Terms:	Due upon receipt

SANDRA VANDERKAAY
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CANADA

Customer Location:
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Canada

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Appendix G
Pre-Module Questionnaire

McMaster University

Facilitating Ethical Decision Making Amongst Student Occupational Therapists
Pre-Questionnaire

PART A: General Information

1. Identifier (Please enter your first initial in upper case followed by the last four digits of your telephone number with no space e.g. S5934. You will be asked to re-enter this identifier on subsequent questionnaires. This will allow us to identify changes in scores over time while maintaining anonymity.)

2. Role (Please choose all that apply.)

☐ PBL Tutor

☐ Clinical Placement Preceptor

☐ EBP Facilitator

☐ Other (please specify)

3. Years of Clinical Experience:

4. Practice Area:

5. Years of Being a Tutor/Preceptor:

6. Please describe any formal ethics training that you may have completed.

1

McMaster University

Facilitating Ethical Decision Making Amongst Student Occupational Therapists Pre-Questionnaire

PART B: Self Assessment of Knowledge and Skills

Please rate the extent to which you agree with the following statements.

1. I am confident with my level of knowledge regarding ethics broadly.

Strongly Disagree

(1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

2. I possess basic knowledge regarding (normative) ethical theories e.g. deontology/virtue ethics.

Strongly Disagree

(1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

3. I have a good understanding of ethical decision making in occupational therapy.

Strongly Disagree

(1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

4. I could provide student OTs with a clear description of ethical decision making in occupational therapy.

Strongly Disagree

(1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

5. I am aware that various ethical theories may apply to decision making in occupational therapy.

Strongly Disagree

(1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

3

6. I am familiar with the COTO Code of Ethics.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

7. Following the COTO Code of Ethics is sufficient in guiding ethical decision making in occupational therapy in Ontario.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

8. Case-based discussions are important in facilitating ethical decision making among student OTs.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

9. I feel confident in my ability to highlight and discuss the ethical dimensions of clinical cases in my interactions with student OTs.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

10. I feel able to facilitate the development of ethical decision making skills among student OTs.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

11. I am familiar with tools such as frameworks or models that may support discussions of ethical decision making with student OTs.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

12. I am interested in engaging in ongoing learning regarding ethics and/or ethical decision making.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

4

13. Please provide any additional relevant information in the box below.

5

McMaster University

Facilitating Ethical Decision Making Amongst Student Occupational Therapists Pre-Questionnaire

PART C: Role as Tutor/Preceptor/Facilitator

Please rate the extent to which you agree with the following statements as they relate to your current or upcoming term as PBL tutor/clinical placement preceptor/EBP facilitator.

1. I will explicitly highlight and discuss the ethical dimension of clinical cases in my discussions with student OTs.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

2. I will prompt student OTs to use tools such as frameworks/models to guide discussions about ethical decision making.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

3. I will encourage student OTs to openly raise any ethical concerns noted or observed during placement/tutorial/seminars.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

4. I will prompt student OTs to explore relevant (normative) ethical theories and how they might influence decision making.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

6

5. I will facilitate discussions with student OTs about the COTO Code of Ethics.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

6. I will engage in ongoing learning regarding ethics/ethical decision making in order to better support student OTs.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

7. Please provide any relevant additional information in the box below

7

Appendix H
Post-Module Questionnaire

McMaster University

Facilitating Ethical Decision Making Amongst Student Occupational Therapists Post-Questionnaire

PART A: General Information

1. Identifier (Please enter your first initial in upper case followed by the last four digits of your telephone number with no space e.g. S5934. Please enter the same identifier/telephone number that was used in pre-questionnaire. This will allow us to identify changes in scores over time while maintaining anonymity.)

1

McMaster University

Facilitating Ethical Decision Making Amongst Student Occupational Therapists
Post-Questionnaire

PART B: Self Assessment of Knowledge and Skills

Please rate the extent to which you agree with the following statements.

1. I am confident with my level of knowledge regarding ethics broadly.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

2. I possess basic knowledge regarding (normative) ethical theories e.g. deontology/virtue ethics.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

3. I have a good understanding of ethical decision making in occupational therapy.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

4. I could provide student OTs with a clear description of ethical decision making in occupational therapy.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

5. I am aware that various ethical theories may apply to decision making in occupational therapy.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

2

6. I am familiar with the COTO Code of Ethics.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

7. Following the COTO Code of Ethics is sufficient in guiding ethical decision making in occupational therapy in Ontario.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

8. Case-based discussions are important in facilitating ethical decision making among student OTs.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

9. I feel confident in my ability to highlight and discuss the ethical dimensions of clinical cases in my interactions with student OTs.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

10. I feel able to facilitate the development of ethical decision making skills among student OTs.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

11. I am familiar with tools such as frameworks or models that may support discussions of ethical decision making with student OTs.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

12. I am interested in engaging in ongoing learning regarding ethics and/or ethical decision making.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

3

13. Please provide any additional relevant information in the box below.

4

McMaster University

Facilitating Ethical Decision Making Amongst Student Occupational Therapists Post-Questionnaire

PART C: Role as Tutor/Preceptor/Facilitator

Please rate the extent to which you agree with the following statements as they relate to your current or upcoming term as PBL tutor/clinical placement preceptor/EBP facilitator.

1. I will explicitly highlight and discuss the ethical dimension of clinical cases in my discussions with student OTs.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

2. I will prompt student OTs to use tools such as frameworks/models to guide discussions about ethical decision making.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

3. I will encourage student OTs to openly raise any ethical concerns noted or observed during placement/tutorial/seminars.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

4. I will prompt student OTs to explore relevant (normative) ethical theories and how they might influence decision making.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

5

5. I will facilitate discussions with student OTs about the COTO Code of Ethics.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

6. I will engage in ongoing learning regarding ethics/ethical decision making in order to better support student OTs.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

7. Please provide any relevant additional information in the box below

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PART D: Module Evaluation

1. Please comment on the length of the module.

2. Please comment on the relevance of the module to your work as PBL tutor/clinical placement preceptor/EBP facilitator.

3. Please comment on the relevance of the module to your clinical practice in general.

4. Please comment on the content level of the module (e.g. too simple/too complex).

5. Please comment on the vignettes and interactive activities.

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6. The module was viewed in

○ one session

○ two to three sessions

○ four or more sessions

7. The module was viewed in

○ the order that it is arranged

○ the order that made most sense to me

Please Explain

[   ]

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Appendix I
Follow-Up Questionnaire

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Follow-Up Questionnaire

PART A: Information Regarding Viewing/Discussions

1. Identifier (Please enter your first initial in upper case followed by the last four digits of your telephone number with no space e.g. S5934. Please enter the same identifier/telephone number that was used in previous questionnaires. This will allow us to identify changes in scores over time while maintaining anonymity.)

2. Have you gone back to review the module in whole or in part since your first viewing?

◯ Yes. I have viewed the full module.

◯ Yes. I have viewed parts of the module.

◯ No. I have not viewed the module again.

Please Explain

3. Have you had the opportunity to discuss the module with colleagues since viewing e.g. in the context of a tutor's meeting?

◯ Yes, once or twice.

◯ Yes, more than twice.

◯ No.

4. If yes please provide details (when/with whom/outcome/helpfulness).

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Follow-Up Questionnaire

PART B: Self Assessment of Knowledge and Skills

Please rate the extent to which you agree with the following statements.

1. I am confident with my level of knowledge regarding ethics broadly.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

2. I possess basic knowledge regarding (normative) ethical theories e.g. deontology/virtue ethics.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

3. I have a good understanding of ethical decision making in occupational therapy.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

4. I could provide student OTs with a clear description of ethical decision making in occupational therapy.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

5. I am aware that various ethical theories may apply to decision making in occupational therapy.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

2

6. I am familiar with the COTO Code of Ethics.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

7. Following the COTO Code of Ethics is sufficient in guiding ethical decision making in occupational therapy in Ontario.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

8. Case-based discussions are important in facilitating ethical decision making among student OTs.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

9. I feel confident in my ability to highlight and discuss the ethical dimensions of clinical cases in my interactions with student OTs.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

10. I feel able to facilitate the development of ethical decision making skills among student OTs.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

11. I am familiar with tools such as frameworks or models that may support discussions of ethical decision making with student OTs.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

12. I am interested in engaging in ongoing learning regarding ethics and/or ethical decision making.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

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13. Please provide any additional relevant information in the box below.

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Facilitating Ethical Decision Making Amongst Student Occupational Therapists Follow-Up Questionnaire

PART C: Role as Tutor/Preceptor/Facilitator

Please rate the extent to which you agree with the following statements as they relate to your most recent term as PBL tutor/clinical placement preceptor/EBP facilitator.

1. I explicitly highlighted and discussed the ethical dimension of clinical cases in my discussions with student OTs.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

2. I prompted student OTs to use tools such as frameworks/models to guide discussions about ethical decision making.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

3. I encouraged student OTs to openly raise any ethical concerns noted or observed during placement/tutorial/seminars.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

4. I prompted student OTs to explore relevant (normative) ethical theories and how they might influence decision making.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

5

5. I facilitated discussions with student OTs about the COTO Code of Ethics.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

6. I engaged in ongoing learning regarding ethics/ethical decision making in order to better support student OTs.

Strongly Disagree (1)	(2)	(3)	Neutral (4)	(5)	(6)	Strongly Agree (7)
○	○	○	○	○	○	○

7. Please provide any relevant additional information in the box below including specific examples of if/how your practice as a tutor/preceptor/facilitator was adapted or changed as a result of viewing the module.

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Facilitating Ethical Decision Making Amongst Student Occupational Therapists
Follow-Up Questionnaire

PART D: Future Considerations

1. Do you have any suggestions on ways to improve the module?

2. Please feel free to provide any relevant additional feedback in the box below.

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