Ethical Dilemmas Experienced by Occupational Therapists Working in Private Practice

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Thesis submitted as a component of the Master of Occupational Therapy Program
The University of Sydney
2015
Declaration and Ethics Statement

I, ALEKSANDRA BABIC declare that this submission is my own work and contains no material previously published or written by another person except where acknowledged in the text. It does not contain any material which has been accepted for the award of another degree. Ethical approval was obtained from the University of Sydney Human Ethics Committee prior to undertaking the research in this study. Informed consent was gained from all participants.

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Date: 28/10/2015
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Thesis Abstract

Background: Contemporary healthcare systems are constantly evolving. Healthcare professionals including occupational therapists are required to adapt to increasing contextual demands while maintaining professional and ethical conduct. Ethical conduct in occupational therapy is guided by ethical principles which are often in conflict with each other resulting in ethical dilemmas. Ethical dilemmas may impact upon the wellbeing of a professional, quality of client care and the reputation of a profession as a whole. Despite this, there is limited research into the nature of ethical dilemmas experienced by occupational therapists, specifically those working in private practice.

Aims: This research asks: What is the nature of ethical dilemmas, and their contributing factors, encountered by private practice occupational therapists? The study aims to explore the nature of ethical dilemmas experienced by occupational therapists working in private practice.

Overview of Thesis: This thesis has been divided into two sections. Section One consists of a comprehensive literature review of the current knowledge base regarding ethical dilemmas in occupational therapy practice. Literature from other allied health professionals working in private practice was also consulted to provide insights about ethical dilemmas these professionals experience.

Section Two contains a journal manuscript entitled “Ethical Dilemmas Experienced by Occupational Therapists Working in Private Practice”. The manuscript has been written with the intention of submission to The Australian Occupational Therapy Journal (See Appendix 1).

Conclusions: Findings from this research project indicate the need to understand the nature of ethical dilemmas experienced by occupational therapists as they are a complex and unavoidable aspect of day-to-day practice. Further, knowledge of the topic at hand within the private sector is critical as these professionals encounter different dilemmas due to the conflict between providing quality services and ensuring a viable business. This knowledge can inform preparation of professional development programs to ensure ethical competency of the occupational therapy profession.
Acknowledgements

I would like to thank my supervisors, Dr. Merrolee Penman and Dr. Srivalli Nagarajan, for all their encouragement, guidance and support throughout this research project.

Additionally, I would like to thank A/Prof. Lynette Mackenzie, my unit of study coordinator, for her enthusiasm and support.

Finally, I would like to extend my thanks to Nicole Vassilieff (Work Integrated Learning Administrator) for her support in the distribution of recruitment emails for this study.
SECTION 1: Literature Review

1. Introduction

The contexts which surround occupational therapy practice are dynamic and fast-evolving, necessitating a need for the profession to simultaneously evolve. Healthcare reforms in contemporary times have changed the nature of practice through the introduction of reimbursement schemes, cost containments and organisational policies, imposing time, cost and productivity demands on occupational therapists (Walker, 2001). Such demands intensify the existent ethical complexity of professional practice, which frequently eventuates in ethical dilemmas.

The profession of occupational therapy is largely influenced by ethical principles of beneficence, non-maleficence, justice and respect for autonomy (Beauchamp & Childress, 2012). This requires health professionals to be ethically competent in practice and make decisions about client care in accordance to these ethical principles. Health professionals are required to prioritise and balance these principles, which are of equal importance but often in competition with each other. For example, when allocating scarce resources within the community, the principles of beneficence for some and justice for all need to be prioritised. These decisions are challenging and can create an ethical dilemma as there is no distinct right or wrong course of action.

This tension between what one ought to do and not do (Flatley, Kenny & Lincoln, 2014), can cause ethical and moral distress for practitioners (Kalvemark, Hoglund, Hansson, Westerholm & Arnetz, 2004). Conflict between professional values, legal obligations and personal values, can create ethical distress and if left unattended, disrupts work-life balance and ultimately leads to professional burnout (Cross, Leitao & McAllister, 2008). This illustrates the importance of ethical-decision making systems for facilitating proactive management of ethical dilemmas. However, prior to developing these management strategies, knowledge of the nature of ethical dilemmas experienced by health professionals is necessary.

To facilitate the understanding of what constitutes an ethical dilemma, key terms need to be defined and differentiated. These key terms are ethical tensions, ethical dilemmas, ethical distress and ethical uncertainty.
Ethical tensions or ethical issues have been defined as “events in professional life that raise morally troubling concerns” (Bushby, Chan, Druif, Ho & Kinsella, 2015, p. 212). Encompassed within ethical tensions are ethical dilemmas, ethical distress and ethical uncertainty. Ethical dilemmas may arise in situations which require a decision between two or more equally pleasant or unpleasant alternatives that are mutually exclusive (Jameton, 1984). Additionally, ethical dilemmas are created when a professional is required to make a choice between conflicting bioethical principles (Beauchamp & Childress, 2012). Ethical uncertainty occurs due to ambiguity about which bioethical principles apply to a situation, or whether the situation is indeed an ethical problem (Jameton, 1984). Finally, ethical or moral distress occurs when the right course of action is known, but its pursuit is constrained by institutional or organisational rules (Jameton, 1984).

Although the aforementioned concepts seem to have clear theoretical distinctions, their relationship in practice is not as distinct and seems to be causative in nature. This review will primarily focus on ethical dilemmas in occupational therapy practice. However, due to the paucity of literature on this topic, relevant literature on ethical tensions in occupational therapy as well as ethical dilemmas in other allied health professions will also be discussed.

2. Purpose of Review

The purpose of this review was to explore the current literature regarding the ethical dilemmas experienced by occupational therapists in daily practice. The information gained from the literature informed the design and analysis of the study “Ethical Dilemmas Experienced by Occupational Therapists Working in Private Practice”.

3. Search Strategy

Initially, three data bases: Medline, CINAHL and AMED were searched, using the terms “occupational therapy” or “allied health” and “ethics” or “ethical dilemmas” or “ethical tensions”. However, due to limited existing literature on the topic, the search was expanded to include ethical dilemmas in other healthcare professions including nursing, medicine, physiotherapy and speech-language pathology. Reference lists of relevant articles were also reviewed to identify additional relevant publications. A Google Scholar search was also conducted using the aforementioned search terms and additional articles were identified using
the ‘Cited By’ and ‘Relevant Articles’ functions, to determine other articles that were missed in the database searches.

An additional Google Scholar search was conducted to inform the nature of private practice within occupational therapy. This search was not comprehensive as it was not the primary focus of the review but rather its aim was to provide insight into the nature of business in healthcare.

4. Overview of Ethics

Ethical dilemmas are encompassed within the realm of ethics. Ethics is a branch of philosophy which critically examines human conduct in reference to the rightness and wrongness of actions (Horner, 2003). Ethics can be divided into two branches, philosophical and descriptive ethics. Philosophical ethics encompasses normative ethics which guide our actions and focus on how we ought to act and who we should strive to be in social, professional and personal situations (Horner, 2003). Descriptive ethics on the other hand is concerned with actual values and actions of individuals, and encompasses, what is known as applied ethics. Normative ethics has played a vital role in the formation of professional codes of ethics; however the primary contribution to health care ethics has resulted from applied ethics.

4.1 Applied Ethics

Applied ethics, or bioethics is the study of issues surrounding medical and healthcare practice, and research with human subjects. In its early years bioethics was concerned with life and death issues such as abortion, euthanasia and reproductive technology (Gordon, 2012). However, in the last 30 years there has been a shift in the focus of bioethics towards health care economics, access to healthcare and issues concerning healthcare systems (Gordon, 2012). As a result, bioethics has had a significant impact on occupational therapy practice. The four bioethical principles, coined by Beauchamp and Childress (2012) have widely influenced healthcare policy and practice in Australia. These principles are:

1. **Autonomy:** highlights the need to respect participants as autonomous agents and allow freedom for action. For health professionals this includes provision of informed consent.

2. **Justice:** implies equal and fair treatment of individuals as moral equals, and fair distribution of benefits.
3. **Beneficence:** addresses duty to do good and prevent harm.
4. **Non-maleficence:** addresses obligation to not cause harm to others

Applied ethics additionally aims to prevent and resolve moral problems through the prescription of standards of conduct (Horner, 2003), such as professional codes of ethics.

### 4.2 Code of Ethics

The Occupational Therapy Australia’s Code of Ethics (2014) is based upon the aforementioned bioethical principles. In addition, the ethos addresses the principles of honesty, confidentiality and veracity (truthfulness) towards clients. The statements enclosed within the Code of Ethics are intended to guide behaviour of occupational therapists professionally, ethically and morally and aid in ethical-decision making (Occupational Therapy Australia, 2014). In addition to acting in accordance to the Code of Ethics, occupational therapists are required to comply with policies and procedures of their employing bodies. These policies within healthcare, however, are constantly changing and herald new ethical dilemmas (Kenny, 2009). As a result, the Code of Ethics may have difficulty keeping step, and cannot predict all ethical issues encountered by occupational therapists. Thus research is needed into the nature of ethical dilemmas, to better guide ethical-decision making frameworks.

### 4.3 Consequences of Ethical Dilemmas

The experience of ethical dilemmas is often unpleasant due to the moral challenges they pose. However, that is not to say that the experience should be entirely avoided, and undoubtedly it is not one that can be avoided. Resolving ethical dilemmas has been linked to increased job satisfaction and retention (Bell & Breslin, 2008). Conversely, unresolved dilemmas have been known to cause practitioner stress (Kalvemark et al., 2004). As previously stated, ethical dilemmas and ethical distress appear to be separate entities: ethical dilemmas result from there being no clear right course of action, while ethical distress mandates a right course of action is known but its pursuit is constrained (Jameton, 1984). However, more recent studies support the notion of a causative relationship where ethical distress is a by-product of the experience of ethical dilemmas (Raines, 2000; Kalvemark et al., 2004).

A recent study involving 224 American occupational therapists whose primary setting was geriatrics or physical disability, reported high incidences of moral distress among therapists (Penny, Ewing, Hamid, Shutt & Walter, 2014). More surprising however, was that
almost half of the occupational therapists reported that they had previously left a position or had considered leaving a position due to moral distress (Penny et al., 2014). Although these findings may not be indicative of all occupational therapists, they do present important possible implications of moral distress. Furthermore, moral distress due to unresolved dilemmas could negatively impact clinical care and patient outcomes in the long term (Aiken et al., 2001). These findings mandate the need for a closer examination of the nature of ethical dilemmas in occupational therapy practice.

5. Ethical Dilemmas Within the Public Sector

Few studies have examined ethical dilemmas experienced by occupational therapists. However, studies from other health professions including medicine, nursing and allied health have provided insight into the nature of ethical dilemmas experienced by these professionals. Although ethical dilemmas may vary, the ethical principles at stake are often shared between professions.

5.1 Medicine and Nursing

Medical and nursing professionals primarily face complex ethical dilemmas surrounding end-of-life care treatment, questionable patient decision making capacity and difficulty revealing diagnoses to patients (DuVal, Clarridge, Gensler & Danis, 2004; Gaudine, LeFort, Lamb & Thorne, 2011). Conflict as a result of end-of-life care, is experienced between the practitioner’s role as a ‘healer’ and their support for the client’s choice to refuse treatment (Kelner & Bourgeault, 1993). Hence, the bioethical principles of beneficence and respect for autonomy are in competition.

A survey of European doctors revealed that the principle of autonomy underpinned many ethical dilemmas (Hurst et al., 2007). Impaired decision making capacity was frequently reported among the doctors, as was disagreement among caregivers. The study also found that the nature and frequency of ethical dilemmas differed between doctors working in hospitals and those in out-patient practices. Additionally, dilemmas varied according to the doctor’s country of origin. This was possibly due to differences in cultural values which could influence the way ethical tensions are perceived and thus experienced. These findings highlight the need for knowledge of ethical dilemmas specific to the profession’s national membership.

While dilemmas about end-of-life care are significant in nature, they are infrequently encountered by occupational therapists. Insights from allied health professions including
physiotherapy and speech-language pathology may be of greater relevance to occupational therapy due to the comparable nature of the professions.

5.2 Allied Health

Trienzenberg (1996) reported the nature of ethical issues experienced by six American physiotherapists who were considered experts in ethical issues for physical therapy. A Delphi questionnaire method was used to obtain data, and results showed consensus between participants for three primary themes: i) patient welfare which included ethical issues related to patient’s right to informed consent and confidentiality, ii) professional issues involving reporting misconduct of others, and iii) business and economics which primarily dealt with fair allocation of resources. No practice context information was provided, making it difficult to infer the role of setting in experiences of ethical dilemmas.

A more recent study reported the nature of ethical dilemmas experienced by eight physiotherapists in Canada (Finch, Geddes & Larin, 2005). Semi-structured interviews were conducted and participants were asked to describe a recent ethically-based clinical decision. The context of the scenarios was either hospital or community based. The study findings were mostly comparable to those reported by Trienzenberg (1996), as the same three themes were reported. However, the dilemmas reported under each theme varied. For example, in addition to allocation of resources, the theme of business and economics also included issues related to funding accessibility (Finch et al., 2005). The findings indicate that while the ethical principles at stake remained the same, the nature of ethical issues changed as a result of time. This change may be attributed to the changes in healthcare policies and demands, across the two decades.

Literature in speech-language pathology on ethical dilemmas is comparable to physiotherapy. The ethical dilemmas encountered by speech-language pathologists related to client management, unethical behaviour of colleagues, resource allocation and maintaining professional competence (Buie, 1997; Kenny, Lincoln, Blyth & Balandin, 2009). An important finding from the speech-language pathology profession was the impact of professional experience on ethical dilemmas (Kenny et al., 2009). In the study, 10 new graduates and 10 experienced speech-language pathologists participated in semi-structured interviews. Participants were from New South Wales, Australia and were employed in a public health setting. Although both groups reported dilemmas due to managing complex clients, defining boundaries in professional relationships and incorporating self into professional role, the nature of these dilemmas differed. For example, in managing difficult clients, new
graduates focused on potential harmful, immediate consequences of client’s choices while experienced speech pathologists focused on client’s rights to autonomous healthcare. These findings reveal that ethical dilemmas are also influenced by demographic factors, such as experience.

Overall, the nature of ethical dilemmas appears to be dependent on various factors including country of practice, workplace setting, professional experience and contextual factors such as time and organizational policies. The consideration of these factors is significant in providing insight into the nature of ethical dilemmas experienced by occupational therapists.

5.3 Occupational Therapy

The ethical dilemmas experienced by occupational therapists are mostly comparable to those of the aforementioned allied health professionals, however, differences do exist. Barnitt (1998) surveyed a large group of 118 occupational therapists and 107 physical therapists from the United Kingdom, employed in the public health sector. Participants were asked to describe people involved, decisions made, how long the dilemma took place and also to categorise the dilemma based on ethical principles. Occupational therapists were primarily from the mental health setting. Both groups described ethical dilemmas relating to difficult patients, resource allocation and unprofessional colleagues. In addition, occupational therapists reported dilemmas about perceived lack of respect by staff members towards vulnerable patients, making difficult or risky decisions about patient discharge and confidentiality issues. In the analysis of ethical principles underpinning the ethical dilemmas, findings revealed justice, patient rights and beneficence and non-maleficence as the most frequently involved for both occupational therapists and physical therapists. Although the findings revealed differences in the nature of ethical dilemmas between the two professions, the involved ethical principles remained the same. This is not an unexpected finding considering both professions are guided by codes of ethics which are based upon the same ethical principles. Although Barnitt’s findings identified the ethical principles involved, the study failed to demonstrate which principles were at stake in each dilemma. Further, these results may not be relevant to contemporary occupational therapists as healthcare systems have evolved from the time the study was conducted.

A recently published scoping review provides the most current knowledge base of ethical tensions encountered by occupational therapists within the public health sector (Bushby et al., 2015). Bushby et al. reviewed 32 peer-reviewed articles published between the years of 2000
and 2013. Studies were located in the USA, the UK, Canada and Sweden. The predominant settings were hospitals and the community. Seven primary themes were identified which highlighted ethical tensions: resource and systemic issues, upholding ethical principles, client safety, working with vulnerable clients, interpersonal conflicts, upholding professional standards and practice management. These themes are discussed in detail below and also include additional articles which were not included in the review.

**Resource and Systemic Issues:** Ethical tensions resulted from a host of factors including time constraints, limited funding, insufficient staff, insufficient economic resources to support therapy and delays in receiving equipment. Tensions within this theme appear to be most frequent in practice. These causative factors are contextual in nature and external to the therapist. As a result, ethical tensions differed according to workplace setting. For example, within the community setting resources are scarce and are delegated via the process of prioritisation which raises important ethical questions regarding which services are provided and to whom (Carrier et al., 2010). As a result, occupational therapists working within a community setting may primarily encounter dilemmas where the principle of justice is at stake.

**Upholding Ethical Principles:** Inherent in this theme were tensions resulting from the need to uphold ethical principles and values. Numerous principles were discussed including autonomy, justice, beneficence/non-maleficence and veracity (truthfulness). For example, dilemmas arose when working with cognitively impaired clients and a decision needed to be made to tell the truth and increase the client’s distress (non-maleficence at stake) or to tell a lie (veracity at stake) (Lohman, Mu & Scheirton, 2004). Although ethical principles were discussed as a separate theme, majority of the reported ethical dilemmas consisted of competing principles.

**Client Safety:** Occupational therapists also reported tensions when client safety was a concern, especially during discharge planning. Durocher and Gibson (2010) reported a case where a patient wished to be discharged home but this was deemed unsafe by the therapist. Principles of autonomy and non-maleficence were at stake as the therapist has a duty to respect the patient’s wishes but also to ensure they are not harmed.

**Working with Vulnerable Clients:** When the decision-making capacity of the client was questionable due to disabilities or impairments, ethical tensions arose. These tensions were more specific to rehabilitation and disability settings. For example, Kassberg and Skar (2008)
interviewed 12 Swedish occupational therapists working in rehabilitation with adults who have learning disabilities, and found that supporting clients’ participation in decision-making and respecting clients’ integrity created frequent ethical concerns.

**Interpersonal Conflicts:** Conflicts arose between occupational therapists, clients, family members and other health professionals. In general the cause of the conflict was dependent upon workplace setting. For example, conflicts about intervention planning between therapist and family members and setting meaningful goals occurred in rehabilitation settings (Daniels, Winding & Borell, 2002; Foye et al., 2002). An additional study of occupational therapists from the Netherlands and Belgium who worked in stroke rehabilitation reported ethical dilemmas due to conflict about recovery when the intervention approach changed from remedial to adaptive (Daniels et al., 2002). Participants reported that patients were often unaware of their impairments and found it challenging accepting the adaptive approach as they regarded this as the finality of progress.

Another source of conflicts was between occupational therapy students who were on placement and their supervisors. Kinsella, Park, Appiagyei, Chang and Chow (2008) interviewed 25 occupational therapy students about ethical tensions that they experienced or had witnessed while on placement. Students reported ethical tensions resulting from differences in opinion between themselves and their supervisors which they seldom attempted to voice as they felt they were in a subordinate position (Kinsella et al., 2008). Although these findings did not contrast the experience of students and therapists, they do suggest that experiences of ethical tensions may be influenced by professional experience, as well as hierarchical position within the workplace.

**Upholding Professional Standards:** The aforementioned ethical tensions are not necessarily unique to occupational therapy. However, some tensions within this theme may be specific to occupational therapy, namely those resulting from constraints to implementing client-centred care. Hammell (2007) noted ethical tensions between therapist’s attempts to remain client-centred and fulfil workplace obligations. Kyler (2008) extends from this and identifies inadequate workplace support and deciding who to include in decision-making processes as barriers to client-centred practice. In addition, difficulties upholding evidence-based practice were also discussed as causes of ethical tensions. In particular, complex practices for which there is limited evidence elicited ethical challenges.
Practice Management: ethical tensions related to professional boundaries such as whether to accept gifts from clients, caseload management and documentation were included within this theme.

Overall, from the review by Bushby et al. (2015) significant conclusions can be drawn. Firstly, it is evident that ethical tensions differ between workplace settings and client groups. Secondly, various ethical principles underpin ethical tensions and some may be more prevalent in specific practice settings. It is important to note that occupational therapists work across a range of settings including hospitals, community centres, private practice, rehabilitation units, psychiatric clinics and school and aged-care facilities (Occupational Therapy Australia, 2015). This review did not offer any insight into the ethical tensions experienced by private practice occupational therapists.

Furthermore, the aforementioned studies were all from international contexts whose healthcare systems differ from that in Australia. One study was identified that examined ethical issues within two hospitals in NSW, Australia, however it was not specific to occupational therapy (Doran et al., 2015). A self-reported survey was completed by 32 medical, 45 nursing and 21 allied health professionals, which examined the degree to which ethical and legal concerns were encountered. Participants expressed ethical concern when dealing with patients who were refusing the recommended treatment and when there was disagreement among staff about the care of a patient. Although these findings have ethical implications such as balancing principles of beneficence and non-maleficence, which are similar to the studies previously discussed, it is not clear whether these professionals experienced ethical dilemmas. Also, no distinction was made between the allied health professionals. Research is therefore needed within an Australian context, to understand the nature of ethical dilemmas experienced by Australian occupational therapists.

6. Ethical Dilemmas Within the Private Sector

Private practice makes up approximately a quarter of the total Australian occupational therapy workforce and employment numbers are increasing (Australian Institute of Health and Welfare, 2013). Despite this, to date, there has been no investigation into the nature of ethical dilemmas experienced by occupational therapists working in private practice. However, research from physiotherapy and speech-language pathology provides insights into the ethical dilemmas experienced by these professionals within the private sector.
6.1 Nature of Occupational Therapy Private Practice

By definition, private practitioners work in a small business and provide services for a fee (McClain, McKinney & Ralston, 1992). They may or may not be self-employed and include both practice owners and employees. Three main forms of private occupational therapy practices have been reported (Anderson & Nelson, 2011). *Agency-contracted direct service* is a form of private practice in which the occupational therapist is an independent contractor to government units, hospitals, school systems, nursing facilities or any healthcare agencies which provide contracted services. *Client-paid direct service* is the classic form of private practice where the source of income comes from the client, either directly or through funding schemes. *Ownership and management of multi-therapist service business* usually results from business growth, where the therapist assumes the role of manager or owner and new therapists are employed within the business. Private practitioners are often faced with challenges resulting from the need to provide quality clinical services and ensure business success (Anderson & Nelson, 2011).

Within the Australian health system, sources of income for private occupational therapists include Private Health Insurance, Medicare, Department of Veterans Affairs, workers compensation authorities, motor vehicle accident insurers and the client themselves (Merritt, Perkins & Boreland, 2013). The involvement of these funding bodies is thought to present additional challenges as they often place policy and cost restrictions on the therapeutic relationship (Anderson & Nelson, 2011). Such challenges, including marketing and competition and the need to make profit can cause additional ethical dilemmas for private practitioners (MacKenzie, 1992).

6.2 National Disability Insurance Scheme

As mentioned in the Introduction, healthcare reform is an inevitable process in today’s society, requiring occupational therapists to adapt to changes and demands of the healthcare system. Australia is presently experiencing a healthcare reform within the disability sector through the introduction of the National Insurance Disability Scheme (NDIS); a federally funded scheme which aims to provide lifelong support for people with disabilities (Russi, 2014). The NDIS serves as an additional source of income for private practitioners. More importantly, it will have a significant impact on occupational therapy resulting in anticipated increases in access to allied health services (Russi, 2014), further increasing demands of service provision. Simpson (2013) alludes to increases in the number
of private practices resulting from the introduction of the NDIS, and draws attention to the unavoidable consequence of competition for clients within the marketplace. These changes within the private sector have great implications for occupational therapists working in private practice and will no doubt intensify ethical complexities of professional practice. Furthermore they mandate the need for research into current ethical dilemmas experienced by occupational therapists working in the private sector.

**6.3 Ethical Dilemmas in Physiotherapy Private Practice**

Physiotherapy private practices are comparable to occupational therapy in their for-profit nature. Considering physiotherapists are most often paid according to the number of patients they see, such a payment structure can elicit behaviours aimed at increasing business revenue, which may not be in the best interest of the client, thereby creating ethical dilemmas (Hudon, Drolet & Williams-Jones, 2015).

A literature review of 39 publications conducted by Hudon et al. (2015) offers insights on ethical issues encountered by physiotherapists working in private practices. This review encompassed studies from America, Canada and Denmark, however differences between country of practice were not discussed. Rather the findings were presented according to three categories similar to those previously reported by Trienzenberg (1996) in the public sector: business and economic issues, professional issues and patient’s rights and welfare issues. Distinctive findings related to business and economic issues primarily involved conflicts of interest. Physiotherapists encountered conflicts between their own financial interests and the best client care. Physiotherapists’ dual accountability to patients and third-party payers were another common source of conflict, which is unique to private practice. Ethical issues also arose due to limited resources and lack of time which affected service provision. Within the professional issues category, physiotherapists reported ethical issues resulting from uncertainty about treatment effectiveness and balancing clinical judgment with employer advice. Patient’s rights and welfare issues encompassed a host of ethical issues such as whether to advocate for patients in contexts of scarce resources and obtaining informed consent where time is lacking.

Although these findings provide insight into the ethical issues experienced by private practice physiotherapists, notably resulting from the nature of the institutional environment (Hudon et al., 2015), they do not provide information specifically on the nature of ethical dilemmas.
6.4 Ethical Dilemmas in Speech-Language Pathology Private Practice

The limitation of the Hudon et al., (2015) study is addressed by the literature in speech-language pathology. Flatley et al. (2014) interviewed 10 private practice speech-language pathologists from New South Wales, Australia, with the aim of identifying ethical dilemmas specific to private practitioners. The participants were all managers or owners of their practice and years of experience in private practice varied from less than five years to more than 25 years. Findings revealed four themes of ethical dilemmas: balancing benefit and harm, fidelity of business practices, personal and professional integrity and accessing and distributing funds. Within balancing benefit and harm ethical dilemmas arose due to the need for clinical outcomes, concerns about quality of services of other speech-language pathologists and making reports about questionable client or parent behaviour. Fidelity of business practices involved dilemmas between participants’ duties to their business and staff members and to their clients. The interplay between business and service provision was evident within this theme as participants aimed to provide quality services but also ensure a viable and profitable business. Dilemmas also occurred due to concerns regarding personal and professional integrity of colleagues. Lastly, ethical dilemmas which arose due to accessing and distributing external funding for services were reported.

Although dilemmas such as personal and professional integrity, confidentiality issues, supervision of staff members and resource/fund allocation are not unique to private practice, they are often experienced differently by private practitioners. For example, supervision of staff is common to public and private sectors, but private practitioners reported that opportunities for making income were reduced as a result of supervision (Flatley et. al, 2014).

Dilemmas such as distributing funds and ensuring beneficence for the client (Flatley et al., 2014) are shared with physiotherapists (Hudon et al., 2015), however differences between the professions also exist. For example, physiotherapists experienced conflict when third-party payers were involved, while speech-language pathologists do not report involvement with third-party payers. This highlights that even within the private sector ethical dilemmas may differ between professions.

Considering the lack of research regarding experiences of ethical dilemmas within occupational therapy private practice, it is unknown to what extent they are unique from those of other health professions.
7. Conclusions

Knowledge of ethical dilemmas is well documented in the medical and nursing professions, however the congruency of these dilemmas to those experienced by occupational therapists is not ideal. Contributions from allied health research, namely in the fields of physiotherapy and speech-language pathology provide insight into the nature of ethical dilemmas experienced by these practitioners, which are comparable to occupational therapy. Research in occupational therapy surrounding ethical dilemmas has shown that some ethical dilemmas are shared between disciplines such as resource allocation and managing difficult patients, while others are specific to occupational therapy. Another conclusion from the literature is that ethical dilemmas are also specific to the area of practice. Private practice is an area with no research into ethical dilemmas in the occupational therapy discipline, however from speech-language pathology and physiotherapy research it is evident that practitioners working in public and private sectors encounter different ethical dilemmas. In addition, private practice is a current area of growth within the occupational therapy profession and one which is likely to encounter increasing ethical complexities in practice. Thus, insufficient knowledge about ethical dilemmas in private practice is a barrier to facilitating preparation of students for employment in private practice, and for developing resources to inform professional competence of currently employed practitioners.

8. Research Aim and Questions

The objective of the current study is to contribute to the knowledge base of practice ethics in the occupational therapy profession by addressing gaps in the existing literature and providing a preliminary analysis of occupational therapists’ experiences of ethical dilemmas. More specifically, this study aims to explore the ethical dilemmas encountered by occupational therapists working in private practice. The research question underpinning this study is: “What is the nature of ethical dilemmas experienced by occupational therapists working in private practice, and the contributing factors to these ethical dilemmas?”
References


SECTION 1: Literature Review


SECTION 1: Literature Review


SECTION 2: Journal Manuscript

Title: Ethical Dilemmas Experienced by Occupational Therapists Working in Private Practice

Target Journal: The Australian Occupational Therapy Journal (see Author Guidelines, Appendix 1).

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Abstract Length: 224 words (including key words)
Word Length: 5008
Number of Tables: 4
Number of Figures: 0
Number of References: 35
Abstract

Background/Aim: The dynamic nature of contemporary healthcare systems has imposed increasing demands on occupational therapists. As a result, ethical dilemmas have become an unavoidable encounter in occupational therapy practice. Ethical dilemmas may impact upon the wellbeing of a professional, quality of client care and the reputation of a profession as a whole. Despite this, there is limited research into the nature of ethical dilemmas experienced by occupational therapists, specifically those working in private practice. The aim of this study was to explore the nature of ethical dilemmas experienced by occupational therapists working in private practice.

Methods: A qualitative design was used. Semi-structured interviews were conducted with a purposive sample of six private practice occupational therapists, and focused on experiences of most frequent and challenging ethical dilemmas. Data was analysed using deductive thematic analysis.

Results: Four themes reflected the nature of occupational therapists’ ethical dilemmas in private practice: balancing benefit and harm, fidelity of business practices, personal and professional integrity and accessing and distributing funds.

Conclusion: In their experience of ethical dilemmas, occupational therapists were required to balance competing ethical principles while ensuring provision of quality clinical care and fulfilment of business needs. Knowledge of these ethical dilemmas may inform training and professional development programs for occupational therapists working in the private sector.

Key words: ethics, ethical tensions, allied health, private sector, qualitative method
Introduction

The contexts which surround occupational therapy practice are evolving rapidly, necessitating a need for the profession to simultaneously evolve. Contemporary healthcare reforms have changed the nature of practice through the introduction of reimbursement schemes and organisational policies imposing time, cost and productivity demands on healthcare professionals (Cross, Leitao & McAllister, 2008). Such demands intensify the existent ethical complexity of professional practice, which frequently eventuates in ethical dilemmas. Ethical dilemmas may arise in situations which require a decision between two or more equally pleasant or unpleasant alternatives about the right or best course of action (Kassberg & Skar, 2008).

Healthcare professions, including occupational therapy, are largely influenced by ethical principles of beneficence/non-maleficence, justice and respect for autonomy, which are defined as doing good/preventing harm, advocating for equality, and fairness and respect for persons, respectively (Beauchamp & Childress, 2012). This requires health professionals to be ethically competent in practice and make decisions about client care in accordance to these principles. Often, ethical principles are in competition and warrant prioritisation, which in itself is difficult due to their equal importance. For example, when allocating scarce resources within the community, decisions regarding whether the principle of beneficence for some should be prioritised over justice for all are challenging, creating an ethical dilemma as there is no distinct right or wrong course of action.

This tension between what one ought to do and not do (Flatley, Kenny & Lincoln, 2014), can cause ethical and moral distress for practitioners (Kalvemark, Hoglund, Hansson, Westerholm & Arnetz, 2004). Cross et al. (2008) found that when conflict arises between professional values, legal obligations and personal values it creates ethical distress, and if left unresolved disrupts work-life balance potentially leading to professional burnout. This highlights the importance of ethical-decision making systems for facilitating proactive management of ethical dilemmas. However, prior to developing these management strategies, knowledge of the nature of ethical dilemmas experienced by health professionals is necessary.

The understanding of ethical dilemmas in healthcare has largely been influenced by the medical and nursing professions. While ethical dilemmas involving end-of-life care
treatment and revealing diagnoses to patients faced by medical and nursing professionals (DuVal, Clarridge, Gensler & Danis, 2004; Hurst et al., 2007) are complex and significant in nature, they are not frequently encountered by occupational therapists. Conversely, allied health professionals such as physiotherapists and speech-language pathologists report ethical dilemmas regarding treatment effectiveness, resource allocation, patient autonomy (Finch, Geddes & Larin, 2005; Barnitt, 1998), client management and maintaining professional competence (Buie, 1997; Kenny, Lincoln, Blyth & Balandin, 2009). It may be that these are of greater relevance to occupational therapists due to the comparable nature of the professions.

Research regarding ethical dilemmas experienced by occupational therapists is limited. However, a recent scoping review provides insights into the types of ethical tensions occupational therapists report in public health practice (Bushby, Chan, Druif, Ho & Kinsella, 2015). Ethical tensions are caused in events that raise morally troubling concerns and encompass ethical dilemmas (Bushby et al., 2015). Bushby et al. reviewed 32 peer-reviewed articles and identified seven primary themes which highlighted ethical tensions: resource and systemic issues, client safety, working with vulnerable clients, upholding ethical principles, interpersonal conflicts, upholding professional standards and practice management. The majority of these tensions were shared inter-professionally, however they may be perceived differently due to differences in professional and ethical codes of practice.

Furthermore, occupational therapists encounter different dilemmas due to differing demands of their workplaces (Flatley et al., 2014), which include hospitals, community centres, private practice, rehabilitation units, psychiatric clinics and school and aged-care facilities (Occupational Therapy Australia, 2015). For example, occupational therapists in an acute medical ward face dilemmas when considering the needs of the organisation to make beds available and the needs of the client who may not be ready for discharge, hence placing the principles of justice and beneficence at stake (Atwal & Caldwell, 2003). Contrarily, in a rehabilitation setting, dilemmas primarily result from the need for patients to make therapy-related decisions and conflicts about intervention planning between therapist and family members (Kassberg & Skar, 2008; Foye et al., 2002).
Within private practice, when addressing business and clinical care concerns, therapists may experience additional dilemmas which are identified in the research of speech-language pathologists who report differences between private and public sectors (Flatley et al., 2014). Flatley et al. interviewed ten private practice speech-language pathologists, all practice managers or owners. They identified four themes of ethical dilemmas: balancing benefit and harm, fidelity of business practices, personal and professional integrity and accessing and distributing funds. Although dilemmas such as personal and professional integrity, supervision of staff members and resource/fund allocation are not unique to private practice, they are often experienced differently by private practitioners. For example supervision of staff is common to public and private sectors, but private practitioners reported that opportunities for making income were reduced as a result of supervision time (Flatley et al., 2014). Physiotherapists in private practice shared the same concerns resulting from the interplay of business and service provision (Hudon, Drolet & Williams-Jones, 2015).

Private practice has been identified as a sector of growth within occupational therapy (Australian Institute of Health and Welfare, 2013). Healthcare reforms, like the National Disability Insurance Scheme have increased professional and ethical demands within private practice (Russi, 2014). Hence therapists will require knowledge about potential ethical dilemmas, to promote ethical competency. However, to date there has been no investigation into the nature of ethical dilemmas experienced by occupational therapists working in private practice. This insufficiency in knowledge is a barrier for developing resources to inform professional competency of currently employed and future practitioners.

Therefore, the aim of this study was address this gap in the literature by exploring the nature of ethical dilemmas experienced by occupational therapists working in private practice.
Method

When exploring phenomena about which little is known, qualitative research can be used to determine the meaning of natural phenomena through description (Al-Busaidi, 2008). A qualitative descriptive approach seeks to discover the ‘who’, ‘what’ and ‘where’ of phenomena and thus produces rich descriptions of experiences (Sandelowski, 2000). Ethics approval for this study was obtained from the University of Sydney Human Research Ethics Committee.

Recruitment

Purposive sampling was the primary method used to recruit participants in this study, as it enables selection of individuals who have the knowledge and experiences needed to address study aims (Teddlie & Yu, 2007). Participants were publically listed as private practitioners and sourced from the Occupational Therapy Australia website. Recruitment emails were sent out by a third party person to a total of 154 occupational therapists employed in the Greater Sydney Metropolitan area. A reminder email was sent out two weeks after the initial contact. Seven responses were received with four participants consenting. To ensure sufficient numbers of participants snowball sampling was then used with consenting participants encouraged to forward the recruitment flyer to personal contacts. This resulted in two additional participants. Six occupational therapists, currently employed in private practice for a minimum of 12 months participated in the study.

Data Collection

Data were collected by the first author using semi-structured interviews. An interview protocol with pre-determined questions was used, to capture in-depth participants’ experiences of ethical dilemmas through a conversation-like approach (Rubin & Rubin, 2012). Interview questions were developed by the authors and compiled into a protocol adapted from Flatley et al. (2014). Prior to interviews, piloting of the protocol with an experienced private practice occupational therapist resulted in adaptation of the interview guide to facilitate flow of the interview. New questions were generated as the interview progressed. Two interviews were conducted face-to-face at the participants’ workplace, while the remaining four were conducted over the phone.

As demonstrated in Table 1, the questions were organised into three levels, preceded by a warm-up question focusing on participants’ work experiences as an occupational therapist. In
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order to minimise bias and to avoid directing participants to certain ethical dilemmas, the interviewer provided general prompts (e.g. please think about an ethical dilemma that occurs frequently in your work). Prompts were also used to gain deeper understanding of the dilemma (e.g. can you think of an example to help me understand the dilemma). Where further clarification and detail was needed, such as what was at stake and what challenged or concerned the participant, probing questions were used.

To ensure a common understanding of ethical dilemmas, interviewees were provided with the following definition: “an ethical dilemma may exist where one option may be considered both right and wrong, or where two options exist and both would be equally reasonable choices to make” (Flatley et al., 2014). Participants were reminded to only discuss dilemmas experienced as a private practice occupational therapist and to think carefully before discussing information deemed notifiable conduct under the National Law (Australian Health Practitioner Regulation Agency, 2014).

All interviews were audio recorded, lasting between 30 and 60 minutes, and were transcribed verbatim, excluding identifying data.

Data Analysis

All data was analysed by the first author using a thematic analysis approach (Braun & Clarke, 2006). A deductive approach was used due to the specific nature of the research question. Initially, the authors familiarised themselves with the data through transcription and by reading and re-reading the data. Following this, instances of ethical dilemmas or discussion thereof, were identified within each individual transcript to differentiate relevant and irrelevant data. An existing thematic framework (Flatley et al., 2014) was used to initially code the relevant data extracts. The generated codes represented the main message of each ethical dilemma. In instances where the content of the ethical dilemma did not match the content of themes reported by Flatley et al., the dilemma was categorised according to its content. The coded data was then reviewed and the researcher generated descriptive phrases which identified different sides of the dilemma and the contributing factors. This was followed by a mapping exercise in which content alignment of the current coded data was checked against the existing themes and sub-themes. Where content misalignment occurred, a new sub-theme was generated or an existing sub-theme modified. The final stage was defining and naming themes. This involved reviewing each theme and re-reading the entire
data set to ensure accuracy of analysis. The content of each theme and sub-theme was also defined. Table 2 illustrates the analysis process through an example.

**Research Credibility**

To improve reliability, an audit decision trail of the researcher’s thought process during data analysis was kept to ensure consistency and transparency in the interpretation of data (Noble & Smith, 2015). The student researcher kept a reflective journal of challenges, beliefs, strengths and weakness encountered during data collection and analysis, and discussed these in debriefing sessions with team members.

Member-checking validation was employed, to ensure accuracy of data collection (Sandelowski, 2000). Following interview transcription, all participants were emailed a copy of their transcript, providing an opportunity to review their responses and make any amendments they deem necessary. Only one participant made changes by elaborating on the discussed ethical dilemmas.

**Results**

**Participants**

A description of the participants is provided in Table 3. Of the six participants recruited in this study, five were female and one was male. Practices varied in size with some being single-clinician, while others had multiple clinicians employed. Practices were located in different socioeconomic areas from Sydney, NSW, with the exception of one practice in Canberra, ACT.

**Interview Data**

Participants reflected upon their clinical, professional and business roles while identifying and describing their most frequent and challenging ethical dilemmas. Four main themes were identified, including: balancing benefit and harm, fidelity of business practices, personal and professional integrity and accessing and distributing funds fairly and honestly (Refer to Table 4).
Theme 1: Balancing Benefit and Harm

All participants identified the need to balance benefit and harm to clients as the most frequent ethical dilemma they experienced. Ethical dilemmas arose when managing differences in expectations of outcomes and making decisions about reporting questionable client behaviour.

Managing expectations of outcomes

Two types of ethical dilemmas raised were those related to: i) dilemmas which arose due to the participant’s anticipation of compromised client outcomes resulting from external factors, ii) managing others’ expectations of outcomes. Participants needed to consider and manage the expectations of several parties including families, clients and insurance companies, while ensuring the need for best client outcomes.

Three examples of ethical dilemmas were provided regarding anticipation of compromised client outcomes due to factors external to the participant. Claire reported that it was challenging to achieve a balance between ensuring evidence-based practice versus appearing to adopt a salesperson role when trying to prescribe additional aids to clients who did not understand the need for such aids: “You are then trying to twist the patient’s arm and get them to purchase the splint as you know it will most likely decrease future treatments and speed up the rehabilitation process”.

Similarly, Rosie described working with families and clients who are unable to attend frequent sessions as clinically recommended, due to financial constraints, even though she believed that increasing the frequency was likely to result in better client outcomes. Both of these participants were aware their recommendations were likely to increase the cost of service from the client’s perspective, yet they were not promoting this to increase their income, rather because they believe their recommendations to be best-practice.

Joanne experienced an ethical dilemma while treating children who were receiving parallel therapy from another provider. In one instance, the dilemma arose due to conflicting approaches to therapy used by the two providers, in which case neither therapist “would’ve got the improvement because it would’ve just confused him [client]”.

Another dilemma of the same nature was reported by Joanne, however, in this case the parent did not provide consent to contact the other provider, resulting in the lack of
knowledge regarding what therapy the client was receiving. Joanne wanted to ensure she was not “doing the same in a different way…it’s sort of not knowing whether it’s going to be that conflict between the two” This ethical dilemma was in relation to making a decision about whether to discontinue client therapy due to anticipation of conflict, even though she believed further improvement was possible, or to continue with the service despite the lack of knowledge about current therapy the client was receiving from another occupational therapist.

Additionally, ethical dilemmas about managing insurance companies’ and clients’ expectations of outcomes were discussed. When dealing with third parties, participants reported a lack of understanding of therapy procedures by the insurance companies as “people who are liaising with these claims don’t actually have any experience as a therapist” (Claire) which resulted in a conflict in the expectations of outcomes between the company and the service provider.

For example, Taylor was contracted by an organisation to determine whether a reclining chair was necessary for an elderly woman who was requiring assistance with transferring on and off her current chair. Taylor reported a conflict between feeling obliged to agree with the organisation who contracted him for the job, and doing what is in the best interest of the client.

I feel that it’s more appropriate to have 2 staff to assist the client, the organisation who was contracting me, would want me…to write in the report…to have 1 staff instead of 2 staff… I think with the chair, it benefits the staff more, rather than the client.

Sarah found it challenging dealing with clients who were expecting a cure and reported a dilemma where she felt like she had to say what clients wanted to hear because they were paying for her opinion; however this was not always possible as she had to be ethical in service provision. In both instances, participants managed conflicting expectations of outcomes with the goal of benefiting the client.

**Reporting behaviour of clients**

Two participants raised concerns about reporting client behaviour to appropriate government agencies. In NSW, it is illegal to offer a bribe in order to acquire a driving licence without having passed the appropriate test, and doing so can incur fines or imprisonment
ETHICAL DILEMMAS IN OCCUPATIONAL THERAPY

(Roads and Maritime Services, 2015). Taylor recounted a dilemma where he was legally required to report a client who offered a bribe to pass their on-road driver’s test, but failed to do so to avoid repercussions for the client.

In NSW, occupational therapists are required by law to report concerns of harm, neglect and abuse toward children, which includes cases where the child should be in school but is not (NSW Consolidated Acts, Children and Young Persons (Care and Protection) Act, 1998). Sarah discussed a dilemma between her obligation to report a parent to NSW Department of Family and Community Services (FACS) because “legally he [the child] needs to be at school...do I keep providing services and saying what this mum wants me to say, or do I make the notification” as she feared ramifications such as discontinuation of occupational therapy services, resulting in the child missing out on therapy. The dilemma in both cases related toupholding professional and legal obligations to report while ensuring clients are not harmed.

Overall, participants experienced ethical dilemmas due to their need to balance personal and professionals responsibilities against ensuring best client outcomes (beneficence/non-maleficence). Ethical challenges were attributed to factors such as cost, third party involvement, who participants believed their client was and client and family understandings of evidence-based practice.

Theme 2: Fidelity of Business Practices

The need to fulfil professional roles and obligations in providing ethical, quality care while ensuring business needs are met was a common source of tension for most participants. Discussions centred on the conflicts caused by the interplay of running a business and providing an occupational therapy service. Owners of private practices who only worked in the private sector experienced dilemmas due to their obligations to the business as well as to their clients. Joanne reported tensions resulting from conflicting goals of business and service delivery and the need to find a balance between the two to ensure fidelity of business practices.

In healthcare it’s supposed to be...the better service that I provide the shorter the treatment plan should be, but from a business point of view, all the coaching that I receive is about...how do you maximise the spend of your client.
The need to protect income was another factor contributing to ethical dilemmas. Taylor reported a dilemma when there was a need to help a client but the client was struggling financially and could not afford the service “I have a responsibility to whoever will reach out to me…I would like to help them as much as I could but...at the same time, I’m a business owner...everyone needs to make money”.

These dilemmas were further complicated by the mutual relationship between income and quality clinical care. Joanne reported income and clinical care as drivers of each other in which one is needed to achieve the other.

If I get paid well for the services I provide, then I’ve got a little bit extra profit...to then put into training my staff and...finding new resources...so that I can provide better clinical care for the same cost.

Overall, for the majority of the participants there was an ongoing balance between clients paying for service resulting in participants’ ethical reasoning being influenced by service provision versus ensuring a viable and profitable business.

**Theme 3: Personal and Professional Integrity**

This theme encompassed ethical dilemmas which questioned the ability of participants’ colleagues to act in accordance with professional codes and guidelines, as well as those which challenged their own personal and professional integrity. Although the ethical dilemmas occurred in different practice contexts, they were uniform in nature and were influenced by competition among the occupational therapy professionals in the private sector.

Sarah described the problematic nature of marketing strategies used by some occupational therapy providers who appear to market a cure which might attract her clients from her practice, yet “if you try to challenge [the client’s decision] then you’re looking as though you want the business but you just want them to spend their money wisely”. Joanne reported her dilemma when clients did not disclose whether they were on a waiting list with another occupational therapy provider, so she does not seem to be “taking clients or poaching clients...because it’s not as if I’m actively doing that”. In both situations the participants anticipated negative impacts to their professional integrity resulting from their actions being perceived as though they want financial gain, even though this was not their motive.
Taylor reported the impact of competition for clients as a divisive factor for occupational therapists working in the same organisation as “the therapists are in a way fighting [for same group of clients] against each other”. However competition was necessary as the participant’s income was based on number of clients seen. In summary, competition within the occupational therapy private sector seems to be the cause of ethical dilemmas, which then potentially negatively impacts the participants’ professional integrity and that of their colleagues.

Theme 4: Accessing and Distributing Funds Fairly and Honestly

Ethical dilemmas which arose due to access and distribution of external funding for services and ensuring fair access to services were included within this theme.

Funding to support therapy and purchase of resources

Ethical dilemmas were associated with the use of finite funding to support therapy. Sarah reported a dilemma in deciding how much funding to use, for a complex home modification case, to ensure best client outcomes. Home modifications are recommended by occupational therapists to increase safety and independence within the home. The process is time-consuming, consisting of numerous steps including completion of home assessments, diagrams and reports, and is extended for complex modification requirements (Home Modifications Australia, 2014). Sarah reported that due to the nature of the case it would have been an ideal case in terms of income as she could have profited a lot. However, she discussed the conflict she felt in billing for excessive hours required for the home modification process, questioning the fairness of using the clients external funding for such a complex case as “they only had a certain bucket of money to do so much”.

Ensuring accessibility of services

Three participants reported dilemmas surrounding determining cost for a service to ensure fair access, particularly when finances were an issue for the client or family. Some participants believed the current fee schedules may be too high for certain families. Sarah discussed challenges in making a fair decision about when to reduce fees and for whom.
Do you not charge them $170…and then you’re undercutting…other people providing a service so that you can help out this family, or do you bite the bullet…But then you’ll get families who try to take advantage of this.

Shannon shared a similar challenge in making a decision whether to charge a client for going overtime, as fees are normally charged per hour, but reported making exceptions for families who were struggling financially.

In summary, participants reported dilemmas related to client management, business practices, personal and professional integrity and access and distribution of funds. Most dilemmas required prioritisation and balance of ethical principles of beneficence and non-maleficence against business commitments. Principles of justice and autonomy were also involved, particularly when making decisions about funding and billing for services.

**Discussion**

This study aimed to explore the nature of ethical dilemmas experienced by occupational therapists working in private practice. Findings revealed ethical conflict occurred when therapists considered issues of client management, fulfilling business needs, personal and professional integrity, and access and distribution to external funding sources. Inherent in each theme was the conflict between providing quality services and ensuring a viable and profitable business. Similar themes are reported in other professions (Flatley et al., 2014; Hudon et al., 2015), however, for this study the nature of ethical dilemmas within each theme appears unique to the profession of occupational therapy. One reason for this uniqueness may lie within the inherent value held by occupational therapists of first and foremost the need to be client-centred (Hammell, 2013).

Client-centred practice is potentially what differentiates occupational therapy from other professions as it ensures a holistic and socially-just approach to care (Townsend & Wilcock, 2004). Client-centred practice is imbedded within professional Codes of Ethics and Codes of Conduct (Occupational Therapy Australia, 2014; Occupational Therapy Board of Australia, 2014) and mandates that the primary allegiance of the occupational therapist is to the client. However, client-centred care in theory can look entirely different in practice. For example, Hammell (2007) noted ethical tensions between therapists’ attempts to remain client-centred and fulfil workplace obligations, attributing these to the shift in allegiance of the occupational therapist.
therapist from the client, to the system in which they are employed. Certainly, this issue was identified by several participants in the current study when discussing ethical dilemmas resulting from involvement of third-party providers (e.g. insurance companies). The source of tension appears to be in deciding who the client is, especially in situations where the therapist is accountable to more than one party, for example the funder and the individual accessing the service. Thus the dilemma results from the need to remain client-centred in a situation of uncertainty regarding to whom the occupational therapist is accountable.

Additionally, ethical dilemmas resulted from the amalgamation of business concerns and client-centred practice. The dilemmas may appear to have distinct causes, but intrinsic to each is the conflict arising from the need to uphold dual roles of occupational therapist and business owner. For example, ethical dilemmas within the theme of personal and professional integrity seem to be caused by the competition amongst private occupational therapists. This differs from the dilemmas related to ensuring accessibility for all which are caused by financial difficulties of clients. However, the nature of both dilemmas is the same. In both cases the therapist is required to make a choice between benefiting the client or benefiting the business, which superficially appear to be mutually exclusive choices. This nature can be exemplified through the analogy of a scale. Much like a scale is composed of two competing sides, so too are ethical dilemmas. Equilibrium is required to keep the competing sides in balance, however when applied to ethical dilemmas it almost seems impossible to achieve equilibrium. In other words the scale will always tip over.

In consideration of the study findings, on one hand the therapist aims to uphold the principles of beneficence and non-maleficence to ensure client-centred practice and best client outcomes. On the other hand, business commitments need to be fulfilled to ensure a successful and profitable business. Ethical dilemmas occurred when attempting to establish equilibrium between the two responsibilities. However, the remaining question is “how do we choose which side will lose out when the scale tips?” This complicated relationship between the business and clinical roles of the therapist is what distinguishes ethical dilemmas in private practice from those in government-funded positions (Flatley et al., 2014; Hudon et al., 2015). Although an occupational therapist employed in a government-funded service may consider the effective use of resources (Bushby et al., 2015), they do not need to plan for the financial viability of their service. This differs from private practice where balanced decisions are needed between what is best for the client versus what is best for business.

Participants reported tensions when balancing principles of justice, beneficence and autonomy while
ensuring client access to services. Private practitioners have greater systemic and operational autonomy of their practices compared to their colleagues in public practice (Hudon et al., 2015). As a result, they have increased responsibility to make sound and just decisions when determining service fees. Ethical dilemmas however, were reported resulting from the uncertainty of when to make financial exceptions and for whom, to ensure accessibility to services and limit financial losses, once again illustrating the conflict between obligations to uphold client-centred practice and ensure a viable business.

**Implications**

Knowledge of the nature of ethical dilemmas experienced by private practice occupational therapists is important in preparing practitioners to think about and manage dilemmas in their daily practice. Findings may inform professional development programs for occupational therapists working or planning to work in the private sector. In addition, understanding the contributing factors to ethical dilemmas has implications for ethical decision-making strategies. Educational programs may draw upon the findings to assist in better preparation of occupational therapy students for working in private practice by equipping them with knowledge about the ethical dilemmas they may encounter in their work and strategies to manage these.

**Limitations**

The private practices in the current study were all within metropolitan locations, and therefore the identified ethical dilemmas may not be representative of rural and remote locations. As participants were reminded not to discuss dilemmas deemed notifiable under the National Law, it is possible that ethical dilemmas were not described in their entirety and those of greater ethical complexity may have been omitted. Finally, as this was a qualitative study with a small number of participants, results may not be generalisable to the wider community (Patton, 2002).

**Future Research**

Future research could repeat the study with a larger sample size. In addition, future studies could explore the nature of ethical dilemmas experienced by occupational therapists in rural and remote locations. Lastly, studies exploring how occupational therapists manage ethical dilemmas would be beneficial.
Conclusion

Ethical dilemmas regarding client management, fidelity of business practices, personal and professional integrity and accessing and distributing funds have been encountered by occupational therapists working in private practice. While many ethical dilemmas are shared with the public sector and inter-professionally, the nature of ethical dilemmas in private practice seems to be due to the interplay between ensuring client-centred practice and a viable business. As healthcare systems continue to evolve and ethical complexities of practice increase, the ability to successfully navigate ethical issues will become imperative. Findings provide insights into the nature of ethical dilemmas experienced by occupational therapists working in private practice, and have contributed to the knowledge base about practice ethics in occupational therapy.

Acknowledgements

The authors would like to thank all participants in the study.
References


SECTION 2: Journal Manuscript
ETHICAL DILEMMAS IN OCCUPATIONAL THERAPY


Table 1: Levels of Questions Used for Data Collection

<table>
<thead>
<tr>
<th>Topics covered</th>
<th>Broad questions†</th>
<th>Probe questions‡</th>
<th>Follow-up questions§</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Most frequent ethical dilemmas</strong></td>
<td>1. Please think about an ethical dilemma that occurs frequently in your work as a private practitioner. As I am interested in exploring your experience with this dilemma; please tell me in as much detail as possible what happened in this case</td>
<td>• What was at stake?</td>
<td>→ Was it an ethical principle, a client’s well-being, professional integrity?</td>
</tr>
<tr>
<td></td>
<td>2. Can you please describe another ethical dilemma you experience most often in your current practice, using a case example?</td>
<td>• Could you describe the two different sides of the dilemma?</td>
<td></td>
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<tr>
<td></td>
<td>Out of the (number) ethical dilemmas we have discussed, which would you say was the most challenging and why?</td>
<td>• What do you think were the factors contributing to the dilemma?</td>
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<tr>
<td></td>
<td>Can you identify any issues which may become ethically challenging to you working in private practice in the next 5-10 years?</td>
<td>• For owners: Do you think the interplay of running a business and providing an OT service influenced the ethical dilemma?</td>
<td></td>
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<tr>
<td></td>
<td>Do you think ethical dilemmas experienced by public practice occupational therapists are different to those in private practice?</td>
<td>• For employees: Do you think having to balance business needs and provide the OT service influenced the ethical dilemma?</td>
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<tr>
<td></td>
<td></td>
<td>• What was at stake?</td>
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<td></td>
<td></td>
<td>• How do you think the introduction of the National Disability Insurance Scheme (NDIS) will influence ethical dilemmas in private practice?</td>
<td>→ Will it impact the frequency, nature or complexity of dilemmas?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• What factors make them different?</td>
<td></td>
</tr>
<tr>
<td>† Open-ended questions to address study aims and allow responses in narrative form</td>
<td>‡ Encourage participants to provide specific examples of ethical dilemmas</td>
<td>§ Allow elaboration of key concepts to ensure in-depth exploration of experiences</td>
<td></td>
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</table>
### Table 2: Process of Analysis

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<tr>
<td><strong>Theme</strong></td>
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<td></td>
<td><strong>Theme</strong></td>
</tr>
<tr>
<td>Balancing Benefit and Harm</td>
<td>“I want her to improve her function and she won’t improve if she’s in the chair, because, I think with the chair, it benefits the staff more, rather than the client”</td>
<td>‘balancing client outcomes with third party expectations’</td>
<td>Alignment was checked against the existing sub-theme ‘Expectations of Outcomes’, however the content was misaligned due to participant’s need to manage third party expectations</td>
<td><strong>Theme</strong></td>
</tr>
<tr>
<td><strong>Sub-Theme</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>Sub-Theme</strong></td>
</tr>
<tr>
<td>Expectations of Outcomes</td>
<td></td>
<td></td>
<td></td>
<td>Managing Expectations of Outcomes</td>
</tr>
</tbody>
</table>
| -included dilemmas which occurred when outcomes were not met due to discontinuation of therapy and where need for outcomes impacted emotional cost of clients | **Coded as:** ‘balancing client outcomes with third party expectations’ | **Descriptive Phrases generated:**  
- expectation of outcome for third party is to benefit staff  
- expectation of outcome for OT is to improve client function | **Sub-theme Modified:**  
‘Managing Expectations of Outcomes’ | - includes all ethical dilemmas in which the participant needed to manage either their own expectations of outcomes, those of the client or of a third party such as an insurance company, to ensure best client outcomes and avoid harm. |

† Reported by Flatley et al., (2014)
Table 3. Participant Demographics

<table>
<thead>
<tr>
<th>Participants†</th>
<th>Years of Experience Working in Private Practice</th>
<th>Caseload</th>
<th>Workload</th>
<th>Multidisciplinary Team (Yes/No)</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claire†</td>
<td>2</td>
<td>Hand therapy, general adult</td>
<td>Part-time</td>
<td>No</td>
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† Pseudonyms have been used to protect identity of participants
‡ In addition to private practice work, also employed full-time within public sector

Table 4. Themes

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<td>-Reporting behaviour of clients</td>
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<td>2. Fidelity of Business Practices</td>
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<td>3. Personal and Professional Integrity</td>
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<td>4. Distributing Funds Fairly and Honestly</td>
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<td>-Ensuring accessibility of services</td>
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APPENDIX 1: Australian Occupational Therapy Journal Submission Guidelines

The Australian Occupational Therapy Journal is the official journal of Occupational Therapy Australia. The journal publishes original articles dealing with theory, research, practice and education in occupational therapy. Papers in any of the following forms will be considered: Feature Articles, Research Articles, Reviews, Viewpoints, Critically Appraised Papers, and Letters to the Editor.

ARTICLE TYPES

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Letters to the Editor 500

**Feature Articles**

Feature Articles can be in the form of research studies, theoretical papers, case reports or descriptive articles. Descriptive articles involve descriptions of interesting clinical, administrative, educational or technological innovations in occupational therapy. Single or multiple case reports may be used to illustrate the application of such innovations. Feature articles should contain the following:

- **Structured abstract:** 250 word limit.
- **Introduction:** The aims of the article should be clearly stated and a theoretical framework (if applicable) should be presented with reference to established theoretical model(s) and background literature. A succinct review of current literature should set the work in context. The introduction should not contain findings or conclusions.
- **Methods:** This should provide a description of the method (including subjects, procedures and data analysis) in sufficient detail to allow the work to be repeated by others.
- **Results:** Results should be presented in a logical sequence in the text, tables and figures. The same data should not be presented repetitively in different forms.
- **Conclusion:** The discussion should consider the results in relation to the purpose of the article advanced in the introduction. The relationship of your results to the work of others and relevant methodological points could also be discussed. Implications for future research and practice should be considered. The conclusion section of your structured abstract should contain the key messages/take home points of your article.

Feature Article manuscripts should not exceed 5000 words, and have no more than 35 references.

**Research Articles**

Research Articles should contain the following:

- **Structured abstract:** 250 word limit.
- **Introduction:** The aims of the article should be clearly stated and a theoretical framework (if applicable) should be presented with reference to established theoretical model(s) and background literature. A succinct review of current literature should set the work in context. The introduction should not contain findings or conclusions.
- **Methods:** This should provide a description of the method (including subjects, procedures and data analysis) in sufficient detail to allow the work to be repeated by others.
- **Results:** Results should be presented in a logical sequence in the text, tables and figures. The same data should not be presented repetitively in different forms.
- **Conclusion:** The conclusion should consider the results in relation to the purpose of the article advanced in the
introduction. The relationship of your results to the work of others and relevant methodological points could also be discussed. Implications for future research and practice should be considered. The conclusion section of your structured abstract should contain the key messages/take home points of your article. Research Article manuscripts should not exceed 5000 words, and have no more than 35 references. For manuscripts that report on randomised controlled trials, please include all the information required by the CONSORT checklist. All manuscripts must include a flow chart showing the progress of participants during the trial. Where applicable, reference should be made to the extension to the CONSORT statement for non-pharmacological treatment and the CLEAR NPT. When restrictions on word length make this difficult, this information may be provided in a separate document submitted with the manuscript.

Reviews

Narrative reviews, systematic reviews and meta-analyses are included in this category. Recommendations for clinical practice and further research should be included. A structured abstract is required of 250 words. Manuscripts should not exceed 5,000 words (not including references).

Viewpoints

Viewpoints provide a forum for the debate and discussion of occupational therapy issues and related concerns. The discussion should highlight the author's opinion and the views presented should be linked, where possible, with an established literature base. Authors are encouraged to discuss topical and controversial issues, and to do so in a manner that sheds light on or challenges established practices and beliefs. In many cases, discussion will require attention to varying opinions. Viewpoint may be an appropriate avenue for readers to debate the content of previous Viewpoints or other articles that have appeared in the Journal. Authors of articles commented on will be invited to respond in a Letter to the Editor which, where possible, will be published in the same issue as the Viewpoint.

Viewpoint manuscripts should not exceed 2000 words, include a 150 word abstract and have no more than 15 references. A title page, abstract, keywords and references should be included. A Viewpoint abstract should, in 150 words, clearly articulate the significance of the professional/practice/theoretical issue you will address, your proposition/contention and an overview of how you will support your case.

Letters to the Editor

The Journal welcomes letters from readers who wish to comment on previous articles in the Journal or on any topic relating to occupational therapy theory, research, practice or education. Letters should not exceed 500 words. A longer letter may be considered as a Commentary if it is a comment on a specific article; however, it should not exceed 800 words. The author(s) of the original article will be given a right of reply to the Commentary. The reply should also not exceed 800 words.

Critically Appraised Papers

Critically Appraised Papers are usually solicited by the Editorial Office. If a submission is planned, please contact the Editorial Office for specific guidelines.

EDITORIAL REVIEW AND ACCEPTANCE

The acceptance criteria for all papers are quality, originality and significance to our readership. Except where otherwise stated, Feature Articles, Research Articles, Reviews and Viewpoint manuscripts are blind peer reviewed by two anonymous reviewers. Final acceptance or rejection rests with the Editorial Board or the editor, who reserves the right to refuse any material for publication. Manuscripts should be written so that they are intelligible to the professional reader who is not a specialist in the particular field. They should be written in a clear, concise, direct style. Where contributions are judged as acceptable for publication on the basis of scientific content, the Editor and the Publisher reserve the right to modify typescripts to eliminate ambiguity and repetition and improve communication between author and reader. If extensive alterations are required, the manuscript will be returned to the author for revision.

COVER LETTER AND ETHICAL CONSIDERATIONS

Papers are accepted for publication in the journal on the understanding that the content has not been published or submitted for publication elsewhere, and this must be stated in the covering letter. The covering letter must contain an acknowledgement that all authors have contributed significantly, and that all authors are in agreement with the content of the manuscript. Authors must also state that the protocol for the research project has been approved by a suitably constituted Human Research Ethics Committee of the institution within which the work was undertaken and that it conforms to the provisions of the Declaration of Helsinki (as revised in 2008). All investigations involving humans must include a statement about the ethical review process. It is expected that most investigations will seek review by a Human Ethics Review Committee. Where ethical review has not been sought or obtained, justification must be provided. It is expected that most investigations involving humans will require informed consent for participant data to be collected and/or used; this process should be described. A statement is also required about preserving participant anonymity.

The Australian Occupational Therapy Journal retains the right to reject manuscripts which do not describe these processes, or which describe unethical conduct related to human or animal studies.

Pre-submission English-language editing

Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. Visit our site to learn about the options. All services are paid for and arranged by the author. Please note using the Wiley English Language Editing Service does not guarantee that your paper will be accepted by this journal.

STYLE OF THE MANUSCRIPT

Chapter in a book

Electronic media

Appendices
These should be placed at the end of the paper, numbered in Roman numerals and referred to in the text. If written by a person other than the author of the main text, the writer's name should be included below the title.

Tables
There is a limit of four tables or figures per manuscript. Tables should be self-contained and complement, but not duplicate, information contained in the text. Number tables consecutively in the text in Arabic numerals. Type tables on a separate sheet with the legend above. Legends should be concise but comprehensive - the table, legend and footnotes must be understandable without reference to the text. Column headings should be brief, with units of measurement in parentheses; all abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, ‖ should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures
There is a limit of four tables or figures per manuscript. All illustrations (line drawings and photographs) are classified as figures. Figures should be cited in consecutive order in the text. Each figure should be labelled on the back in very soft marker or chinagraph pencil, indicating name of author(s), figure number and orientation. Do not use adhesive labels as this prohibits electronic scanning. Figures should be sized to fit within the column (80 mm), intermediate (114 mm) or the full text width (171 mm).
Line figures should be supplied as sharp, black and white graphs or diagrams, drawn professionally or with a computer graphics package. Lettering must be included and should be sized to be no larger than the journal text. Photographs should be supplied as sharp, glossy, black-and-white or colour photographic prints and must be unmounted. Individual photographs forming a composite figure should be of equal contrast, to facilitate printing, and should be accurately squared. Magnifications should be indicated using a scale bar on the illustration.
If supplied electronically, graphics must be supplied as high resolution (at least 300 d.p.i.) files, saved as .eps or .tif. A high-resolution print-out must also be provided. Digital images supplied only as low-resolution print-outs and/or files cannot be used.

Colour figure publication charges
A charge of A$1000/US$530/¥64000 for the first three colour figures and A$500/US$265/¥32000 for each extra colour figure thereafter will be charged to the author.

Figure legends
Type figure legends on a separate sheet. Legends should be concise but comprehensive - the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

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SUBMISSION OF MANUSCRIPTS
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Australia
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Email: aot.eo@wiley.com
APPENDIX 2: Human Research Ethics Committee Approval

The University of Sydney

Research Integrity
Human Research Ethics Committee

Thursday, 25 June 2015

Ms Merrolee Penman
Health Systems and Global Populations, Faculty of Health Sciences
Email: merrolee.penman@sydney.edu.au

Dear Merrolee,

I am pleased to inform you that the University of Sydney Human Research Ethics Committee (HREC) has approved your project entitled "Ethical Dilemmas Experienced by Occupational Therapists Working in Private Practice".

Details of the approval are as follows:

Project No.: 2015/414
Approval Date: 25 June 2015
First Annual Report Due: 25 June 2016
Authorised Personnel: Penman Merrolee; Babic Aleksandra; Nagarajan Srivalli

Documents Approved:

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HREC approval is valid for four (4) years from the approval date stated in this letter and is granted pending the following conditions being met:

Condition/s of Approval

- Continuing compliance with the National Statement on Ethical Conduct in Research Involving Humans.
- Provision of an annual report on this research to the Human Research Ethics Committee from the approval date and at the completion of the study. Failure to submit reports will result in withdrawal of ethics approval for the project.
- All serious and unexpected adverse events should be reported to the HREC within 72 hours.
All unforeseen events that might affect continued ethical acceptability of the project should be reported to the HREC as soon as possible.

Any changes to the project including changes to research personnel must be approved by the HREC before the research project can proceed.

Note that for student research projects, a copy of this letter must be included in the candidate’s thesis.

**Chief Investigator/Supervisor’s responsibilities:**

1. You must retain copies of all signed Consent Forms (if applicable) and provide these to the HREC on request.

2. It is your responsibility to provide a copy of this letter to any internal/external granting agencies if requested.

Please do not hesitate to contact Research Integrity (Human Ethics) should you require further information or clarification.

Yours sincerely

[Signature]

Dr Stephen Assinder  
Chair  
Human Research Ethics Committee

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This HREC is constituted and operates in accordance with the National Health and Medical Research Council’s (NHMRC) National Statement on Ethical Conduct in Human Research (2007), NHMRC and Universities Australia Australian Code for the Responsible Conduct of Research (2007) and the CPMP/ICH Note for Guidance on Good Clinical Practice.
APPENDIX 3: Interview Guide

Illustrative Interview Protocol


Interview

**Warm up Question:** Thank you for taking the time to participate in our study. Before we start the interview regarding your experiences of ethical dilemmas, could you please say a few words about your experience working as an OT, whether it was in private or public practice?

**Probe Questions:** *(Please Note: Use of probe questions will depend on the depth of the participant’s response to the warm up question)*

- Approximately how long have you been working as an OT? How much of that time have you been a private practice OT?
- Do you currently work in just one, or more private practices?
- Do you currently also work in the public health sector?
- Have you worked in more than one private practice? If so, what area of practice?
- What services do you currently provide? Who are the clientele?
- Is this practice interdisciplinary or OT only?
- What is the size of the practice? Small practice <5, large practice >5
- What is your position within the private practice? (e.g. manager, owner, employee)
- What is your current case load?
- How often do you work? (days/week)

**Questions related to study aims**

In this part of the interview I will be asking questions related to your experience of ethical dilemmas that you may have faced working in the private sector. Please only include ethical dilemmas that you have faced during your time as a private practice occupational therapist. I am also going to ask you to think carefully before doing either of the following:

- Describe any situations which might be deemed notifiable under the National Law as per the *AHPRA Mandatory Notifications Guidelines*. These include:
  - practising the practitioner’s profession while intoxicated by alcohol or drugs
  - engaging in sexual misconduct in connection with the practice of the practitioner’s profession
  - placed the public at risk of substantial harm in the practitioner’s practice of the profession because the practitioner has an impairment
  - placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.
Disclosing any names/locations of clients and/or colleagues.

Note: A copy of AHPRA Guidelines for the Mandatory Notification will be kept on hand if the participants would like to refresh their memory regarding these guidelines.

Before we start, let me provide a definition of an ethical dilemma.

“An ethical dilemma may exist where one option maybe considered both right and wrong, or where two options exist and both would be equally reasonable choices to make”.

1. **Main question:** Please think about an ethical dilemma that occurs frequently in your work as a private practitioner. As I am interested in exploring your experience with this dilemma; please tell me in as much detail as possible what happened in this case.

**Probe Questions:**

- Who was involved in the ethical dilemma?
- What type of dilemma was it? **F/Up question:** Was it focussed on client/carer management, service delivery, professional relationships, resource allocation?
- What was at stake? **F/Up question:** Was it an ethical principle, a client’s well being, professional integrity, the organisation etc?
- Could you describe the two different sides of the ethical dilemma?
- What do you think were the factors contributing to the dilemma? **F/Up question:** Were they external or internal to yourself?
- For managers/owners:
  - Do you think the interplay of running a business and providing the occupational therapy service influenced the ethical dilemma? **F/Up question:** Did you feel conflicted in your choices because you are both a manager/business owner and a therapist?
- For employees:
  - Do you think having to balance business needs and provide the occupational therapy service influenced the ethical dilemma?
- What concerned you most about the ethical dilemma? **F/Up question:** Why did it present as challenging for you personally?
- Do you think this type of dilemma is specific to private practice? **F/Up question:** Why/ or Why not?
- Is this a re-occurring dilemma in your practice? **F/Up question:** How often does it occur? Why do you think that is?
- Can you think of any additional information or factors which contributed to the dilemma?

2. **Main Question:** Can you please describe another ethical dilemma you experience most often in your current practice, using a case example?

**Probe Questions:**

- Why do you think it is a recurring dilemma? **F/Up question:** Is it specific to this workplace context? Have you encountered it in other private practice contexts?
• What factors do you think contribute to the recurrence of this dilemma? **F/Up question:** Are they personal, organisational, colleague related, client related?
• How often does it occur? **F/Up question:** Does it occur across clientele or is it specific to certain client/s?
• Do you think this type of dilemma is specific to private practice? **F/Up question:** Why or why not?
• Can you see this type of dilemma occurring in other private practices?

3. **Main question:** Have you experienced any other ethical dilemmas while employed in private practice that you would like to share? Please tell me in as much detail as possible what happened during this dilemma. Out of the (3) ethical dilemmas we have discussed, which would you say was the most challenging and why?
**Probe Questions:** (draw from Question 1)

4. **Main question:** I would also like to ask you a few questions relating to the future of ethical issues in private occupational therapy practice. Can you identify any issues which may become ethically challenging to you working in private practice in the next 5-10 years?
**Probe Questions:**
• What do you think will be the consequences of these issues to private practice?
• How do you think the introduction of the National Disability Insurance Scheme (NDIS) will influence ethical dilemmas in private practice? **F/Up question:** Will it impact the frequency, nature or complexity of dilemmas?

5. **Main question:** Do you think ethical dilemmas experienced by public practice occupational therapists are different to those in private practice?
**Probe Questions:**
• What factors make them different? **F/Up question:** Are they related to structure of practice, clientele, resources, services etc?

**Conclusion**
Recap the ethical dilemmas discussed and provide opportunity for participant to add any relevant information they may have missed. Is there anything else you would like to add that we have not yet covered?

Thank you for participating in the study.

*Probe and follow up questions are a guide only. Changes may be made, as appropriate during the interview.*