Article

Canadian Journal of Occupational Therapy
2014, Vol. 81(3) 154-162
DOI: 10.1177/0008417414535083

Values and ethics in practice-based decision making

Les valeurs et l'éthique lors des prises de décision dans la pratique

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Key words: Client-centred care; Evidence-based practice; Occupational therapy; Values-based ethical reasoning.

Mots clés : ergothérapie; pratique fondée sur les données probantes; raisonnement éthique basé sur les valeurs; soins centrés sur la personne.

Abstract

Background. Values are evident in health ethics literature; however, it is seldom clear how they are visible in practice. **Purpose.** The aim of this study was to illuminate how values inform occupational therapists' decision making in practice. **Method.** Fifteen New Zealand community occupational therapists completed this embedded experimental mixed-methods study. A pre-deliberation questionnaire was completed prior to deliberation of a case study using web-based values transparency software, the Values Exchange, followed by a post-deliberation questionnaire. Categorical data were analyzed using non-parametric statistics. Written responses to open questions were thematically analyzed. **Findings.** Most participants disagreed with the proposed action for the case. Degrees of divergence, concern for dignity and risk, and values-based reasoning were found, revealing how ethical deliberation was values based. **Implications.** Recognition and transparency of the values inherent in practice-based decision making is possible and desirable in promoting sound ethical reasoning.

Abrégé

Description. Les valeurs sont évidentes dans la littérature sur l'éthique en matière de santé; toutefois, elles sont rarement clairement visibles dans la pratique. **But.** Cette étude avait pour but de mettre en relief la façon dont les valeurs orientent la prise de décision des ergothérapeutes dans la pratique. **Méthodologie.** Quinze ergothérapeutes travaillant dans les services à base communautaire en Nouvelle-Zélande ont participé à cette étude basée sur des méthodes expérimentales mixtes et intégrées. Un questionnaire a été rempli avant la délibération sur une étude de cas, à l'aide de Values Exchange, un logiciel sur la transparence des valeurs basé sur le web, suivi d'un questionnaire après la délibération. Les catégories de données ont été analysées à l'aide de statistiques non-paramétriques. Les réponses aux questions ouvertes ont été analysées thématiquement. **Résultats.** La plupart des participants n'étaient pas d'accord avec l'action proposée pour le cas. Les degrés de divergence, les préoccupations relatives à la dignité et au risque et le raisonnement basé sur les valeurs ont été mis en évidence, indiquant à quel point la délibération éthique était basée sur les valeurs. **Conséquences.** La reconnaissance et la transparence des valeurs inhérentes à la prise de décision dans la pratique sont possibles et souhaitables pour favoriser un raisonnement éthique solide.

Funding: No funding was received in support of this work.

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"Work for health is a moral endeavour" (Seedhouse, 1998, p. 111) because of the degree to which it can affect others' lives (Austin, Lemermeyer, Goldberg, Bergum, & Johnson, 2005; Wright-St Clair, 2001). This suggests that every health encounter, rather than being the reserve of hard cases, has an ethical component (Beagan & Ells, 2009; Christiansen & Lou, 2001; Kassberg & Skär, 2008; Wright-St Clair & Seedhouse, 2004). Therefore, ethical reasoning, as the deliberate use of processes for thinking through moral issues, should be part of every health practitioner's skill base (Hudon et al., 2013; Park, Kjervik, Crandell, & Oermann, 2012; Weston, 2001). Yet, occupational therapy ethics education that focuses on rules-based reasoning, rather than taking account of the personal and contextual complexities, may unduly contribute to practitioners' moral distress (Penny & You, 2011). Furthermore, Seedhouse (2005) suggests practitioners' integration of ethical reasoning with practice-based decision making is integral to evidence-based practice.

There is no shortage of literature related to evidence-based practice in health care. Since the early 1990s, most disciplines have reiterated the call for health care practice to be evidence based (e.g., Cody, 2006; Guyatt, 1991). However, in response to criticism, evidence-based medicine theorists now assert that the original goal of the evidence-based "movement" was to add rigour to deliberating the objective rather than exclude the subjective dimensions of practice decisions (Haynes, Devereaux, & Guyatt, 2002). Broader understandings of evidence for practice include other ways of knowing, such as the practitioners' and clients' experiences (Fulford, Dickenson, & Murray, 2002; Haynes et al., 2002; Kvåle & Bondevik, 2008; Murtagh & Thorns, 2006). In accord, Fulford and colleagues (2002) described a general, inclusive, values-based approach to ethical reasoning instead of the "quasi-legal," fact-based approach that many others adopt. Values, or appreciation of the subjective (Fulford et al., 2002), can also be defined as preferences, with the terms often being used interchangeably (Fulford, 2004; Haynes et al., 2002; Seedhouse, 1998, 2005; Weston, 2002). For clarity, this article uses the term *preferences* when referring to health care recipients' values and *values* when discussing those held by health practitioners.

People's preferences or values are purported as underpinning the subjective influences in ethical reasoning (Fulford et al., 2002; Haynes et al., 2002; Seedhouse, 2005; Wright, 1987). Wright (1987) went so far as to assert that values should be considered part of evidence-based practice decisions. Yet, while practitioner values are often made evident in the theoretical health ethics literature, they are seldom made visible in practice-based decision making (Seedhouse, 2005). Interestingly, recent research suggests an increasing interest in the place of values in ethics. For example, nurses' moral distress was found to be heightened by conflicts between the practitioners' values and those of the practice setting (Holt & Convey, 2012; Vanderheide, Moss, & Lee, 2013), and physiotherapists' moral values contributed toward their moral sensitivity in ethically challenging practice situations (Kulju, Suhonen, & Leino-Kilpi, 2013). It may be that, as with taking explicit account of emotions during ethical reasoning (Molewijk, Kleinlugtenbelt, & Widdershoven, 2011), making one's values transparent may deepen moral deliberation.

Assertions for occupational therapy practice to be evidence based are prevalent in the literature (see Glegg & Holsti, 2010; Hammell, 2001; Illot, Taylor, & Bolanos, 2006; Stube & Jedlicka, 2000) with considerable agreement that "evidence" should include practitioner experience and the service recipients' preferences in addition to research-based evidence. Practice underpinned by the service recipients' preferences is often described as being "client-" or "person-centred" (e.g., Duggan, 2005; Hasselkus, 1991; Sumsion & Law, 2006; Sumsion & Smyth, 2000). What is missing is the inclusion of practitioner values and an awareness of how "values-based" ethical reasoning might influence the process of making evidence-based practice decisions. In spite of this, the case for health practitioner values to be explicit in practice-based decision making is well made, suggesting research is needed to understand how such internalized values come into play within health practitioners' everyday practice-based decision making and how they can be made visible. In accord, the purpose of this study was to illuminate how values inform occupational therapists' decision making in practice when deliberating a common case.

Method

Study Design

An embedded experimental mixed-methods design (Creswell & Plano Clark, 2007), formerly classified as concurrent nested mixed methods (Creswell, 2003), was used, with a qualitative descriptive component nested within the overall quantitative design. Online values-transparency software, the Values Exchange, provided the platform for participants' ethical deliberation. Responses included selecting deliberation factors from a standardized list of choices as well as participants' written responses to open questions explaining their position or decision. The software was used for its potential to make practitioners' values visible and to highlight the divergence or convergence of decisions and values across multiple practitioners deliberating a single case.

The Auckland University of Technology Ethics Committee granted ethics approval. All participants consented in writing. One person chose anonymous participation for the online ethical deliberation component of the study.

Developing the scenario for deliberation. The practice scenario used in the study emerged from a consultative process. Initially, occupational therapists attending an open meeting about the project were invited to describe practice events they considered ethically challenging. Then, three experienced community occupational therapists were invited to collectively identify a suitable case for use in the project. The scenario for deliberation was chosen for its ordinariness in everyday practice and its inclusion of a common concern related to limited resources and potential disparity between the clients' preferences and the therapists' values. A pseudonym has been used to preserve confidentiality.

> Mrs. Andrews (83) is struggling to adjust to a recent below-knee amputation, necessitated by diabetes. You have been asked to assess her needs for modifications to her home to facilitate wheelchair access. The logical place for a ramp seems to be the front entrance, which has a wide doorway into a spacious hall, and good access to car and letter box. There is sufficient room for a ramp with very good gradients at the front. The client (and her daughter, a nurse who is putting pressure on all the team) is adamant that the ramp should be at the back entrance, as that way it will not mark her out as "disabled." Mrs. Andrews lives alone and says that she feels vulnerable by having her disabled status advertised to the world in this way. She also is unhappy that a ramp will change the look of the front of her property and require the removal of a rose garden that she has tended lovingly for 10 years since living here. The back has a narrower entrance and is higher off the ground, meaning that the gradient, while still within the 1:12 guidelines, is steeper than the ideal for those days that she will walk on the ramp. The back is also a shadier aspect of the house and so more likely to be slippery. A ramp at the back will need to be longer, adding some cost. You decide to use the Values Exchange to assist your own process of deliberation and to ascertain the view of a range of colleagues. It is proposed that an application for a ramp at the front of the property is supported.

Participants

The study planned to recruit as many participants as possible, recognizing that analysis would likely be restricted to descriptive statistics because of small participant numbers. Eligible participants were currently practising New Zealand registered occupational therapists with existing or previous experience working in a community setting. No minimum duration was specified. Participants were recruited by way of convenience sampling. First, an announcement for the study, with information about what to do if interested in participating, was placed in the New Zealand Association of Occupational Therapists' monthly newsletter, which was distributed nationwide to all current members. Second, verbal and written information about the study was presented to 20 occupational therapists in two Auckland-based district health boards within regular staff meetings. Third, professional leaders for the remaining 21 New Zealand district health boards were contacted by phone and invited to distribute participant information sheets to all community occupational therapists within their organizations. In total, 35 potential participants were sent information about the study, a consent form, a copy of the pre-participation questionnaire, and a reply-paid envelope. Reminders were sent out after 4 weeks.

Twenty-six occupational therapists returned a signed consent form and a completed pre-deliberation questionnaire. Nineteen had been practising for more than 8 years, four between 4 and 8 years; two for 1 to 3 years, and one for less than 1 year. All were female and identified their culture as being European with the exception of one participant who identified as "other" (New Zealander). After submitting their written, pre-deliberation questionnaire, consenting participants were sent instructions for registering online in a restricted access site within the Values Exchange (http://www.values-exchange.com/). Instructions for using the software were provided on the website. Eleven participants dropped out without completing the online deliberation; lack of time to complete was the main reason given. The remaining 15 participants completed the online case deliberation and returned a written, post-deliberation questionnaire.

Data Collection

Data collection occurred in three phases with 15 full data sets collected.

Pre-deliberation written questionnaire. Demographic data were gathered, including whether participants currently worked in a community setting, their years since qualifying, gender, and ethnicity. They were then invited to nominate practice situations they considered were ethically challenging and to explain why. Further questions were added with the aim of determining, by comparison with a post-deliberation questionnaire, whether deliberating a practice case using the Values Exchange software would influence how participants thought about values in ethics and their ethical reasoning skills. Using a 5-point Likert scale, participants then self-rated three questions about ethical decision making, including what ethical practice meant to them, what they think about when confronted with an ethically challenging situation, and the personal and organizational factors that influence practice decisions. Finally, participants read eight statements about expectations of participating in the study, such as "I want to improve my skills of ethical deliberation in everyday practice" and "I would like to discover what values-based decision making is about," and selected all statements that were true. Additional open responses were invited.

The online case deliberation. In Phase 2, participants were invited to engage online in an individual ethical-reasoning process, within a given time frame, that required thinking about personal values and moral concerns. Participants were sent login information once their pre-deliberation questionnaire was submitted. Once in the online environment, participants were presented with the case of Mrs. Andrews (above) and the proposed course of action: *that an application for a ramp at the front of the property is supported*. Participants used drop-down menu options to indicate their agreement or disagreement with the proposed action, to select whose interests were of primary importance, and to specify what they considered was the most important aspect of the case. Participants then used the program's "Perceptions Rings" to select case-related statements about what they believed and how they felt about the proposed action from an options menu. The interactive software enabled participants to consider the relative importance of ethical dimensions, such as human dignity, emotions, primary risk, the law, and human rights. Following this, the "Values Grid" enabled participants to consider ethical

concerns, such as respecting persons equally, respecting wishes, and cultural norms, as part of supporting the argument for what they thought should happen. Concluding thoughts could be entered before participants submitted their analyses online. Once completed, participants could view a report of their own and others' analyses and comments. Participants had 8 weeks to complete the online deliberation. A full description of the online reasoning process has been published (Newcombe, 2007).

Post-participation written questionnaire. Post-participation questionnaires were distributed to participants after completion of the online ethical deliberation. Participants were asked to reconsider what ethical practice meant to them and what they now think about when confronted with an ethically challenging situation. Last, participants read 11 statements about experiences of participating in the study, such as "I have extended my knowledge about ethics" and "I think this tool will provide a useful forum for professional discussion," and selected all statements that were true. Additional open responses were invited.

Data Analysis

Categorical data from the pre-deliberation questionnaires were analyzed using descriptive statistical methods and reported in frequency tables. Post-deliberation questionnaire data were analyzed by way of tabulating the degree of change in scores compared to pre-deliberation responses. Open responses were categorized by the researcher into nine themes using Morse and Richards' (2002) method for analyzing qualitative descriptive research. Categorical data generated through the online ethical deliberation process were reported using the software's inbuilt analysis function. Online written responses were analyzed by content and clustered into themes. In keeping with the embedded experimental mixed-methods design of the study, the findings are drawn from all data sources (Creswell & Plano Clark, 2007), the pre- and post-deliberation questionnaires, and the Values Exchange online reports.

Findings

Collectively, the 26 participants nominated 58 ethically challenging practice situations (on average 2.23 situations each). The 16 most-commonly nominated pertained to circumstances in which funding restrictions and gatekeeping impacted on access to funding or equipment for clients (see Table 1).

Of the 15 complete data sets, nearly three quarters of participants, before deliberating the online case, agreed or strongly agreed that ethical practice meant "knowing the right thing to do" (see Table 2); whereas post-deliberation, a third of them revised their scores down by 1 or 2 points. Similarly, pre-deliberation, nearly two thirds affirmed it meant "doing what is best for the patient," with a fifth of them revising their score downward by 1 or 2 points post-deliberation. In comparison, nearly two thirds pre- and post-deliberation thought ethical practice meant "doing what is best for the community."

Table 1
Categories of Practice Situations Considered Ethically Challenging

Category	Frequency
Funding restrictions/gatekeeping	16
Waiting list/resources	13
Client disagreeing with therapist recommendations	9
Client/family/support situation	6
Client personal factors—behaviour, culture, actions	5
Organization, e.g., management accountability	3
Client rights not met, e.g., informed consent	3
Team issues, e.g., racist comments from others	2
Therapist issues, e.g., competence	1

When making ethically challenging decisions pre-deliberation, the majority agreed or strongly agreed they thought about following practice guidelines (87%; see Table 2). Few score changes were evident post-deliberation.

In relation to the personal and organizational factors that influenced decision making pre-deliberation, participants most frequently agreed or strongly agreed that they needed enough facts to make a decision (80%), feared making a wrong decision (40%), and took others' opinions into account (40%). Examination of the pre- to post-deliberation scores that on average changed ± 0.25 Likert points or more showed that 33% of participants increased their score for how influential "knowing the right thing to do" was compared to 7% who decreased their score. No participants increased their score for how influential "doing what is best for the patient" was, whereas 20% decreased their score for this factor. Forty percent increased their score for how influential the "fear of making the wrong decision" and "other people's opinions" were, while 13% decreased their scores for both factors. Last, 20% scored "having enough facts to make a decision" more highly, compared to 40% who determined it had less influence.

Participants reported their experiences of engaging in the online case deliberation as exceeding their expectations in all but one area: how beneficial it was to see others' deliberations. Post-deliberation, 12 reported it as being beneficial, whereas 13 had expected it would be. While the reason for this is not evident, it may be that reading decisions and reasons that are different from one's own causes some uncertainty. Of the evaluation questions asked post-deliberation only, a third "thought the process was too complex for everyday use," with the process taking 30 to 60 min by most (80%) participants; whereas all but one reported they "would like to use the method to deliberate a specific case from practice."

Online Case Deliberation

After reading Mrs. Andrews' case on the Values Exchange site, 11 out of the 15 participants disagreed with the proposal to install a ramp at the front of the property. Of these, 7 had more than 8 years' experience. All participants identified the patient's, or the patient and family's, interests as being primary regardless of whether they agreed or disagreed with the proposal. Participants then deliberated the considerations most

Table 2
Pre-Deliberation Personal and Organizational Factors That Influenced Decision Making

	Strongly disagree		Disagree		Neutral		Agree		Strongly agree	
Factor	*n*	(%)	*n*	(%)	*n*	(%)	*n*	(%)	*n*	(%)
Ethics is . . .										
Knowing the right thing to do	0	—	1	(7)	3	(20)	7	(47)	4	(27)
Doing what is best for the patient	0	—	1	(7)	4	(27)	6	(40)	3	(20)
Doing what is best for the community	0	—	2	(13)	7	(47)	5	(33)	0	—
I think about . . .										
Following the code of ethics	0	—	0	—	2	(13)	10	(67)	2	(13)
The preferences of everyone involved	0	—	2	(13)	4	(27)	6	(40)	2	(13)
Following guidelines	0	—	0	—	1	(7)	12	(80)	1	(7)
I am influenced by . . .										
Fear of making the wrong decision	1	(7)	4	(27)	4	(27)	6	(40)	0	—
Lack of training	0	—	6	(40)	4	(27)	5	(33)	0	—
Other people's opinion	0	—	3	(20)	6	(40)	6	(40)	0	—
Having enough facts to make a decision	0	—	0	—	2	(13)	6	(40)	6	(40)

influential in determining their agreement or disagreement with the proposal. Quotes from participants' written explanations of deliberations and decisions are presented.

Reasons for agreeing with the proposal referred to practice guidelines on optimal ramp placement and the need to weigh up conflicting considerations primarily between the perceived risk of harm (identified by 44%) to Mrs. Andrews and how important her dignity (17%) was. Other considerations were human rights issues (14%), the therapist's role (9%) and emotions (9%), and the law (7%). Those who agreed with the proposal perceived the likelihood of her incurring physical harms from using a ramp at the back of the house as high, as two explanations show: "Although I recognise this client's wishes as significant what I see as the risks to her override her preference," and "The proposal is supported on the grounds of the occupational therapy criteria and what we are bound to. The client's rights and dignity are important but must be enhanced with participation and balance with the client's safety."

In contrast, those in disagreement with the proposal most frequently based their decision on respect for Mrs. Andrews' dignity (identified by 30%) and human rights (26%) as a health service recipient, as explained in the following quotations:

> While the front door proposal appears a more expedient and possibly more cost-effective option, the opinion and feelings of the family are important. The client has raised valid issues in firstly her own safety and her perception of how this will be changed with a ramp in full public view and secondly her concern of the loss of her garden. This is also part of her "home" and her feelings about the loss of this in addition to the loss of a limb are understandable and deserve respect and catering to if possible.

> I am uneasy with this proposal. I do not feel an application for a ramp at the front is warranted. My reasons are (1) the client is not in agreement with this proposal and will probably not sign the application papers, and (2) the client is still coming to terms with the loss of her leg and the changes this has made in her life. This may be clouding her judgment and her families. The client's view may change in time.

Interestingly, participants who decided that a ramp at the back of the house was ethically right rated the risk of physical harm (17%) as an equally important consideration as one's role as a client-centred practitioner. However, unlike those in agreement with the proposal, the perceived likelihood of harm occurring was insufficient to override Mrs. Andrews' expressed wishes for a ramp fitted at the back of the house: "Patient dignity must be upheld, but simultaneously, primary risk must be investigated. I believe it is a team decision which should include both patient and her family, and all options should be considered prior to a decision being made."

> I think that the back access should be considered as an option for access because of the client's reasons for privacy and her rose garden, and because I think there may be a better option to consider. My feelings are that the ramp needs to be client-centred and address client's needs/wishes. My instinct is that I don't believe she will use the ramp if it is at the front of the house and that would be a waste of public funding.

Results from the next section of the online deliberation, the Perception Rings, provided elaboration of the values underpinning the stance of supporting the proposal or not: the perceived willingness to carry out the proposal, how much emphasis was given to the risk, and how confident that this risk could be avoided if the proposal went ahead.

The importance of Mrs. Andrews' rights were rated as very important by 75% of those who favoured the proposal compared with 63% of those who did not support it. Unsurprisingly, 82% of those who disagreed with the proposal, compared with one person in agreement, thought that going ahead with a front ramp would breach those rights.

In the final section, participants selected the Grid Tiles representing the ethical principles and practical considerations they used to build their argument. Interestingly, three were selected most frequently by those who agreed (4) and disagreed

(11) with the proposal: effectiveness of actions (100% and 63%, respectively), telling the truth to the client (100% and 63%, respectively), and doing what is most beneficial for the individual (75% and 55%, respectively). The greatest discrepancy between the two groups showed in the importance of risk (100% and 18%, respectively) and the person's wishes (25% and 55%, respectively). Typical arguments made by participants who agreed with building the ramp at the front of the house, considered a "practice norm" or accepted practice, were "The client is at greater risk of falls if the housing alteration she wants goes ahead" and

> Although I consider it of primary importance to consider the client (and family) and to work in partnership with them, in this case I consider that having a ramp in an unsuitable position puts the client at considerable physical risk and therefore believe this is not a good use of the available resources.

Finally, the following explanation is highly illustrative of the final arguments put forward by those who disagreed with the proposal:

> Should ramp be installed at front of house, there is risk patient won't use ramp, and/or patient's dignity will be offended which will affect her self-esteem and sense of self efficacy. As the patient is already struggling to accept her new health status, these are real issues which need investigation. Should the ramp be installed at back of house, several safety issues need consideration, e.g. safety of access, risk of patient falling at back of house, and not being seen by passers-by. . . . Has the patient been informed of all options or considered the primary risk; has the administrator of this case considered the client-centred approach???

Evaluative responses to using the values transparency software elicited in the post-participation questionnaires indicated that participants' knowledge about ethical deliberation was extended by engaging in the study (14/15), understanding about values-based reasoning was increased (14/15), and how they thought about client-centred care was challenged (12/15). A minority (5/15) found the process too complex for everyday use.

Discussion

This descriptive mixed-methods study explored community-based occupational therapists' deliberations for an ethically challenging practice scenario using the values transparency software the Values Exchange. The online tool was chosen for its capacity to make values visible in ethical reasoning. Participants engaged in the reasoning process in a deep and thoughtful way by arguing what they thought was the most ethically defensible action to take and why. Participant responses to the pre-deliberation questionnaire about their ethical reasoning in practice showed that primacy was given to fact-based considerations, whereas post-deliberation, the pattern of questionnaire responses indicated participants were less influenced by having enough facts and knowing the right thing to do.

Three main findings emerged from the data. First was the degree of divergence among participants' support for the scenario's proposal *that an application for a ramp at the front of the property is supported* and how their stance was justified. Second, although perception of risk was a ubiquitous factor in arguments for and against the proposal, for a majority, participants' concerns about client dignity and rights were sufficient for the majority to argue for an opposing action, which seemingly posed the greatest potential for physical harms to the client. Third, the ethical reasons given for arguing for or against the proposal illuminate the participants' personal and practice values, which were made visible in the described tensions between wanting to be client-centred on the one hand and taking account of perceived risk for the client on the other.

Degree of Divergence

Data analysis revealed how using the Values Exchange elicited participants' thoughtful deliberations as well as the apparent divergent thinking behind how participants ethically justified their decisions. Mrs. Andrews' case was chosen for ethical deliberation because of its "familiarity" to community-based occupational therapists. Yet, from the outset, just over a quarter (27%) of the participants agreed with the proposed course of action to install the ramp at the front of the house; the position rejected by the client. However, none of these participants were entirely comfortable doing so because of its potential influence on the person's dignity. This degree of divergence is interesting, as all those who agreed with the proposal, and 7 (out of 11) who disagreed, had more than 8 years of practice experience. Given that these experienced practitioners were all working with the same "facts," it may be reasonable to assume the justifications for action would show more convergence than divergence. Analysis showed that not only was there divergence of views regarding the overall practice decision, but there was variation in the ethical factors considered in supporting the arguments. However, in general, those who agreed with the proposal, like those who opposed it, tended to pose similar explanatory arguments. Convergence in thinking showed with all participants identifying the patient's, or the patient and family's, interests as being primary, regardless of whether they agreed or disagreed with the proposal. Thus, the evaluative nature of practice-based decision making in this setting was made visible.

Concern for Dignity and Risk

The minority of participants who agreed with the proposal identified the risk of physical harm as the primary ethical consideration, a view reflected in the occupational therapy literature (see Barnitt & Partridge, 1997; Foye, Kirschner, Brady Wagner, & Siegler, 2002; Russell, Fitzgerald, Williamson, Manor, & Whybrow, 2002). Their arguments centred around their perception of risk of potential physical harms posed by a ramp at the back of the house as a rationale for overriding the client's preference to position it at the back. This finding is

congruent with research evidence suggesting occupational therapists' willingness to override clients' wishes when the practitioner believes the person "might not be 'safe'" (Russell et al., 2002, p. 374) if the action is carried out. This finding suggests a preparedness for occupational therapists to support clients' wishes if the person's perception of risk aligns with their own (Russell et al., 2002). In contrast, the great majority of participants in this study disagreed with the proposal and argued for installing the ramp at the back of the house, in line with the client and family's wishes. Deliberations did consider the influence of perceived risk but focused on respecting the client's dignity and human rights as the most compelling ethical consideration. Even though fitting the ramp at the rear of the property apparently posed more safety risks, those against the proposal weighted individual dignity and rights more highly. Interestingly, this finding is congruent with the literature identifying client safety as a fairly ubiquitous factor creating ethical tensions for occupational therapists (Barnitt & Partridge, 1997; Durocher & Gibson, 2010; Foye et al., 2002; Moats, 2007; Russell et al., 2002). Yet this study's findings seemingly contradict the research evidence by revealing experienced occupational therapists' willingness to argue in favour of respecting the client's preferences, even when safety is a concern. This may be because those who disagreed with the proposal felt the risks could be managed whereas offending the client's dignity could not.

Values-Based Reasoning

The online moral deliberation process inherent in the Values Exchange made it evident how the occupational therapists participating in this study thought through and generated their arguments for a preferred, ethically defensible action in response to the ethically challenging situation posed. In doing so, participants demonstrated values-based ethical reasoning. The results affirm the practice setting as a values-rich context (Fondiller, Roage, & Neuhaus, 1990). Accepting the notion that values are non-quantifiable influencers on performance, the results of this study illuminated how the participants' values were working within the ethical decision-making process in which two fundamental ethical principles (minimizing risk and respecting people's dignity) competed. It stands to reason that values will also come into play when making evidence-based practice decisions.

Occupational therapy evidence-based decision making is defined as including client preferences (Canadian Association of Occupational Therapists, Association of Canadian Occupational Therapy University Programs, Association of Canadian Occupational Therapy Regulatory Organizations, & Presidents' Advisory Committee, 1999/2009). The lack of specific reference to practitioners' values-based reasoning may contribute to the gap that some writers describe between theory and practice in the area of client-centred care (Carpenter, 2004). Interestingly, while the professional literature points to the notion that occupational therapy practice is underpinned by common professional values related to humanism, occupation, participation, and client-centred practice (Sumsion, 2000; Wright-St Clair, 2001; Wright-St Clair & Seedhouse, 2004), this study revealed how practitioner values were in play. Community practice is morally rich in nature as the work is highly evaluative because of the diversity of, and interplay between, client preferences and practitioner values. Therefore, practitioner values cannot be ignored for practical purposes (Parker, 2002), particularly when contemplating how to integrate values-based ethical reasoning into the decision-making process in evidence-based practice (Seedhouse, 2005).

Limitations of the Study

While the study's findings might be recognizable by other practitioners, the non-representative sample of occupational therapists means the findings are not generalizable within New Zealand or to other countries. The case used for deliberation was drawn from practice; however, the limited description of the situation does not reflect the nuances and complexities of being in an actual practice situation. Also, participants could take time deliberating the case, which does not necessarily resemble often time-limited demands in a practice context.

Conclusion

Diversity in what ethical factors were most salient, and arguments why, were evident amongst occupational therapists with community-based experience using the same information and facts about a seemingly familiar practice situation. The ethical deliberations were focused on two conflicting principles of minimizing risk for the client and respecting the client's or the client and her family's wishes. Using the values transparency software, the Values Exchange, enabled practitioners' values to be illuminated, in addition to highlighting how they took account of the client's goals, preferences, and the contextual and practical considerations, when ethically reasoning a common case scenario. Rather than being detrimental to sound ethical reasoning, accepting that community occupational therapy practice occurs in a values-rich context, it is beneficial to make the interplay of values and facts transparent in everyday ethical deliberation.

Key Messages

- Community occupational therapists' values contribute to the divergence in deciding what to do and why, when using ethically reasoning in a common case scenario.
- Respecting the client's dignity and human rights were the most compelling ethical considerations for the majority of experienced occupational therapists, even though the resulting action was perceived as incurring more risk than the alternative.
- Community occupational therapy practice occurs in a values-rich context; therefore, practitioners ought to make the interplay of values and facts transparent in everyday ethical deliberation.

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Book Review

George, Michael. (2012).
Third time lucky: How Ben shows us the way.
Bloomington, IN: iUniverse.
358 pp. $22.95. ISBN: 978-1-46203-918-0

DOI: 10.1177/0008417414527573

Third Time Lucky: How Ben Shows Us the Way is a very personal account of Michael's life as Ben's dad. Ben is Michael and Jan's third and youngest child, joining his brother, Conor (3 years older), and sister, Tori (1½ years older). Ben has multiple physical and sensory challenges identified from birth as a result of exposure to the cytomegalovirus (CMV) during pregnancy.

Michael's story, covering the first 6 years of Ben's life, starts with the birth of his son. The reader is instantly drawn in by vivid descriptions, honest emotions, and reflective thoughts as Michael recounts their family's life as they first learn about, and then adjust to, having a child who has multiple challenges. Nothing prepares Michael and Jan for the endless stress, uncertainty, doctor appointments, and hospital visits that become part of their new life.

Their story illuminates how challenging, exhausting, and complicated life can become, but it is also extremely inspiring. Their family's love and dedication to each other, combined with their goal of optimizing their children's development and well-being, highlight their incredible strength and resilience. The most valuable contribution for me was reading Michael's reflections on his many interactions with health professionals—positive and negative. His candid responses to a range of manners, words, actions, or inactions are quite insightful and provide much food for thought.

In summary, this book is a worthwhile resource for those who work in paediatrics or are interested in client-centred practice. It brings an awareness of the many issues parents face when caring for children who have multiple challenges.

Debbie Field

