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Continuing competency in ethical decision making: An interpretive description of occupational therapists' perspectives

La compétence continue dans la prise de décisions éthiques : Description interprétative des perspectives des ergothérapeutes

Sandra VanderKaay, Bonny Jung, Lori Letts, and Sandra E. Moll

Key words: Continuing education; Ethics; Mentors; Occupational therapy; Professional practice.

Mots clés : Formation continue; Éthique; Mentors; Ergothérapie; Pratique professionnelle.

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 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 from a grounded theory study regarding ethical decision making. In-depth interviews were conducted with a purposive sample of 18 occupational therapists. Data analyses focused on identifying gaps and future directions regarding continuing competency. **Findings.** Two main themes regarding gaps were identified: "I didn't have the knowledge" and "I don't have anybody." Education, tool development, and ethics mentorship were identified directions for development. **Implications.** Findings advance understanding of continuing competency needs of occupational therapists regarding ethical decision making.

Abrégé

Description. La compétence relative à la prise de décisions éthiques est un critère de la pratique fondée sur l'éthique et on s'attend à ce que cette compétence évolue au fil du développement professionnel continu. Toutefois, peu de recherches ont été menées sur les besoins des ergothérapeutes face à l'amélioration continue de leur compétence pour la prise de décisions éthiques. **But.** Le but de cette étude était d'explorer les lacunes et les avenues possibles en matière de développement en ce qui concerne l'amélioration continue de la compétence pour la prise de décisions éthiques et ce, du point de vue d'ergothérapeutes en exercice. **Méthodologie.** Une description interprétative a permis d'orienter une analyse de données secondaires de textes descriptifs professionnels provenant d'une étude théorique à base empirique sur la prise de décisions éthiques. Des entrevues en profondeur ont été menées auprès d'un échantillon choisi à dessein de 18 ergothérapeutes. Les analyses de données étaient centrées sur l'identification des lacunes ainsi que des avenues futures pour favoriser l'amélioration continue de cette compétence. **Résultats.** Deux thèmes principaux ont été repérés en ce qui concerne les lacunes : *Je n'avais pas les connaissances requises* et *Je n'ai personne*. Les avenues identifiées en ce qui concerne le développement de la compétence étaient la formation, la création d'outils et le mentorat en matière d'éthique. **Conséquences.** Les résultats permettent de mieux comprendre les besoins des ergothérapeutes en ce qui concerne l'amélioration continue de leur compétence pour la prise de décisions éthiques.

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Corresponding author: Sandra VanderKaay, School of Rehabilitation Science, McMaster University, 1280 Main Street West, Hamilton, ON L8S 1C7. Telephone: 905-525-9140 ext. 22867. E-mail: vandes22@mcmaster.ca

In the *Profile of Practice of Occupational Therapists in Canada*, the Canadian Association of Occupational Therapists (CAOT; 2012) put forth a continuum that 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 (Hickerson-Crist, 2014; 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; Hickerson-Crist, 2014). 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). Advancing competency through continuing professional development 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 one key competency for occupational therapists. Ethical competency includes adhering to codes of ethics, applying ethical frameworks to facilitate decision making, and responding appropriately to ethical issues in practice (Association of Canadian Occupational Therapy Regulatory Organizations, 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 (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.

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 codes of ethics may suggest conflicting courses of action, and individual occupational therapists may not have sufficient ethics knowledge to negotiate such conflicts (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). Current contexts for the delivery of occupational therapy services are challenging worldwide (Pattison, 2018), and the Canadian context is no exception. Resource limitations, extensive waiting lists for services, excessively large caseloads, and complexity of medical needs are common scenarios faced by occupational therapists practising in Canada (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 ethical decision making that was 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) 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" (p. 56). However, Durocher et al. (2016) stated that individual learning is not enough. 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 therapists regarding competent ethical decision making (Slater, Doherty, & Erler, 2018).

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. The research question guiding this study was: What are the perceived challenges and support needs of occupational therapists regarding ethical decision making in practice?

Method

An interpretive description approach was adopted for this study since the goal was to answer questions specific to clinical practice (Thorne, 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). 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 (Vander-Kaay, Letts, Jung, & Moll, 2018a). 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 had not been utilized because they were not specifically relevant to informing the original research question (Fine & Kurdek, 1994; Long-Sutehall, Sque, & Addington-Hall, 2012; Thorne, 2012, 2016). Ethics approval was granted by the research ethics board (Project No. 0670).

Recruitment/Sampling

All participants ($N = 18$) 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 were perceived to (a) have advanced clinical reasoning skills, (b) be able to reflect on and explain their reasoning, and (c) be 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).

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 that allowed participants to describe their decision-making processes in day-to-day practice (Thorne, 2016). Data analysis for this study was centred upon a subset 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).

Findings

Fifteen female and three male occupational therapists participated in this study. Sixteen participants possessed either a bachelor's ($n = 7$) or master's degree ($n = 9$) in occupational therapy. Two participants had a diploma in occupational therapy. Provinces of practice included British Columbia ($n = 2$), Alberta ($n = 1$), Ontario ($n = 11$), Quebec ($n = 2$), and Nova Scotia ($n = 2$). Seventeen participants described their role as primarily clinical and one as primarily administrative. Years of practice experience ranged from less than 2 years to 37 years. Practice areas included paediatric rehabilitation, private practice, acute care, inpatient/outpatient rehabilitation, home care, primary care, community mental health, and outpatient 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

Table 1
Examples of Participant Responses Reflecting Ethical Theory

Participant comment	Ethical theory
"Compassion . . . care . . . in the sense of like caring for someone . . . " (Participant 9)	Ethics of Care
"My experience of prior ethical decisions and things that I've learned from them . . . are informing it . . . " (Participant 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?" (Participant 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." (Participant 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 [*sic*] . . . I don't know." (Participant 8)	Principles-based Approach (autonomy/ nonmaleficence)
"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." (Participant 16)	Rule Deontology

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 support 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 (a) foundational knowledge upon which to base ethical decision making, (b) ethical language required to articulate ethical decision making, and (c) 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 prelicensure occupational therapy program or via postgraduate 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, and (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 master's 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.

As stated above, most participants did not explicitly report considering ethical theories in decision making. However, ethical and philosophical theories were reflected in responses even when participants did not appear to possess the language of ethics to articulate ethical decision making. 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.

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, 'OK, 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 practising occupational therapists. Other suggestions included in-person professional development workshops, online 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 flowcharts, 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 [someone], whereas in the community, you're kind of on your own . . . . As sole-charge [occupational therapist], I don't have anybody. I'm . . . on my own.

Of the participants who 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 [regulatory body says,] '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 this way: "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" (Participant 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: Formal support for ethical decision making. Support for ethical decision making was identified by participants as a key area for professional development. Participant 17 stated, "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 practise." Participant 8 stated, "Oh, what would be great? If there was a 1-800 number . . . ." Several participants named ethicists as potential support persons to guide decision making. However, other potential support persons included managers and other clinicians with advanced training in ethics. Participants indicated that ethics support persons should be formally recognized as such and possess the following qualities: (a) be available/readily accessible, (b) be knowledgeable on the topic of ethics/ethical decision making, and (c) be knowledgeable about specific practice areas.

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: 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 support for ethical decision making 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 toward 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 ongoing ethics education to support competent ethical decision making. Occupational therapists wanted ethics education in a variety of formats and a broad range of topics (e.g., 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 practising occupational therapists may benefit from education regarding addressing ethical tensions in practice. The finding is also consistent with 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 practising occupational therapists.

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 online ethics education module for occupational therapy clinician-educators found that ethics knowledge cultivated via viewing the online 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 practising 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 health care (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, that is, didactic events, such as lectures with written notes. Instead, the authors suggested an "outcomes-based" professional development model. Outcomes-based professional development involves supplementing new learning delivered 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 posteducation 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 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), and several tools to guide ethical decision making are currently available. Examples include the Patient-Centred Care Ethics Analysis Model for Rehabilitation (Hunt & 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 that evaluates the effectiveness of these tools to guide ethical decision making. 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 that 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 support for ethical decision making in the form of both ethics mentorship and access to ethics consultations. The reported limitations to accessing support 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 (Cheyney-Brandt & Yarett-Slater, 2011; Doherty, 2014; Government of Ontario, 1991).

Mentorship and consultation are distinct but related forms of support for decision making that are widely discussed within the health care literature (Burgess, van Diggele, & Mellis, 2018; Engelbrecht, 2012; Shaw & Fulton, 2012). *Mentorship* has been defined in occupational therapy as an ongoing 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). *Consultation* in occupational therapy has been defined as a time-limited collaborative process to resolve a specific problem (Rainville, Cermak, & Murray, 1996). Thorough examination of mentorship and consultation is beyond the scope of this study. However, research indicates that occupational therapists prioritize mentorship and consultation as means of professional development and problem solving (Myers et al., 2017; Rainville et al., 1996). Milner and Bossers (2005) reported the results of a quantitative study that 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. Evidence supporting the use of consultations in occupational therapy is limited. However, one early study indicated that consultations with expert occupational therapists were beneficial in improving the quality of occupational therapy services in paediatrics and increasing job satisfaction among occupational therapists (Rainville et al., 1996). Neither study addressed mentoring or consultation specific to ethics (Milner & Bossers, 2005; Rainville et al., 1996). Occupational therapists in this interpretive description indicated a desire for formal options for mentorship and consultation specific to ethical decision making. The CAOT has recently initiated a Mentorship on Demand program that allows occupational therapists to seek mentorship on an as-needed basis (Baptiste & CAOT, 2018). Similarly, the Ontario Society of Occupational Therapists (OSOT) also facilitates mentorship through its find-a-mentor online program (OSOT, 2017). Although these mentorship programs can be personalized according to

mentees' self-identified needs, they are not specifically targeted to ethics mentorship (J. Craik, personal communication, February 5, 2018).

No published literature was located related specifically to mentoring or consultation in ethical decision making in occupational therapy. However, literature in related disciplines, such as nursing, clinical psychology, and medicine, indicates that both mentorship and consultation have been explicitly applied to ethical decision making (American Psychological Association, 2006; Au et al., 2018; 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). A systematic review of ethics consultations to support ethical decision-making within adult intensive care units indicated that ethics consultations facilitated decision making and increased satisfaction among health care providers (Au et al., 2018). 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 support to occupational therapists in continuing to develop competent ethical practice. Doing so may require capacity building among occupational therapists in the role of mentor or consultee 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 having advanced reasoning skills. Clearly defining the construct of advanced reasoning skills may have strengthened study recruitment and sampling. 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 preclude the researcher from following 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: 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 access to formal support in the form of ethics mentorship and ethics consultations. To address these findings, further pedagogical development regarding ethics education for practising occupational therapists is required that extends beyond traditional didactic formats. Furthermore, there appears to be a need for clear, evidence-based tools and access to mentorship and consultations to support ethical decision making. Despite several noted limitations, it is hoped that the findings of this study will encourage broader-scale rigorous research to further examine and support continuing competency in ethical decision making in occupational therapy.

Key Messages

- Canadian occupational therapists practise in complex environments that 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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ORCID iD

Sandra VanderKaay https://orcid.org/0000-0002-1937-0103

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Author Biographies

Sandra VanderKaay, PhD, OT Reg. (Ont.), is Research Coordinator, School of Rehabilitation Science, McMaster University, Hamilton, ON, Canada.

Bonny Jung, PhD, is Associate Professor, School of Rehabilitation Science, McMaster University, Hamilton, ON, Canada.

Lori Letts, PhD, OT Reg. (Ont.), is Assistant Dean, School of Rehabilitation Science, McMaster University, Hamilton, ON, Canada.

Sandra E. Moll, PhD, OT Reg. (Ont.), is Associate Professor, School of Rehabilitation Science, McMaster University, Hamilton, ON, Canada.