Ethical dilemmas experienced by Australian public practice occupational therapists

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Statement of Authenticity

I certify that this submission is my own work and contains no material which has been accepted for the award of another degree. Materials previously published or written by another person are acknowledged duly in text.

Ethics approval was received from the Western Sydney Local Health District Human Research Ethics Committee.

Informed consent was obtained from all participants.

Name: Emma Clarke
Signed: [Signature]
Date: 27 Oct 2015
Thesis Abstract

Occupational therapists working within Australia’s dynamic and complex publicly-funded health sector may experience ethical dilemmas as they fulfil their professional responsibilities, compromising client care, straining collegial relationships and negatively affecting their personal well-being. This thesis describes and explores the nature of the ethical dilemmas experienced by public practice occupational therapists.

Section One: LITERATURE REVIEW

The literature review comprises two parts. First a background to ethics in health care is outlined, where the Person-Environment-Occupation Model is presented as a way of evaluating the ethical dilemmas experienced by occupational therapists. This is followed by a review of literature exploring the ethical dilemmas experienced by health professionals including occupational therapists, speech pathologists, physiotherapists, social workers, rehabilitation counsellors and nursing and medical professionals. However, no literature was identified exploring the nature of ethical dilemmas experienced by public practice occupational therapists, providing an opportunity for further research.

Section Two: JOURNAL MANUSCRIPT

The journal manuscript outlines a qualitative, descriptive study exploring the ethical dilemmas experienced by five public practice occupational therapists. Findings indicate that public practice occupational therapists experience an array of ethical dilemmas which reflect the complexities of working within Australia’s publicly-funded health care context. Ethical dilemmas reported by public practice occupational therapists are encompassed by five themes: defining boundaries in professional relationships, fair access to quality services, professional status, life choices and the complex client at the heart of the dilemma. Person, environment and occupation factors were all found to contribute to the ethical dilemmas experienced by participants.

It is intended that the journal manuscript will be submitted to the Australian Occupational Therapy Journal.
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**Figure 2**: The Ethical Grid (Seedhouse, 2009)

Section Two: JOURNAL MANUSCRIPT

N/A
Section One: LITERATURE REVIEW

Introduction to the Topic

Occupational therapy is a client-centred health profession, concerned with promoting the health and well-being of individuals through meaningful engagement in self-care, productivity, leisure and rest occupations (Australian Association of Occupational Therapists, 2015). In order to uphold ethical practice standards, occupational therapists must balance a range of factors, including their personal and professional values with the values of their clients, multidisciplinary colleagues and workplace. They must also acknowledge and overcome environmental barriers including funding and resource limitations to ensure optimal service provision is afforded to their clients and to demonstrate practice that is professionally and ethically appropriate, hence upholding the reputation of their profession (McAllister, 2006).

Ethics is core to the professional practice of health professionals including occupational therapists. As a branch of philosophy, ethics examines the concepts of right and wrong surrounding human behaviour and character, encompassing personal, professional and social values of how we should act and strive to be (Kenny, 2010). Health professionals make multiple decisions every day, a process which often results in needing to determine: What is the right thing to do? What is the best choice to make? However, balancing competing and differing values when making decisions is not a simple process; and may result in health professionals experiencing ethical dilemmas. An ethical dilemma exists when one option is considered both right and wrong, or when two or more options exist with equally supporting and opposing elements, therefore presenting as equally reasonable choices (Beauchamp & Childress, 2013; Flatley, Kenny & Lincoln, 2014).

This literature review will examine the topic of ethics and how it relates to everyday occupational therapy practice. Due to limited specific evidence regarding the nature of ethical dilemmas experienced by occupational therapists, ethics research drawn from other allied health professions will be examined to provide a comprehensive overview of ethical dilemmas arising in contemporary health care that may also be experienced by occupational therapists. Firstly a background to ethics in health care and more specifically in occupational therapy is outlined. This section is followed by a review of contemporary ethics literature.
outlining ethical dilemmas experienced by medical, nursing, allied health and occupational therapy professionals.

**Philosophical Approaches**

Questions regarding how to live a ‘good’ life have troubled communities for many centuries. Thus philosophers identified a need to develop systematic frameworks for analysing ethical problems and making ethical decisions. In response, normative theories have been developed to guide ethical conduct and decision-making (Beauchamp & Childress, 2013).

Normative ethical theories: consequentialism, deontology, liberalism, communitarianism and virtue ethics are defined in Table 1.

<table>
<thead>
<tr>
<th>Theory</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consequentialism</td>
<td>The right decision is one that produces the greatest outcome for the greatest number of people (Mitchell, Lovat &amp; Kerridge, 1996).</td>
</tr>
<tr>
<td>Deontology</td>
<td>Focuses on the nature of actions rather than their consequences; human morality is derived from rationality rather than experience (Schönecker &amp; Wood, 2015).</td>
</tr>
<tr>
<td>Liberalism</td>
<td>Personal freedom is central to ethical decision-making within social constraints; the right of an individual to make choices is upheld unless their choices threaten others or society (Berglund, 2012).</td>
</tr>
<tr>
<td>Communitarianism</td>
<td>Acknowledges the needs of individuals, but places greater emphasis on the rights of community and common good (Berglund, 2012).</td>
</tr>
<tr>
<td>Virtue Ethics</td>
<td>Focuses on the heart of the moral agent when making an ethical decision. Virtuous character will develop from living and practicing a ‘good’ life (Berglund, 2012).</td>
</tr>
</tbody>
</table>

Occupational therapy and other health professions’ codes of ethics are largely derived from a combination of these normative theories. Consequences, duties, individual and community rights and moral character are important elements of current ethical allied health care practice (Kenny, 2010). For example, when engaging in ethical decision-making occupational therapists have a duty to afford their clients respect and autonomy in order to demonstrate the profession’s client-centred values. In the community development context, occupational therapists may utilise utilitarian or communitarianism approaches when making ethical decisions to ensure the greatest outcome for the community at large. More broadly, occupational therapists must demonstrate virtuous character in order to provide quality occupational therapy services (Australian Association of Occupational Therapists, 2001). Accordingly, registered and practicing occupational therapists in Australia must abide by a professional Code of Conduct, which seeks to assist and support practitioners to deliver appropriate, effective services within an ethical framework (AHPRA, 2014). The Occupational Therapy Australia Code of Ethics provides occupational therapists with further guidance for
ethical practice (Australian Association of Occupational Therapists, 2001). Public practice occupational therapists must also uphold ethical practice standards consistent with workplace policies such as the NSW Health Code of Conduct (NSW Health, 2012).

**Applied Ethics**

Health professionals have endeavoured to practice ethically since their founding with physicians vowing to uphold ethical standards consistent with the Hippocratic Oath, swearing to uphold virtues of modesty, sobriety, patience, promptness and piety (Beauchamp & Childress, 2013). The field of bioethics emerged in the late 1960s applying normative theories to human rights issues in health care research and then encompassing life and death issues and moral problems raised by new technology in health care contexts (Beauchamp & Childress, 2013; Kass, 2001). Bioethical principles of autonomy, non-maleficence, beneficence and justice, outlined in Beauchamp and Childress’s Four-Principle Approach (Beauchamp & Childress, 2013), have been highly influential in the development of ethical expectations in contemporary health care. The four principles draw upon theoretical concepts of supporting clients to freely and independently make decisions, avoiding harm, providing benefit and ensuring fair and equitable distribution of resources (Beauchamp & Childress, 2013). Similar to normative ethical theories, bioethical principles have been widely adopted in health professions’ codes of ethics and conduct. The occupational therapy Code of Ethics is founded on the bioethical principles of beneficence, non-maleficence, honesty, veracity, confidentiality, respect, justice and autonomy (Australian Association of Occupational Therapists, 2001). Ultimately these codes guide occupational therapists in ethical decision-making by stating they must do good, prevent harm and injustice and demonstrate respect for their clients (Cross, Leitao, McAllister, 2008; Flatley, et al., 2014).

Bioethics is just one framework for considering ethical practice in health care. Alternative applied ethical approaches including the Ethics of Care Approach, Casuistry Approach, Narrative Approach and Principles-Based Approach, defined in Table 2, may also provide a basis for understanding and managing ethical dilemmas experienced by health professionals, including occupational therapists (Kenny, 2010). These alternative approaches each present a different focus and process, aiming to guide health professionals when making ethical decisions in practice (Kenny, 2010).
Table 2: Ethical Approaches

<table>
<thead>
<tr>
<th>Approach</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethics of Care</td>
<td>- Four phases of care: ‘caring about,’ ‘taking care-of,’ ‘care-giving,’ and ‘care receiving.’</td>
</tr>
<tr>
<td></td>
<td>- Encompasses care and caring relationships within health professions; through effective care relationships, ethical dilemmas can be managed effectively (Gilligan, 1993).</td>
</tr>
<tr>
<td>Casuistry</td>
<td>- New or complex cases are compared with precedent cases to solve ethical dilemmas.</td>
</tr>
<tr>
<td></td>
<td>- Largely embedded in case-based learning, requiring critical analysis (Arras, 1994).</td>
</tr>
<tr>
<td>Narrative</td>
<td>- Listen to and consider the client’s whole story (past, present, future) and their perception of options,</td>
</tr>
<tr>
<td></td>
<td>- benefits and harms to make an ethical decision (Charon &amp; Montello, 2002).</td>
</tr>
<tr>
<td>Principles-Based</td>
<td>- Draws upon bioethical principles of autonomy, non-maleficence, beneficence and justice (Beauchamp &amp; Childress, 2013):</td>
</tr>
<tr>
<td>Approach</td>
<td>- <em>Autonomy</em>: Support clients to freely make decisions for themselves.</td>
</tr>
<tr>
<td></td>
<td>- <em>Non-Maleficence</em>: Obligation to do no harm to their clients or subject them to any risk of harm.</td>
</tr>
<tr>
<td></td>
<td>- <em>Beneficence</em>: Do good and balance potential risks and benefits in favour of their client’s welfare.</td>
</tr>
<tr>
<td></td>
<td>- <em>Justice</em>: Refers to fair, equitable and appropriate distribution of service resources.</td>
</tr>
</tbody>
</table>

Ethics in Occupational Therapy

The bioethical principles embedded in the occupational therapy Code of Ethics are perceived as equally important to uphold. However in reality, occupational therapists need to prioritise these principles. Factors which result in competition between ethical principles can be demonstrated by using the Person-Environment-Occupation Model (PEO) (Christiansen, Baum, & Bass, 2015). In occupational therapy, this model is more typically used to examine the interactions of person, environment and occupation factors surrounding a client’s occupational performance. However as illustrated in Figure 1, this model can also demonstrate competing and interrelated person, environment and occupation factors which may result in ethical dilemmas.

Figure 1: Person-Environment-Occupation Model in Ethics (Adapted from Christiansen et al., 2015).
Applying the Person-Environment-Occupation Model to Ethics in Occupational Therapy

Public practice occupational therapists are employed within Australia’s complex and dynamic public health environment. Public health services are provided and funded by local, state and federal levels of government. Australian citizens, overseas visitors, visa holders and asylum seekers all utilise Australia’s public health system. Currently public health resources are being tailored to accommodate Australia’s aging population, prevalence of chronic diseases and improving the health status of Indigenous Australians (AIHW, 2014). The roll out of the National Disability Insurance Scheme (NDIS) is expected to change the face of public health in Australia in the near future (NDIS, 2015), potentially resulting in new ethical dilemmas for occupational therapists.

The scope of public health care in Australia is undoubtedly broad and increasingly managed in a business fashion (Callahan & Jennings, 2002; McAllister, 2006). Not surprisingly, public health professionals have identified ethical dilemmas arising from resource constraints and increasingly complex caseload demands where the ethical principle of justice is at stake (Kenny, Lincoln & Balandin, 2010; Roberts & Reich, 2002). It is reasonable to expect that occupational therapists may experience similar ethical dilemmas; especially when occupational therapy values of client-centeredness and autonomy conflict with the utilitarian desires of public health, where the best choice is perceived as one that results in the most gain for the population, not necessarily the individual (Roberts & Reich, 2002). Yet, there may also be specific ethical dilemmas associated with fulfilling the roles and responsibilities of an occupational therapist within the public health context. Furthermore, public practice occupational therapists often work with and among a diverse range of health professionals, resulting in a dynamic interplay of professional expectations, needs and skills (Callahan & Jennings, 2002). Professional values and goals of occupational therapists may not align with values and intentions of other health professionals involved in providing health services to the same client, potentially resulting in ethical dilemmas relating to the occupation component of the PEO Model. Occupation factors may also encompass professional codes of ethics and caseload demands, while person factors may include personal values and practice experience as an occupational therapist. For example, occupational therapists may have personal beliefs towards death and dying based upon life experiences, religious beliefs or working with palliative care clients, which may conflict with professional values or workplace expectations.
Managing the PEO Factors of Ethical Dilemmas

Ethical dilemmas are considered unavoidable in health care due to the complex interactions of personal, professional, client and workplace values and expectations (Flatley et al., 2014). When managed effectively ethical dilemmas have the potential to enhance service provision as PEO factors contributing to the dilemma are balanced in a way that results in effective, client-centred services (Preshaw, Brazil, McLaughlin & Frolic, 2015). However, ineffective management of ethical dilemmas can have a detrimental impact on health professionals’ personal well-being, client care and collegial relationships. Moral distress may lead to burnout, illness, low self-esteem and loss of professional confidence (Kälvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004; McAllister, 2006). Furthermore, inadequate management of ethical dilemmas may lead to litigation and professional sanctions (McAllister, 2006). Detrimental consequences of ethical dilemmas include professional abandonment, which is problematic given the costs of training and the health workforce demands in Australia (AIHW, 2014).

Knowing the potentially negative consequences of unresolved ethical dilemmas, it is essential to identify and proactively manage ethical dilemmas in occupational therapy practice. The Ethical Grid (Seedhouse, 2009) is one ethical reasoning tool that addresses factors which may contribute to ethical dilemmas experienced by practicing health professionals, as shown in Figure 2. By identifying key decision-making factors, the Grid aims to facilitate health professionals’ ethical reasoning (Seedhouse, 2009). The Ethical Grid has four layers. The blue centre layer represents the core foundations of ethical theory in health care, those which are also encompassed in occupational therapy codes of ethics and codes of conduct, while the red and green layers encourage deontological (duties) and consequentialist (outcomes) viewpoints respectively. The outer, black layer identifies factors that are not traditionally encompassed in ethical theory, providing a level of environmental considerations. Essentially the Ethical Grid aligns with the PEO Model as it outlines person, environment and occupation factors that may interact to cause ethical dilemmas for public practice occupational therapists.

By using Seedhouse’s Ethical Grid (2009) and being aware of the complex interplay of PEO factors, occupational therapists may be better able to identify and manage ethical dilemmas in their everyday practice. Ethical reasoning tools can help make the resolution of ethical
dilemmas easier for health professionals and may highlight factors which otherwise may have been ignored during the reasoning process. However, ethical reasoning tools are typically used in response to an ethical dilemma, not to proactively develop policies and procedures that avoid breaches. Therefore, to effectively manage ethical dilemmas and to continue to provide quality occupational therapy services in the contemporary health care context, proactive efforts must be taken to firstly gain an understanding of the nature of ethical dilemmas experienced by public practice occupational therapists; and secondly to develop suitable and effective solutions surrounding the management of ethical dilemmas. This study proposes to take the first step in this process, aiming to describe and explore the nature of ethical dilemmas experienced by public practice occupational therapists.

*Figure 2:* The Ethical Grid (Seedhouse, 2009).

**Search Strategy**

A critical interpretive review methodology was adopted for this literature review. This involved an iterative approach to refining the research question and searching and selecting literature (Barnett-Page & Thomas, 2009). Bioethicists commonly use critical interpretive reviews to capture key ideas and insights relevant to the research question. While the literature search must be thoughtfully designed and thorough, a critical interpretive review does not result in the compilation of every article relevant to the research question, just
those that are influential in discussions surrounding the research question to date (McDougall, 2015). To ensure all relevant literature was identified and included in this review a rigorous literature search was conducted. This included a comprehensive electronic database search of Medline, Cinahl, Web of Science and OTSeeker databases. Search terms included: ethical dilemma, ethics, clinical decision-making, ethical reasoning, occupational therapy, allied health and health professional. Key word searches of occupational therapy journals from Australia, America, the UK and Canada and a general internet search through Google Scholar were also conducted using a combination of the search terms above. To be included in the review studies were required to be published in English between 2000-2015, be peer reviewed and address ethical dilemmas experienced by health professionals. The initial search process retrieved 908 articles following the removal of duplicates in Endnote. Using Endnote search functions the inclusion criteria was applied resulting in 327 relevant articles. The titles and abstracts of these articles were reviewed. Twenty three articles that related closely to the research aims were then selected for inclusion in this review.

There is some diversity in the definition and use of the term ‘ethical dilemmas’ (Preshaw et al., 2015). Thus studies referring to moral dilemmas and ethical issues/problems/challenges/conflicts were selected if considered by the author to meet the inclusion criteria. Furthermore, as an exception to the inclusion criteria, three studies published in the 1990s (Barnitt, 1998; Barnitt 1993; Barnitt & Partridge, 1997), that specifically address ethical dilemmas experienced by occupational therapists were included due to their direct association with the research topic in the absence of relevant contemporary literature. Due to the extensive literature available surrounding ethical dilemmas experienced by medical and nursing professions, only three relevant literature reviews and one qualitative study identifying and comparing doctors' and nurses' perceptions of ethical problems (Oberle & Hughes, 2001) were included in this review.

The selected articles were read in their entirety. The following data were extracted and collated in a table format: study reference, study aim, study methodology, study findings, study limitations and the health professions in which the study was conducted. The studies were grouped and reviewed according to health professions and then ethical dilemmas were sorted into PEO categories.
Ethical Dilemmas in the Health Professions

Empirical knowledge of ethical dilemmas experienced by health professionals is a relatively new contribution to the philosophical and applied ethical approaches that lay the foundation for ethics in health care. Contemporary ethics research reflects a shift from philosophical underpinnings of what ‘should be done’, to a scientific understanding of what ‘is done’ regarding the balancing of ethical principles in contemporary health service provision (Borry, Schotsmans & Dierickx, 2005). Currently, significant gaps exist in the literature surrounding the nature of ethical dilemmas experienced by occupational therapists. Studies exploring ethical dilemmas arising in health service provision primarily encompass ethical dilemmas experienced by medical and nursing professionals working in acute practice contexts (Kirschner, Stocking, Wagner, Foye & Siegler, 2001). Findings show that ethical dilemmas in medical and nursing professions encompass life and death issues such as withdrawing/withholding life-sustaining treatment, assessment of decision-making capacity and do-not-resuscitate orders (Georges & Grypdonck, 2002; Oberle & Hughes, 2001; Preshaw et al., 2015; Schluter, Winch, Holzhauser & Henderson, 2008). Resource limitations, communication challenges and competing values between clients, their families and multidisciplinary colleagues are also frequently reported factors contributing to ethical dilemmas experienced by medical and nursing professionals (Georges & Grypdonck, 2002; Oberle & Hughes, 2001; Preshaw et al., 2015; Schluter et al., 2008).

The bioethical underpinnings of ethical dilemmas experienced by medical and nursing professionals have been consistently reported in specific workplace contexts such as palliative care and nursing homes (Georges & Grypdonck, 2002; Oberle & Hughes, 2001; Preshaw et al., 2015). However, different PEO factors are identified by these professionals as contributing to ethical dilemmas they experience. For example in nursing homes communication issues, resource distribution and quality of care provision were identified as factors resulting in ethical dilemmas (Preshaw et al., 2015); whereas in the palliative care context, end-of-life issues, patient suffering and appropriateness of treatment were identified as ethical dilemmas experienced by medical and nursing professionals (Georges & Grypdonck, 2002; Oberle & Hughes, 2001). Therefore health professionals’ experience of ethical dilemmas is likely to vary depending on their workplace context and caseload or the balance of occupation and environment factors surrounding the dilemma.
Doran et al. (2015) determined that medical, nursing and allied health professionals working in two NSW public hospitals primarily encountered ethical dilemmas due to: managing patient preferences when making treatment decisions, breaches of professional and workplace guidelines and disagreements between staff. These findings provide valuable insight into ethical dilemmas experienced by Australian public health professionals. However, the authors failed to recognise that although health professionals may encounter the same ethical dilemma, each health professional’s experience of that dilemma will vary according to their unique professional values and responsibilities. For example, doctors have a professional responsibility to make decisions regarding surgical intervention whereas nurses must manage health care consequences on the ward. In this instance an ethical dilemma arises for both professions surrounding treatment decisions, however doctors’ and nurses’ experience of this dilemma is unique (Oberle & Hughes, 2001). The grouping of allied health professionals in the study by Doran et al. (2015) is particularly limiting due to the sheer diversity of professional roles and responsibilities which fall within this category; and subsequently prevents the identification of ethical dilemmas specifically experienced by occupational therapists.

**Allied Health Professions**

Despite knowledge of negative consequences resulting from unresolved ethical conflict, literature exploring ethical dilemmas experienced by allied health professionals is limited. Recent studies in speech pathology (Flately et al., 2014; Kenny et al., 2010; Kenny, Lincoln, Blyth & Balandin, 2009), physiotherapy (Kulju, Suhtone & Leino-Kilpi, 2013; Praestegaard & Gard, 2013), social work (Dennis, Koenig & Washington, 2014) and rehabilitation counselling (Tarvydas & Barros-Bailey, 2010) have provided insight into profession-based ethical dilemmas. Several studies exploring ethical dilemmas experienced by occupational therapists have also been identified (Atwal & Caldwell, 2003; Barnitt, 1998; Barnitt, 1993; Barnitt & Partridge, 1997; Bushby, Chan, Druif, Ho & Kinsella, 2015; Daniëls, Winding & Borell, 2002; Foye, Kirschner, Wagner, Stocking & Siegler, 2002; Kassberg & Skår, 2008). However the literature search revealed no studies exploring ethical dilemmas experienced by occupational therapists employed within Australia’s publicly-funded health system. In keeping with recommended standards for a quality bioethics review (McDougall, 2015), findings were reviewed within a theoretical (PEO) framework. *Table 3* summarises the PEO factors which contribute to ethical dilemmas experienced by allied health professionals.
based upon empirical findings. All studies, summarised in Table 3, were undertaken using qualitative methodologies providing findings based on the unique experiences and interpretations of practicing allied health professionals (Sandelowski, 2000); with the exception of Barnitt (1998), Foye et al. (2002) and Kulju et al. (2013) who employed survey methodologies producing a mix of qualitative and quantitative data and a scoping literature review by (Bushby et al., 2015).

**Table 3**: Ethical Dilemmas Experienced by Allied Health Professionals

<table>
<thead>
<tr>
<th>Person Factors</th>
<th>Speech Pathology</th>
<th>Physiotherapy</th>
<th>Social Work</th>
<th>Rehabilitation Counselling</th>
<th>Occupational Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balancing personal and professional values</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Experience in the profession</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupation Factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balancing benefit and harm in achieving outcomes for clients</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being honest to clients, telling the truth</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintaining client confidentiality</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managing complex clients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respecting client preferences and autonomy regarding intervention and treatment decisions (especially when client rejects professional opinion/recommendations)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Experiencing conflict around goal setting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Ensuring equality and justice in delivery of intervention/ treatment plans</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upholding professional values and responsibilities</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintaining professional relationships with clients</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Legal concerns regarding client’s illegal or dishonest conduct</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Witnessing unethical conduct of colleagues</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conflicting values between multidisciplinary colleagues; especially when making treatment decisions</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Environment Factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managing resources</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Conflict or pressures arising from employer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workplace policy and procedures conflicting with professional values or needs of clients</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Fidelity of business practice</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Person Factors**

Studies in occupational therapy, speech pathology and physiotherapy identified ethical dilemmas arising due to health professionals needing to balance personal and professional values (Foye et al., 2008; Kassberg & Skär, 2008; Kenny et al., 2010; Kulju et al., 2013). Occupational therapists, speech pathologists and physiotherapists take on professional roles and establish professional identities within their workplace. However, their personal values and worldviews were reported to conflict with their professional decisions and actions resulting in ethical dilemmas. Alternatively, Dennis et al. (2014) found that social workers did not report an ethical dilemma of this nature. This finding perhaps reflects that social workers are aware of the necessity to uphold professional values and responsibilities in their practice as opposed to personal values and opinions (Dennis et al., 2014). However, the rarity of
person factors in ethics findings may reflect issues in the research approach. During an interview participants may not feel comfortable disclosing personal ethical dilemmas they experience due to fears of being perceived as incompetent and unprofessional by the interviewer; or perhaps interviewers and survey methodologies have simply failed to probe for person factors to date. For example, Foye et al. (2002) collected data using a survey instrument consisting of three parts. The second and third parts of the survey related to ethics education. However, the first part asked participants to describe up to three ethical dilemmas they experienced in their day-to-day practice. The wording of this question may have guided participants to recount occupation related ethical issues. Furthermore, limiting participants to only three examples may not be effective in enabling participants to provide detailed recounts of person factors that contribute to their experience of ethical dilemmas.

The second person factor, identified by Kenny et al. (2009), was that new graduate and experienced health professionals interpret ethical dilemmas differently. New graduates were reported to encounter ethical dilemmas which encompassed themes of making safe choices for clients, avoiding conflict, following rules and building professional identity, whereas experienced speech pathologists reported ethical dilemmas when making life choices for clients, adapting policies and upholding professional status (Kenny et al., 2009). This finding highlights an important implication for ethical practice. Education is needed to prepare health professionals for ethical issues following graduation and continuing ethics education is necessary as health professionals adopt new roles and responsibilities throughout their careers. This is consistent with recommendations made by Bourne et al. (2013) and Kinsella, Park, Appiagyei, Chang and Chow (2008) who explored ethical dilemmas experienced by allied health students in Australia and Canada respectively. However providing appropriate ethics education to Australian occupational therapy students may be problematic due to the limited knowledge of ethical dilemmas experienced by practicing occupational therapists in Australia. Hence, further research is necessary to determine the specific nature of ethical dilemmas experienced by Australian public practice occupational therapists to ensure appropriate ethics support is afforded, enabling the provision of quality occupational therapy services.
Occupation Factors

Table 3 demonstrates occupation factors were more widely reported as contributing to ethical dilemmas experienced by allied health professionals when compared to person factors. Comparable to the findings of Praestegaard and Gard (2013), a strong theme of being beneficent towards clients underpins all occupation factors. Three occupation factors were consistent across all allied health professions: respecting client preferences and autonomy regarding intervention and treatment decisions, witnessing unethical conduct of colleagues, and when professional values conflict with those of multidisciplinary colleagues during treatment decisions. Investigators also identified profession-specific occupation factors. For example conflict around goal setting was an occupation factor specifically experienced by occupational therapists in rehabilitation contexts (Daniëls et al., 2002; Foye et al., 2002; Kassberg & Skär, 2008). Interestingly, this factor was not identified in the one study which explored ethical dilemmas experienced by rehabilitation counsellors (Tarvydas & Barros-Bailey, 2010); and none of the remaining studies explored ethical dilemmas experienced by their respective allied health professionals employed within rehabilitation contexts. Kirschner et al. (2001) argued that ethical dilemmas experienced by health professionals in rehabilitation settings will likely differ from health professionals in other practice settings because the rehabilitation context addresses the complexities of clients living with a transformative disability and encompasses intervention values inherent in disability and rehabilitative medicine. Furthermore findings from previous studies were drawn from occupational therapists employed in rehabilitation contexts in America, Sweden, Belgium and The Netherlands and reflect ethical dilemmas relative to their national health contexts. These contextual variables warrant the need for research which specifically explores the nature of ethical dilemmas experienced by Australian public practice occupational therapists.

Two studies conducted during the 1990s established a broad understanding of ethical dilemmas experienced by British occupational therapists (Barnitt, 1993; Barnitt & Partridge, 1997). Ethical dilemmas identified in these studies encompassed occupation factors including treatment decisions, maintaining confidentiality of clients, being honest with clients and maintaining professional relationships. However findings from Barnitt (1993) must be interpreted with caution due to limited description of the study methodology and total number of participants, as well as development in health care since the publication
date. Barnitt (1998) further explored ethical dilemmas experienced by occupational therapists employed within an acute hospital setting in Britain’s publicly-funded health system and found an additional occupation factor of discharge planning. Atwal and Caldwell (2003) also reported that discharge planning on acute British hospital wards was ethically fraught with occupational therapists unintentionally breaching their professional Code of Ethics and workplace Code of Conduct. Interaction of person and environment factors, including failing to consider the opinions and preferences of the client, pressures from multidisciplinary colleagues and institutional demands for quick discharges were associated with unintended unethical behaviours. While these studies provide insight into ethical dilemmas experienced by occupational therapists, this research was conducted in Britain, and with the exception of Atwal and Caldwell (2003), was published in the 1990s. Therefore, these findings cannot be considered reflective of the contemporary ethical dilemmas experienced by Australian public practice occupational therapists.

To summarise, the breadth and diversity of occupation factors identified suggests that ethical dilemmas experienced by one allied health profession cannot be generalised to another or between practice contexts. Whilst some ethical issues are shared concerns of health professionals, discipline and context specific ethics research is necessary to determine the unique ethical dilemmas experienced by each allied health profession relative to their practice context.

**Environment Factors**

While the range of environment factors identified in the allied health literature was not as broad as the range of occupation factors, each allied health profession identified environment factors relevant to specific workplace contexts. For example, Flatley et al. (2014) and Praestegaard and Gard (2013) explored ethical dilemmas experienced by private practice speech pathologists and physiotherapists respectively. Both studies found that duties and responsibilities associated with running a business in addition to upholding professional practice standards, was a unique environment factor contributing to the ethical dilemmas experienced in this practice context. In contrast, two studies were also identified which explored ethical dilemmas experienced by physiotherapists and speech pathologists employed within publicly-funded health systems (Kulju et al., 2013; Kenny et al., 2010). In both of these studies, managing resources was reported by participants as the sole
environment factor contributing to ethical dilemmas. Similar ethical dilemmas may also be experienced by occupational therapists in the Australian public practice context but this has yet to be explored. Notably, participants in the study by Kenny et al. (2010) were employed in Australia’s publicly-funded health system; and resources and systemic issues have been identified in occupational ethics literature arising from rehabilitation contexts (Kassberg & Skär, 2008). However specific research needs to be conducted to confirm the impacts of resource constraints upon Australian public practice occupational therapists and to determine if there are any additional environment factors that contribute specifically to ethical dilemmas experienced by public practice occupational therapists. Understanding the environment factors contributing to ethical dilemmas experienced by Australian public practice occupational therapists is especially important when considering potential ethical implications associated with the roll out of the NDIS.

**Implications of Ethical Dilemmas in Occupational Therapy Practice**

Bushby et al. (2015) made a range of ethical practice recommendations in their review of ethics in occupational therapy. The authors highlighted ethics awareness and supportive ethics policy as two primary means to enable occupational therapists to be proactive in the management of ethical dilemmas to ensure the provision of quality occupational therapy services into the future, while also maintaining the well-being of occupational therapy professionals. As reported by Bushby et al. (2015), the root causes of ethical dilemmas must be exposed so that they can be resolved not only by the profession but also by institutions and policies within which occupational therapists practice and are educated. Thus researching ethical dilemmas experienced by public practice occupational therapists appears a timely addition to existing empirical occupational therapy ethics literature.

**Conclusion**

Australian public practice occupational therapists strive to practice ethically in accordance with the profession’s Code of Conduct, Occupational Therapy Australia’s Code of Ethics and state based codes of conduct such as the NSW Health Code of Conduct. However within the dynamic public practice environment it is likely that occupational therapists will have to prioritise and balance ethical principles outlined in these codes due to interrelated person, environment and occupation factors; resulting in ethical dilemmas. Specifically, PEO factors
may include balancing personal and professional values, respecting client preferences and autonomy regarding intervention decisions and managing resources.

Current literature exploring the nature of ethical dilemmas in health is largely based on experiences of medical and nursing professionals. No studies have been identified that explore ethical dilemmas experienced by Australian occupational therapists, and no research specifically aims to describe and explore the nature of ethical dilemmas experienced by Australian public practice occupational therapists. PEO factors identified in previous research provide insight into ethical dilemmas in health care. However Australia’s publicly-funded health system is constantly evolving and varies from other national health systems; and occupational therapists have unique professional roles and values making existing findings difficult to generalise to Australian public practice occupational therapists. Knowledge of ethical dilemmas experienced by Australian public practice occupational therapists is essential if occupational therapists are to effectively manage ethical dilemmas and deliver quality occupational therapy services into the future.

Empirical knowledge of ethical dilemmas experienced by Australian public practice occupational therapists may provide opportunities for ethics education, professional development programs and advances in workplace policy to facilitate effective management of ethical dilemmas within Australia’s complex publicly-funded health system. Tailored support to balance competing PEO factors will assist occupational therapists to minimise the occurrence of moral distress and adopt a proactive approach to managing ethical dilemmas, subsequently maintaining the well-being of the profession and enhancing service delivery. Furthermore findings may lead to changes in curricula of tertiary education courses to better prepare occupational therapy students for ethical practice upon graduation and also during clinical placements. Importantly, as an exploratory study, research findings will provide a foundation for future ethics research in occupational therapy. Therefore, the aims of this study are to describe and explore the nature of ethical dilemmas experienced by public practice occupational therapists.
References


Section Two: JOURNAL MANUSCRIPT

Title: Ethical dilemmas experienced by Australian public practice occupational therapists

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Abstract

**Background/Aim:** Occupational therapists may experience ethical dilemmas as they fulfil their professional responsibilities, potentially compromising client care, professional reputation and personal well-being. No previous studies have been identified that investigate ethical dilemmas experienced by Australian public practice occupational therapists. The aim of this qualitative study was to describe and explore the nature of ethical dilemmas experienced by public practice occupational therapists.

**Methods:** Semi-structured interviews were completed with five occupational therapists employed within a large metropolitan public hospital. Participants described the ethical dilemmas they most frequently experience in their practice and those that were most challenging, and offered insight into ethical dilemmas that may arise in their future practice. Data was analysed using thematic analysis and application of the Person-Environment-Occupation Model.

**Results:** Five themes reflect the nature of ethical dilemmas experienced by public practice occupational therapists: defining boundaries in professional relationships, fair access to quality services, professional status, life choices and the complex client at the heart of the dilemma. Person, environment and occupation factors were all found to contribute to the ethical dilemmas experienced by participants.

**Conclusions:** Public practice occupational therapists experience an array of ethical dilemmas that reflect the challenges of working within Australia’s dynamic, publicly-funded health care context.

**Significance of the study:** Findings may enable the provision of ethics education and promote advances in workplace policy to assist occupational therapists to more effectively manage ethical dilemmas. Findings also provide a foundation for future ethics research in occupational therapy.

**Key words:** Allied health occupations, ethics, hospital ethics, occupational therapy, public health practice.
Introduction
Occupational therapists must practice ethically to uphold professional practice standards and to successfully assist their clients to engage meaningfully in occupations (Australian Association of Occupational Therapists, 2001). For occupational therapists employed within Australia’s dynamic, publicly-funded health care sector, ethical practice is unlikely to be a straightforward process. Australia’s public health care system comprises a diverse range of health professionals and is constantly evolving to meet the health care demands of complex client groups and population health care needs at large (AIHW, 2014). Furthermore, public health services are increasingly managed in a business fashion resulting in resource constraints and complex caseload demands (McAllister, 2006; Roberts & Reich, 2002). Notably, the National Disability Insurance Scheme (NDIS) is currently generating uncertainty surrounding future health care in Australia (NDIS, 2015). To practice ethically, public practice occupational therapists must therefore balance a range of factors and adapt their practice to fit their workplace. For example, professional values and responsibilities must be balanced with those of multidisciplinary colleagues and resource limitations must be considered when decision-making despite desires to achieve the greatest outcomes for clients. In doing so, public practice occupational therapists may experience ethical dilemmas, where one option is considered both right and wrong, or when two or more options exist with equally supporting and opposing elements, therefore presenting as equally reasonable choices (Beauchamp & Childress, 2013).

Australian occupational therapists are guided by a Code of Ethics (Australian Association of Occupational Therapists, 2001) and Code of Conduct (AHPRA, 2014) to deliver appropriate, ethical services to clients. The NSW Health Code of Conduct provides NSW public health professionals with additional, context specific ethics guidance (NSW Health, 2012). These codes are primarily based on bioethical principles of autonomy, non-maleficence, beneficence and justice, stating that occupational therapists must do good, prevent harm and injustice and demonstrate respect for their clients (Beauchamp & Childress, 2013; Cross, Leitao, McAllister, 2008; Flatley, Kenny & Lincoln, 2014). Ethical principles are perceived as equally important to uphold. However in practice, occupational therapists must prioritise competing principles, resulting in ethical dilemmas. The authors propose that occupational therapists may use the Person-Environment-Occupation Model (PEO) (Christiansen, Baum, & Bass, 2015), which is typically used to examine the interaction of PEO factors surrounding
clients’ occupational performance, to identify factors that result in competition between ethical principles. Environment factors may include workplace policies; person factors may include personal values and professional experience, while occupation factors may encompass professional values and caseload demands.

If managed well ethical dilemmas may enhance service provision as PEO factors contributing to the dilemma are balanced resulting in effective, client-centred service delivery (Preshaw, Brazil, McLaughlin & Frolic, 2015). However, unresolved ethical dilemmas can negatively impact upon personal well-being, client-care and collegial relationships. For example, moral distress may cause occupational therapists to experience burnout and loss of professional confidence, affecting the quality of services received by clients (Kälvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004; McAllister, 2006); and may lead to professional abandonment which is problematic given the costs of training and health workforce demands in Australia (AIHW, 2014). Despite knowledge of such consequences, ethical dilemmas experienced by occupational therapists have received limited empirical attention. In previous ethics studies, authors commonly report ethical dilemmas experienced by medical and nursing professionals, including biomedical life and death issues such as withdrawing/withholding life-sustaining treatment and do-not-resuscitate orders (Oberle & Hughes, 2001; Preshaw et al., 2015). Studies have also explored ethical dilemmas experienced by allied health professionals including speech pathologists (Flately et al., 2014; Kenny, Lincoln, Blyth & Balandin, 2009), physiotherapists (Kulju, Suhonen & Leino-Kilpi, 2013; Praestegaard & Gard, 2013), rehabilitation counsellors (Tarvydas & Barros-Bailey, 2010) and social workers (Dennis, Koenig & Washington, 2014). PEO factors can be identified in the results of these studies including: balancing personal and professional values, being beneficent towards clients and managing resources. However, it is difficult to generalise these findings to ethical dilemmas experienced by occupational therapists when considering their unique professional values and responsibilities.

Pioneering qualitative studies conducted in the 1990s reported that British occupational therapists primarily experienced ethical dilemmas due to difficult/dangerous behaviours in patients, unprofessional behaviour of colleagues (Barnitt, 1998), not preventing harm and inadequate respect for patient views (Barnitt & Partridge, 1997). However, further research is necessary to determine whether ethical dilemmas experienced by occupational therapists
have changed over time in response to developments in health care. More recent studies have explored ethical dilemmas experienced by occupational therapists employed in rehabilitation contexts in America, Sweden, Belgium and The Netherlands (Daniëls et al., 2002; Foye et al., 2002; Kassberg & Skär, 2008). Ethical dilemmas in these studies encompassed conflict around goal setting, discharge planning and decision-making capacity of clients. However, additional research is required to establish whether public practice occupational therapists in Australia experience similar or unique ethical dilemmas relative to their practice context. Doran et al. (2015) recently determined that medical, nursing and allied health professionals working in two NSW public hospitals encountered ethical dilemmas due to managing patient preferences in treatment decisions, breaches of professional and workplace guidelines and disagreements between staff. These findings provide insights into the ethical dilemmas experienced by Australian public health professionals. However in this study, grouping of allied health professionals with diverse professional values and responsibilities prevents identification of ethical dilemmas specifically experienced by occupational therapists.

No previous studies have explored ethical dilemmas experienced by public practice occupational therapists in Australia. Empirical knowledge of ethical dilemmas experienced by public practice occupational therapists may support the provision of appropriate ethics education to ensure ongoing ethical practice standards and minimise the occurrence of ethical distress amongst professionals. Furthermore, knowledge of contemporary ethical dilemmas may lead to changes in tertiary education curricula to better prepare occupational therapy students to proactively manage ethical dilemmas upon graduation.

This study aims to describe and explore the nature of ethical dilemmas experienced by public practice occupational therapists.

**Methods**

**Approach**

This exploratory study used a qualitative, descriptive research design (Sandelowski, 2000). Located within an interpretive paradigm, qualitative descriptive studies draw upon principles of naturalistic inquiry to examine real-world situations. In conjunction with the PEO Model, this design enabled investigators to discover the basic nature and shape of ethical dilemmas.
experienced by public practice occupational therapists from the perspective of practicing professionals (Sandelowski, 2000).

**Recruitment**

Participants were recruited using a convenience sampling method (Polgar & Thomas, 2008) from a large, multi-faceted metropolitan hospital. A recruitment email was sent via a person external to the study to approximately 40 occupational therapists at the sample site. Coinciding with the distribution of the recruitment email, the principle investigator and a second investigator employed as occupational therapists at the sample site promoted the study to their colleagues during staff meetings. A follow-up recruitment email was distributed two weeks later. The inclusion criteria stated that participants must be occupational therapists currently employed primarily in public practice and with a minimum of 12 months public practice experience.

Five occupational therapists responded to the recruitment email. All respondents met the inclusion criteria and consented to participate. The study was approved by the Human Research Ethics Committee at the participating health site.

**Data Collection**

Data was collected through individual, semi-structured interviews conducted by the first author, face-to-face at the participants’ workplace. Interviews were audio-recorded, lasting 33-48 minutes (\( \bar{X} = 40 \) minutes).

The interview guide (see appendix III) was adapted from a protocol used in previous ethics research in speech pathology (Flatley et al., 2014). The adapted interview guide was piloted with one experienced occupational therapist, with recent public practice experience. A combination of open-ended, follow-up and probe question were used. Consistent with responsive interviewing techniques, follow-up and probe questions enabled the first author to encourage participants to expand upon their answers and provide greater detail surrounding their unique experiences of ethical dilemmas (Rubin & Rubin, 2004).

At the beginning of each interview the first author collected demographic information from the participant before defining an ethical dilemma as: “An ethical dilemma exists where one option may be considered both right and wrong, or where two options exist and both would be equally reasonable choices to make” (Beauchamp & Childress, 2009; Flatley et al., 2014). Participants were also asked to only recount ethical dilemmas they experienced most
recently as a public practice occupational therapist. The interview was structured around five areas:

1. Most frequent ethical dilemma experienced
2. Most challenging ethical dilemma experienced
3. Any additional ethical dilemmas experienced
4. Perceived differences of ethical dilemmas experienced by public and private practice occupational therapists
5. Future ethical dilemmas that may arise

Data Analysis

Data was analysed using thematic analysis, a robust process for analysing descriptive data (Braun & Clarke, 2006). Thematic analysis allowed for the identification of shared and recurring themes between interview transcripts by following the structured six phase process outlined by Braun & Clarke (2006), presented below. During thematic analysis, the PEO Model was also applied, identifying the PEO factors contributing to ethical dilemmas experienced by participants.

1. Familiarising yourself with the data

The first author transcribed each interview verbatim, excluding identifiable information to protect participants’ identity. Each interview recording was reviewed three times to facilitate accurate transcription. To assist with data familiarisation, meaning units of raw data were extracted and summarised. The underlying meaning of each data segment was then determined during active readings of each transcript, demonstrated in Table 1.

2. Generating initial codes

Codes, shown in Table 1, identified semantic and content features of the data that related to the research aim. Inclusion of raw data units in the analysis table ensured the context of the data was retained when coding. During this phase codes were further grouped into PEO categories. Person codes represented intrinsic factors that make up a person’s skills and abilities including personal values and professional experience. Environment codes characterised extrinsic factors including workplace policy and resource limitations, while occupation codes included professional activities and tasks performed in the role of an occupational therapist (Christiansen et al., 2015).
3. Searching for themes
Themes were applied to codes in a deductive manner from a previous ethics study in public practice speech pathology (Kenny et al., 2009). The study by Kenny et al. (2009) was similar to the present study, aiming to describe, compare and contrast the nature of ethical dilemmas identified by new graduate and experienced speech pathologists. Three categories of themes were devised by the authors based on their findings: shared themes (ethical dilemmas experienced by new graduates and experienced speech pathologists), new graduate themes and experienced speech pathologist themes. As new graduate public practice occupational therapists were excluded from participating in the present study, only shared and experienced themes were searched for during data analysis. Adopting this framework enabled direct comparison between ethical dilemmas experienced by Australian public practice speech pathologists and occupational therapists. Codes of similar meaning were grouped to form sub-themes within each theme, shown in Table 2.

4. Reviewing themes
Themes were refined by visually mapping codes to ensure themes cohered meaningfully and that clear distinctions were present between each theme. Raw data extracts were also reviewed to make sure themes accurately reflected the meaning within the data set.

5. Defining and naming themes
Definitions were developed outlining the meaning of each theme. Themes were further organised to reflect a coherent recount of the raw data.

6. Producing the report
The final stage in the analysis process was the compilation of the results section below.

Research Authenticity
During data analysis, strategies were employed to ensure research authenticity (Creswell, 2014). Member checking occurred following the transcription of interview recordings. This involved providing participants with a copy of their transcript via email. Participants were encouraged to review their transcript to add any further detail or remove statements they did not wish to be included in the study. Furthermore, codes were developed and themes were applied through author consensus between the first and second authors, while the third author independently verified the themes. A decision-making audit trail was also maintained to ensure data was coded consistently.
Results

Participants

Table 3 describes the five participants. All participants were women and primarily employed as public practice occupational therapists. Three participants were employed part-time, working $\bar{X}=21.5$ hours per week. Two participants reported experience working as a private practice occupational therapist, with one of those participants indicating she was currently working in both public and private settings. To ensure the findings remained relevant to the research aim, all participants were asked at the commencement of their interview to only disclose ethical dilemmas they had experienced as a public practice occupational therapist.

Findings

All participants identified ethical dilemmas in their workplace, reflected by five themes summarised in Table 2. Challenging and frequently occurring dilemmas are presented within each theme. Various PEO factors were found to contribute to these ethical dilemmas. Person factors included professional experience, environment factors included resource limitations and efficiency pressures, while occupation factors included utilising evidence in practice, interacting with multidisciplinary colleagues, providing occupational therapy specific services and managing clients.

**Theme 1: Defining boundaries in professional relationships**

Defining boundaries in professional relationships with clients, colleagues and the workplace were core to many participants’ ethical dilemmas. Participants described ethical dilemmas when occupation factors of professional roles and responsibilities outlined in the code of ethics were challenged by their clients, colleagues and the context in which they live and work.

All participants reported ethical dilemmas where their professional boundaries/responsibilities, including maintaining professional-client relationships, being honest with clients, documenting truthfully and ensuring client safety, were challenged by environment factors including discharge pressures and resource limitations, and occupation factors such as demands from colleagues and needs and preferences of clients. For example, Karen reported frequently experiencing ethical dilemmas when needing to be honest with
parents about their child’s prognosis, reporting that parents may become overwhelmed and confused: “Telling parents, delivering bad news, deciding what you need to say and how to say it. That’s hard, but necessary... a core role for my position.”

Four participants experienced ethical dilemmas when their professional roles and responsibilities conflicted with those of multidisciplinary colleagues. Participants reported that their recommendations, particularly for home modifications, were sometimes disregarded by team members resulting in tension within the team and poor outcomes for clients. For example, Lucy stated: “I had assessed somebody... recommended home modifications. The Doctor said ‘we’re not waiting for home modifications’... and discharged the person... The person fell and came back within a month.”

The four most experienced participants discussed how ethical dilemmas were influenced by workplace (environment) boundaries, particularly workplace expectations and policy. For example, Katie reported: “… There needs to be more education about who... is it the prescribing therapist that has to see it all through? Whether it be home mods... equipment prescription... there just seems to be a grey area where people think that you can just hand it over to someone else when I don’t know if you really can.” In contrast, Karen explained: “… Before I’ve been in more doubt about my role and whether I should make a report to the Department... It’s become a little bit... clearer, just with rules and regulations that have changed around child protection.” These participants reflected that professional experience (person factor) has enhanced their understanding of professional responsibilities, enabling them to more effectively manage ethical dilemmas. Participants reported that less experienced colleagues may find ethical dilemmas more challenging to manage. For example, Katie experienced a dilemma when asked by management to sign-off on $20 000 home modifications she had not prescribed, believing they should be signed-off by the prescribing therapist. Katie reported: “I was very stubborn and said I’m not doing this because I don’t think it is ethically right... If I didn’t have the experience I wouldn’t be as confident in saying no I am not doing that…”

Leanne and Hannah raised ethical dilemmas surrounding personal versus professional boundaries when referred people whom they knew socially. Hannah stated: “I didn’t think that it was right for me to do the types of therapy that they needed... based on the fact that I
knew them well.” Leanne and Hannah also discussed challenges to maintaining client confidentiality in their social networks. Leanne reported that her hairdresser had been persistently asking about one of her clients: “... I went into my hairdresser and my hairdresser is going ‘you’ve got such and such on your ward haven’t you?’... I said... if she’s there or not I can’t tell you. I am not having this discussion...” Leanne noted the consequences were she to compromise her clients’ confidentiality: “... I end up in huge trouble... I’m breaching the code of conduct; I might not get re-registered...” Leanne predicted that ethical dilemmas of this nature may become more frequent: “You’re also going to get more ethical dilemmas with social media and... people stalking you on Facebook...”

Theme 2: Fair access to quality services
All participants reported ethical dilemmas surrounding fair access to quality services, primarily due to environment factors of resource limitations and efficiency pressures, including limited funding, time, staff and access to interpreters, as well as discharge and patient prioritisation pressures. For example, Lucy reported: “... We had decreased staffing... they weren’t approving positions... so we had to prioritise... people that needed to be discharged home which was frustrating... people that needed you, you weren’t allowed to see and the people that often didn’t need you were the ones where our time went...”

Hannah and Lucy further discussed ethical dilemmas where client-centred practice, an occupation factor, was challenged by resource limitations. Lucy described a client who required a $40 000 operation which she perceived the doctor would not perform unless she deemed the client was able to follow post-operation requirements: “… If I had determined his functional cognition was impaired... he was unable to use compensatory strategies or... didn’t have family support... they weren’t going to operate on him...” Lucy reported that this request conflicted with her professional values: “I am always the client advocate... I am not somebody that goes well yes I understand this is not cost effective, get them home and hopefully they won’t start a fire...”

Katie and Hannah suggested that future ethical dilemmas may arise surrounding the equality of the NDIS eligibility criteria. Katie questioned: “… Why is someone more eligible for this amount of money than someone else, or these types of services and others aren’t?”
Furthermore, Karen suggested criteria for access to the NDIS may create future dilemmas for professionals working in diagnostic and assessment services: “... Clients will need to have a diagnosis... children will miss out on early intervention services if a diagnosis isn’t given so that puts pressure on services like ours.”

Theme 3: Professional status
Four participants discussed ethical dilemmas relating to the ethical culture in their workplace. Participants acknowledged the value of having discussions with colleagues to resolve ethical dilemmas. Lucy stated: “... discussing different views helps me and others grow and develop as therapists and... provide the best care to our clients... it’s important to have robust discussions...” Karen and Lucy noted that private practitioners may not have the same level of collegial support: “With the public system you’ve got more support and people to talk with in relation to ethically challenging issues, but with private practice you may not necessarily have that level of support...” (Karen). However, participants reported concerns regarding potential conflict that may occur when questioning their colleagues’ practice, particularly questioning therapy administered by senior colleagues. Hannah noted potentially negative consequences as “rocking the boat” and compromising her career prospects, despite knowing the client’s well-being was at stake. Katie and Hannah discussed the importance of questioning practice that is not evidence-based to uphold the profession’s reputation and ensure best possible outcomes for clients: “… there were different ways of addressing the deficits of this patient that would have worked better... based on my experience... but also best practice guidelines and evidence-based practice... It was my role... to address the therapist and not just let it slide because... it’s about best patient-centred care...” (Hannah).

Theme 4: Life choices
Four participants described ethical dilemmas surrounding a client’s right to make autonomous and informed decisions. Three participants reported experiencing ethical dilemmas when limited resources and efficiency pressures restricted their client’s ability to autonomously choose from a range of treatment options. Hannah stated: “... If the medical team get a whiff that the patient is not agreeable... they will... discharge them... and we don’t really get to explore a lot of options with these patients and give them time to consider before making the decision...” Katie and Hannah further reported frequently
experiencing ethical dilemmas when their need to respect clients’ autonomous choices conflicted with their professional duty to avoid harm: For example, Katie stated: “… His wife wants to use a standing hoist whereas professional recommendation was… a standard hoist… do I make… the patient’s wife happy because she is going to be using the equipment or do I have to go with what I think is best?”

Theme 5: The complex client at the heart of the dilemma
Four participants experienced ethical dilemmas when managing complex clients (occupation factor). Notably, all ‘complex clients’ described by participants had a cognitive impairment or mental health diagnosis. Participants explained that social and cultural environments add a layer of complexity to their clients’ diagnosis and ethical dilemmas arise when occupational therapists attempt to holistically address diagnostic, social and cultural variables in practice: “The more complex the client the more chances of these ethical dilemmas arising… if it’s a straightforward client there is usually more of a… black and white answer… The majority of our clients are already complex… It’s the added complexities on top of that… complex social… family… or home issues…” (Katie)

Discussion
This qualitative study explored the nature of ethical dilemmas experienced by public practice occupational therapists. Findings revealed that public practice occupational therapists experience ethical dilemmas related to their professional roles and responsibilities within the publicly-funded health care context. Application of the PEO Model revealed that ethical dilemmas reported by participants were consistently impacted by PEO factors, particularly environment and occupation factors, as shown in Table 2.

Ethical dilemmas reported by participants encompassed three out of four shared themes and two out of three experienced professional themes from the study by Kenny et al. (2009). ‘Incorporating self into professional role’ (shared theme) and ‘adapting policies’ (experienced professional theme) were not found in the present study. This may be due to the variance in sample size between the present study (n=5) and the study by Kenny et al. (2009) (n=20), or could reflect differences in professional roles and responsibilities between speech pathologists and occupational therapists. Within the five themes that were found in both studies, some PEO factors were consistent between the professions, including
environment factors of resource and efficiency pressures. However ethical dilemmas also reflected participants’ unique professional roles and responsibilities. For example, ethical dilemmas surrounding the occupation factor of home modifications, within the ‘defining boundaries’ theme, were specific to occupational therapy practice.

Interpretation of Themes
Ethical dilemmas raised by participants under the ‘defining boundaries’ theme primarily arose when occupation factors of professional boundaries/duties outlined in the Code of Ethics and Code of Conduct were challenged. For example, when needing to provide accurate prognostic information conflicted with professional responsibilities to avoid potential emotional harm. Ethical dilemmas of this nature were consistent with previous findings (Barnitt, 1998; Foye et al., 2002; Praestegaard & Gard, 2013). Participants also reported ethical dilemmas when their professional roles and responsibilities conflicted with those of multidisciplinary colleagues; and when their professional practice was restricted by workplace (environment) boundaries including resource limitations and discharge pressures. Similar ethical dilemmas have been reported in previous studies (Atwal & Caldwell, 2003; Foye et al., 2002), and reflect the consistent challenges of providing occupational therapy services in the public practice context. Effort to promote cohesive practice within multidisciplinary teams, such as through inter-professional development activities, may assist health professionals to work together to overcome environment factors imposing on public health service provision.

Home modifications were frequently discussed by participants as an occupation factor contributing to ‘defining boundaries’ dilemmas. Participants described parallel examples to British public practice occupational therapists (Atwal & Caldwell, 2003; Barnitt, 1998), where recommendations for home modifications were disregarded by medical professionals and patients were discharged, but were readmitted following falls that may have been prevented with home modifications. The timely and costly nature of home modifications does not appear to align well with the expectation that public health professionals will facilitate quick discharges. This is an international occupational therapy dilemma and policy developments to increase the efficiency of implementing home modifications may be effective in avoiding preventable harm currently experienced by clients. Furthermore, education promoting the
value and importance of home modifications to multidisciplinary colleagues may reduce ethical tension within the workplace.

Unsurprisingly, resource limitations and efficiency pressures were environment factors core to many ethical dilemmas discussed by participants. Similar to findings in public practice speech pathology (Kenny et al., 2009), participants frequently described ethical dilemmas between upholding professional practice standards and needing to distribute scarce resources across large caseloads, where the ethical principle of justice is at stake. Australia’s public health care system is increasingly managed in a business fashion (McAllister, 2006), suggesting that ethical dilemmas of this nature will continue to be experienced by public health professionals. Professional practice support is therefore necessary to assist public health professionals to distribute available resources in a way that consistently provides clients with quality health care service, thus enabling professional practice standards to be upheld and ethical distress to be prevented.

A workplace culture that addresses ethical dilemmas is integral to maintaining quality health service provision (Kenny et al., 2009). Under the ‘professional status’ theme, participants noted the importance of having robust discussions with colleagues to support ethical practice, but reported fearing conflict between colleagues as an unintended consequence. Organisational hierarchy, as an environment factor, was significant in these dilemmas with the person of lower professional status feeling constrained to act out their moral position. Similar to private practice speech pathologists (Flatley et al., 2014), occupational therapists were conflicted between occupation factors of supporting their colleague’s professional autonomy, maintaining harmonious collegial relationships, advocating for client outcomes and upholding the reputation of the profession. Participants reflected that professional experience (person factor) enables them to confidently approach their colleagues. This finding suggests that less experienced occupational therapists may benefit from support to effectively engage in ethical discussion with senior colleagues. A workplace where colleagues freely discuss ethical issues and question practice may enhance professional competence and benefit clients.

The ‘life choices’ theme revealed public practice occupational therapists endeavour to support clients to make informed, autonomous choices. Comparable to previous studies
(Atwal & Caldwell, 2003; Flatley et al., 2014; Foye et al., 2002), participants reported experiencing ethical dilemmas when their desire to respect clients’ autonomous choice conflicted with their duty to avoid harm. However findings also revealed an ethical dilemma that may be unique to public practice occupational therapists. Participants reported that, due to resource limitations and discharge pressures, treatment/intervention options were presented to clients in a ‘take it or leave it’ manner, which placed ethical principles of autonomy, justice and beneficence at stake. Occupational therapists’ efforts to provide contemporary, evidence-based, client-centred health care may be undermined by public health policies that apply the bioethical principle of beneficence at a population level. This is reflective of utilitarian values in public health, where population benefits are favoured over individual needs and preferences (Berglund, 2012). Thus, our findings suggest that within the publicly-funded health care system clients’ autonomous choice can only be upheld if their choice aligns with population resources.

In accordance with findings in public practice speech pathology (Kenny et al., 2009); participants reported a relationship between client complexity and ethical dilemmas. Reflective of findings by Barnitt (1998), participants consistently referred to complex clients as those with cognitive impairments or mental illnesses. However our participants provided additional insight, reporting that clients’ social and cultural environments further influence ethical decision-making in practice. Kenny et al. (2009) reported ‘complex clients’ to be vulnerable health care consumers, who may have unmet needs. Thus, occupational therapists should endeavour to embrace their advocate role when working with ‘complex’ clients in the utilitarian public health environment to afford true client-centred care.

Overall, findings reflect occupational therapy specific ethical dilemmas and dilemmas that are shared by other health professionals including speech pathologists. Some findings were consistent with previous ethics research in occupational therapy indicating long-term ethical dilemmas within the profession. This suggests that tailored ethical practice support for occupational therapists is well overdue. Future ethical dilemmas predicted by participants, such as those surrounding the NDIS, highlight areas where ethical support may need to be targeted.
Implications
Findings may enable health care organisations and professional associations to support occupational therapists to effectively manage ethical dilemmas. Specifically, findings may promote the development of ethics education materials surrounding resource management, home modifications and working cohesively with multidisciplinary colleagues. Clarifying professional roles and responsibilities through ethics education may enhance occupational therapy services afforded to clients and minimise ethical distress within the profession. Universities may also draw on findings to provide occupational therapy students with up-to-date insight and support regarding the contemporary ethical dilemmas they may experience upon graduation or during clinical placements. Furthermore, the authors suggest that occupational therapists consider adopting the PEO Model in their practice to evaluate and overcome the ethical dilemmas they encounter.

Limitations & Directions for Future Research
Due to the exploratory nature of this study, participants were recruited from one large, metropolitan public hospital. The participant sample was diverse. However, occupational therapists employed in different practice contexts may experience different ethical dilemmas. Future research should explore ethical dilemmas experienced by occupational therapists working in different contexts such as community health services, private practice and rural locations. Replicating this study with a larger sample may also provide greater insight into ethical dilemmas experienced by public practice occupational therapists. Furthermore, participants in this study were experienced occupational therapists. Thus, findings may not reflect dilemmas experienced by new graduate occupational therapists warranting a need for further research.

Conclusion
This study explored the nature of ethical dilemmas experienced by public practice occupational therapists. Ethical dilemmas reported by participants encompassed an array of PEO factors and represent the unique challenges of providing ethical occupational therapy services within Australia’s dynamic publicly-funded health care context.
Acknowledgements: The authors would like to thank the occupational therapists who participated in the study and the occupational therapy department at the research site for accommodating this research.

Declaration of interest: The authors declare no conflicts of interests. The authors alone are responsible for the content and writing of this paper.
Table 1. Example of Data Analysis Table

<table>
<thead>
<tr>
<th>Meaning Unit (Raw data)</th>
<th>Description close to the text</th>
<th>Interpretation of the underlying meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>The client is very dependent and his wife wants to use a standing hoist whereas professional recommendation was more to have a standard hoist as opposed to the standing hoist just because his function varies too often to warrant getting something, a piece of equipment that may not be suitable for him all the time whereas one would be more suitable for him all the time. I guess the ethical dilemma for me was do I make the family and the patient’s wife happy because she is going to be using the equipment or do I have to go with what I think is best.</td>
<td>Uncertain whether to prescribe a standing hoist preferred by the client’s wife or a standard hoist perceived more suitable in professional opinion due to client’s variable function.</td>
<td>Balancing the preferences of the client’s family against professional judgement to achieve the best long-term outcome for the client.</td>
</tr>
</tbody>
</table>

Table 2. Summary of Themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-Themes</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Defining boundaries in professional relationships</td>
<td>Filling professional roles and responsibilities</td>
<td>Patient autonomy vs potential harms</td>
</tr>
<tr>
<td></td>
<td>Defining and respecting the scope of the OT role and roles of multidisciplinary colleagues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Impact of confidence and experience on professional roles and responsibilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Boundaries within the public practice context</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintaining boundaries between friends and clients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintaining client confidentiality</td>
<td></td>
</tr>
<tr>
<td>2. Fair access to quality services</td>
<td>Resource limitations and efficiency pressures</td>
<td>Life choices</td>
</tr>
<tr>
<td></td>
<td>OT duty to ensure client’s receive quality services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Implications associated with the NDIS</td>
<td></td>
</tr>
<tr>
<td>3. Professional status</td>
<td>Having ethical discussions with colleagues and seeking ethical practice support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reputation of the profession compromised in the absence of evidence-based practice</td>
<td></td>
</tr>
<tr>
<td>4. Life choices</td>
<td>Resource and efficiency pressures as a barrier to client’s autonomous choice</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Client’s right to autonomous choice versus OT duty to avoid harm</td>
<td></td>
</tr>
<tr>
<td>5. The complex client at the heart of the dilemma</td>
<td>Diagnostic, social and cultural complexities associated with clients</td>
<td></td>
</tr>
</tbody>
</table>

Table 3. Participants

<table>
<thead>
<tr>
<th>Participants</th>
<th>Age</th>
<th>Years of experience as an occupational therapist</th>
<th>Caseload</th>
<th>Workload</th>
</tr>
</thead>
<tbody>
<tr>
<td>Katie</td>
<td>30-40</td>
<td>5-10 years</td>
<td>Brain Injury</td>
<td>Full-time</td>
</tr>
<tr>
<td>Leanne</td>
<td>40-50</td>
<td>20-25 years</td>
<td>Adolescent Medicine</td>
<td>Part-time</td>
</tr>
<tr>
<td>Hannah</td>
<td>20-30</td>
<td>1-5 years</td>
<td>Amputees/Trauma-Ortho</td>
<td>Full-time</td>
</tr>
<tr>
<td>Karen</td>
<td>40-50</td>
<td>25-30 years</td>
<td>Paediatrics</td>
<td>Part-time</td>
</tr>
<tr>
<td>Lucy</td>
<td>30-40</td>
<td>15-20 years</td>
<td>Brain Injury</td>
<td>Part-time</td>
</tr>
</tbody>
</table>

*Pseudonyms have been used to protect the identity of participants*
References


APPENDIX I: Australian Occupational Therapy Journal - Author 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.

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.

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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.

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STYLE OF THE MANUSCRIPT

Spelling. The Journal uses Australian spelling and authors should therefore follow the latest edition of the Macquarie Dictionary.

Units. All measurements must be given in SI or SI-derived units.

Abbreviations. Abbreviations should be used sparingly - only where they ease the reader's task by reducing repetition of long, technical terms. Initially use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only. The abbreviation of OT is not allowed in the manuscript.

PARTS OF THE MANUSCRIPT
Manuscripts should be presented in the following order: (i) title page, (ii) abstract and key words, (iii) text, (iv) acknowledgements, (v) references, (vi) appendices, (vii) figure legends, (viii) tables (each table complete with title and footnotes) and (ix) figures. Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.

Title page
The title page should contain (i) the title of the paper, (ii) the full names, qualifications and designations of the authors and (iii) the addresses of the institutions at which the work was carried out, together with (iv) the full postal and email address, plus facsimile and telephone numbers, of the author to whom correspondence about the manuscript should be sent. The present address of any author, if different from that where the work was carried out, should be supplied in a footnote.

The title should be short, informative and contain the major key words and consider including the study design for research articles. Do not use abbreviations in the title. A short running title (less than 40 characters) should also be provided.

All submitted manuscripts must indicate the total word length for the manuscript, word length of the abstract, number of references, figures and tables on the title page of the manuscript.

Abstract and key words
Research, Feature and Review articles must have a structured abstract that states in 250 words or fewer the purpose, basic procedures, main findings and principal conclusions of the study. Divide the abstract with the headings: Background/Aim, Methods, Results, Conclusions and significance of the study. Viewpoint articles should have an unstructured abstract of 150 words or fewer. Abstracts should not contain abbreviations or references.

Key words
Three to five key words must be supplied. They are required to index the content of the paper and should be selected from the US National Library of Medicine's Medical Subject Headings (MeSH) browser list. Key words should be arranged in alphabetical order. Please do not use words already written in your title or abstract.

Text
Authors should use the following subheadings to divide the sections of their manuscript: Introduction, Methods, Results and Conclusion. All articles should include an introduction that provide a background to the article, describes its purpose and outlines its relevance to occupational therapy. References should be made to an established theoretical background and/or background literature. The implications of the work for occupational therapy practice, and further research and/or conceptual development, should be clearly described.

Acknowledgements
The source of financial grants and other funding must be acknowledged, including a frank declaration of the authors' industrial links and affiliations. Authors should state any potential conflicts of interest. The contribution of colleagues or institutions should also be acknowledged. Personal thanks and thanks to anonymous reviewers are not appropriate.

References
The American Psychological Association (author, date, title, source) system of referencing is used (examples are given below). In the text give the author's name followed by the year in parentheses: Smith (2000). If there are two authors use 'and': Smith and Jones (2001), but if cited within parentheses use '&': (Smith & Jones, 2001). When reference is made to a work by three to five authors, cite all the authors the first time: (Davis, Jones, Wilson, Smith, & Lee, 2000); and in subsequent citations, include only the name of the first author followed by et al.: (Davis et al., 2000). When reference is made to a work by six or more authors, the first name followed by et al. should be used in all instances: Law et al. (1997). If several papers by the same author(s) from the same year are cited, a, b, c, etc. should be inserted after the year of publication. Within parentheses, groups of authors should be listed alphabetically. In the reference list, references should be listed in alphabetical order.

In the reference list, cite the names of all authors when there are six or fewer; when seven or more, list only the first six followed by et al. Do not use ibid. or op cit. Reference to unpublished data and personal communications should not appear in the list but should be cited in the text only (e.g. A. Smith, unpublished data, 2000). All citations mentioned in the text, tables or figures must be listed in the reference list.

Authors are responsible for the accuracy of the references.

We recommend the use of a tool such as Reference Manager for reference management and formatting.

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Advanced online publication of journal article with DOI

**Book**

**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. Vertical lines should not be used to separate columns. 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.

**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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APPENDIX II: Ethics Clearance

HREC Committee Secretariat:
A/Prof Clement Loy
Medical Graduate – Neurologist
Mrs Patricia Fa
Clinical Trials Pharmacist

HREC Committee Members:
Ms Narelle Bell
Lawyer
Dr Sangeetha Bobba
General Practitioner
Sr Patricia Bolster RSM
Catholic Chaplain
Mrs Therese Burke
Clinical Trial Coordinator
Dr John Fisher
Lawyer
A/Prof Anthony Harris
Medical Graduate – Psychiatrist
Mr John McLeod
Layman
Mrs Janette Parry
Laywoman
Mr John Shaw
Layman
Dr Geoff Shead
Medical Graduate – Surgeon
Dr Lynn Sinclair
Clinical Nurse Consultant
Dr Howard Smith
Medical Graduate – Endocrinologist
Ms Shane Waterston
Laywoman
Ms Christine Wearn
Clinical Psychologist

HREC Ref: (4294) AU RED LNR/15/WMEAD/187
SSA Ref: AU RED LNR SSA/15/WMEAD/216

29 June 2015

Ms Gretel Evans
Department of Occupational Therapy
Westmead Hospital

Dear Ms Evans

LNR Research Project: ‘Ethical dilemmas experienced by public practice occupational therapists’

Your request to undertake the above protocol as a Low and Negligible Risk (LNR) research project was reviewed by a subcommittee of members of the Scientific Advisory Committee (SAC) and the Human Research Ethics Committee (HREC). We are satisfied that your protocol meets the criteria for an LNR research project and does not require review by the full HREC.

The WSLHD HREC has been accredited by the NSW Ministry of Health as a lead HREC to provide the single ethical and scientific review of proposals to conduct research within the NSW public health system. This lead HREC is constituted and operates in accordance with the National Health and Medical Research Council’s National Statement on Ethical Conduct in Human Research and the CPMP/ICH Note for Guidance on Good Clinical Practice.

This proposal meets the requirements of the National Statement and I am pleased to advise that the HREC has granted ethical approval of this LNR research project to be conducted at:

- Westmead Hospital, Chief Investigator Ms Gretel Evans

The following documentation has been reviewed and approved by the HREC:

- LNR Application Form submission code AU8/08/C8CE113
- Study Plan / Scientific Protocol version 2, dated 22 June 2015
- Participant Information and consent Form, version 2, dated 22 June 2015
- Interview Guide, version 1, dated 7 May 2014
- Recruitment Email, version 1, dated 7 May 2014
- Recruitment Email, Follow up, version 2, dated 7 May 2014
Please note the following conditions of approval:

- The chief investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including unforeseen events that might affect continued ethical acceptability of the project.
- The chief investigator will immediately report any protocol deviation / violation, together with details of the procedure put in place to ensure the deviation / violation does not recur.
- Proposed amendments to the protocol or conduct of the research which may affect the ethical acceptability of the project, must be provided to the HREC to review in the specific format. Copies of all proposed changes must also be provided to the research governance officer.
- The HREC must be notified, giving reasons, if the project is discontinued at a site before the expected date of completion.
- The chief investigator must provide an annual report to the HREC and a final report at completion of the study, in the specified format. HREC approval is valid for 12 months from the date of final approval and continuation of the HREC approval beyond the initial 12 month approval period is contingent upon submission of an annual report each year.
- It should be noted that compliance with the ethical guidelines is entirely the responsibility of the investigators.

You are reminded that this letter constitutes ethical approval only. You must not commence this research project until separate authorisation from the Chief Executive or delegate has been obtained. Copies of this letter, together with any approved documents as enumerated above, must be forwarded to the Research Governance Officer as part of the Site Specific Assessment (SSA) application.

In all future correspondence concerning this study, please quote approval number (4294) AU RED LNR/15/WMEAD/187. The HREC wishes you every success in your research.

Yours sincerely

Mrs Patricia Fa
Secretary
WSLHD Human Research Ethics Committee

cc Ms Margaret Piper, Research Governance Officer
13 August 2015

Ms Gretel Evans
Occupational Therapy
Westmead Hospital

Dear Ms Evans

**HREC reference number:** LNR/15/WMEAD/187
**SSA reference number:** LNRSSA/15/WMEAD/216
**Project title:** Ethical dilemmas experienced by public practice occupational therapists
**Protocol number:** version 02 dated 22 June 2015

Thank you for submitting a Low/Negligible Risk (LNR) application for site authorisation of this project. I am pleased to inform you that site authorisation has been granted for this study to take place at the following sites:

- Westmead Hospital

The approved information and consent documents for use at this site are:

- Participant Information Sheet version 02 dated 22 June 2015
- Initial Recruitment Email version 01 dated 7 May 2015
- Follow up Recruitment Email version 02 dated 7 May 2015

The following conditions apply to this research project. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval:

1. Non WSLHD research team members who will be conducting study visits within WSLHD are to organise a time with the Research Governance Officer to be accredited as an external researcher to conduct study activity within WSLHD;
2. Insurance certificate must be current for governance clearance to remain valid. The insurance certificate submitted expires 31 October 2015. Please submit updated certificate when issued.

3. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project, and which are submitted to the lead HREC for review, are copied to the research governance officer;

4. Proposed amendments to the research protocol or conduct of the research which may affect the ongoing site acceptability of the project, are to be submitted to the research governance officer.

Yours faithfully

Maggie Piper
WSLHD Research Governance Officer

CC: Belinda Kenny, Belinda.Kenny@sydney.edu.au
APPENDIX III: Interview Guide

Demographics:
Gender: Male Female

Qualifications:

Age group: 20-30 30-40 40-50 50-60 60+

Cultural and linguistic background:

The Workplace:

- How long have you been working as a public practice occupational therapist?
  - 1-5 years  5-10 years  10+ years

I would like to understand the general context of your work.

- What is your current position within your workplace? (e.g. generalist, specialist)
- Please describe your current workplace. (e.g. hospital, community setting etc.)
- Please describe your current caseload. (e.g. adults, paediatrics, etc.)
- How often do you work? (part-time, full-time?)
  - (If relevant) Do you currently work in any other settings as an occupational therapist? (public or private)
- Have you worked as a public practice occupational therapist in a setting other than your current workplace? (For how long, caseload?)
- Have you worked as a private practice occupational therapist before? (How long? Caseload?)
Interview:
In this interview, I will be asking questions related to your experience of ethical dilemmas as a public practice occupational therapist. Please only include ethical dilemmas that you have experienced as a public practice occupational therapist most recently.
During this interview, I will be asking you to describe ethical dilemmas that you have experienced as a public practice occupational therapist. It is important to understand the nature of these dilemmas and to protect clients’ confidentiality and privacy. Please do not disclose any information which is deemed reportable under the National Law as per the AHPRA Mandatory Notifications Guidelines. Reportable information includes: practice while intoxicated by alcohol or drugs, sexual misconduct in connection with the practice of the practitioner’s profession, placing the public at risk of substantial harm because of an impairment and placing the public at risk of harm because of practice that constitutes a significant departure from accepted professional standards. Also, please do not disclose any identifiable information, such as names and locations of clients and colleagues.
You may find recalling ethical dilemmas that you have experienced distressing. If you would like to take a break from the interview at any time that is okay and you are free to withdraw at any time without consequence.

I will define an ethical dilemma for you:
“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.”

Questions:
1. Please describe the most frequent ethical dilemma you experience in your current practice, using a case example.

Probe Questions:
- Why do you think this is a recurring dilemma?
  - Follow up questions: Do you believe this dilemma is specific to your workplace context? Have you encountered this dilemma in other public practice contexts?
- What factors do you think contribute to the recurrence of this dilemma?
  - Follow up questions: Are they personal, organisational, colleague/client related? Do you think any existing policies or workplace constraints contributed to the cause of this ethical dilemma?
- How often does the dilemma occur?
  - Follow up questions: Does it occur with specific clients or more broadly across your practice?
- Do you think this type of dilemma is specific to public practice?
  - Follow up questions: Why/Why not? Have you encountered this dilemma in other public practice settings?
- Do you think this dilemma is/could be experienced by other public practice occupational therapists?
  - Follow up questions: Why may colleagues need to manage similar issues?
2. Please think about the most challenging ethical dilemma you have experienced while working as a public practice occupational therapist. 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 area of practice did the dilemma occur?
  - **Follow up questions:** Was it focussed on client/carer management, service delivery, professional relationships, resource allocation?
- What was at stake?
  - **Follow up questions:** Was it an ethical principle, a client’s wellbeing, professional integrity, workplace reputation, or?
- Could you describe the two different sides of the ethical dilemma? Was your view different from that of the client/carer/another OT/health professional?
- What do you think were the factors contributing to this dilemma?
  - **Follow up questions:** Were they external or internal to yourself? Were there any specific factors that led to your involvement? Do you think any existing policies or workplace constraints contributed to the cause of this ethical dilemma?
- What concerned you most about the ethical dilemma?
  - **Follow up questions:** Why did it present as challenging for you personally/professionally?
- Do you think this type of dilemma is specific to public practice?
  - **Follow up questions:** Why/Why not?
- Is this dilemma reoccurring in your practice? Yes/No?
  - **Follow up questions:** How often does it occur? Why do you believe it continues to reoccur?
- Have you experienced this dilemma in any other settings as an occupational therapist?
  - **Follow up questions:** Did it arise under similar or different circumstances when compared to your current practice?
- Is there any extra information you would like to add that may help me to understand your experience with this ethical dilemma?

3. Have you experienced any other ethical dilemmas as a public practice occupational therapist that you are willing to share? Please tell me in as much detail as possible what happened during this dilemma.

**Probe Questions:**
- Draw from question one.

4. Do you think the ethical dilemmas experienced by public practice occupational therapists are different to those experienced by private practice occupational therapists?

**Probe Questions:**
- Why do you think they are the same/different?
5. The Future: I would now like to focus on ethical dilemmas that may be experienced by public practice occupational therapists in the future. Can you identify any issues which may become ethically challenging to your practice in the next 5-10 years?

 Probe Questions:
  - Are there any features of public practice that may change or influence the types of ethical dilemmas experience by public practice occupational therapists in the future?
    - Follow up questions: What do you think will be the consequences of these issues to public practice? What new ethical dilemmas will you need to manage?
  - How do you think future ethical dilemmas can be best avoided or resolved?
  - How do you think the roll out of the NDIS will impact your ethical practice as a public practice occupational therapist?
    - Follow up questions: Will the NDIS impact the frequency, nature or complexity of ethical dilemmas?

 Conclusion:
 Recap the ethical dilemmas discussed and provide an opportunity for participant’s to add any relevant information or make clarifications.
 Is there anything else you would like to add about your experience of ethical dilemmas we have not yet covered?
 I have contact details for the Employee Assistance Program and Occupational Therapy Australia if you would like to seek support regarding the ethical dilemmas you experience. Would you like any of this information?

 Thank you for participating in the study.

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