

Ethics

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INTRODUCTION

Within the healthcare sector, healthcare professionals such as occupational therapists and students frequently experience a multitude of ethical tensions during their daily fieldwork practices^{1,2}. Ethical tensions can range for example, from unethical or incompetent colleagues to interacting and collaborating with team members with difficult personalities³. Ethics education has been highly regarded as a way to resolve ethical tensions by equipping healthcare students with the necessary knowledge and skills to overcome clinical tensions confidently⁴. At the Department of Occupational Therapy at a university in South Africa, undergraduate students are exposed to various modes of ethics education including reflective practice using journaling as guided by Kolb's Cycle of Experiential Learning⁵, case discussions using Sokol's decision-making model⁶ and consolidating their learning by participating in an annual Interprofessional-Ethics World Café⁷. Despite the well-documented significance of ethics education during undergraduate training, research exploring ethics education in occupational therapy is limited, particularly in the South African context. Additionally, the ethical tensions experienced by occupational therapy students in fieldwork are scarcely documented, thus posing the question: Are occupational therapy ethics curricula responsive to social and political climates where the students will subsequently serve as occupational therapists? This paper aims to bridge the gap in the literature by exploring occupational therapy students' reflections on ethical tensions experienced during fieldwork practice and how they dealt with the tensions.

LITERATURE REVIEW

Within the healthcare sector, it is widely recognised that fieldwork brings varying degrees of ethical tensions^{1,2}. Henry^{8,132} proposes that ethics "assesses the ways in which we behave and the quality of moral values that we have" and seeks to uphold this through the provision of mandated codes of conduct and ethical guidelines for good practice such as those legislated by the Health Professions Council of South Africa (HPCSA)⁹. Additionally, occupational therapists and occupational therapy students are required to adhere to an ethical code of conduct proposed by the Occupational Therapy Association of South Africa (OTASA)¹⁰ and derived from the World Federation of Occupational Therapists (WFOT) code of practice¹¹.

Kinsella et al¹ and Nortje² outlined three variations of ethical tensions namely, ethical uncertainty, ethical distress, and ethical dilemmas. Ethical uncertainty may transpire when a healthcare professional is unsure, or unfamiliar with, which ethical principle is applicable to their experience, or whether their experience is central to a subjective moral perturbation^{1,2}. Ethical distress may occur when a healthcare professional is cognizant of the correct course

of ethical action, ⁶ but feels constrained to act owing to institutional or societal norms^{1, 2}. An ethical dilemma arises when a healthcare professional faces two or more equally distressing alternatives that are mutually exclusive^{1, 2}. Evidence systematically delineating the definition(s) of ethical tensions is transversely explored across professions, however, case studies or contextual experiences of these ethical tensions in South Africa are scarcely documented.

Barnitt¹², in a preliminary exploration of 35 occupational therapy and 37 physiotherapy clinicians and students, ¹⁷ proposed ineffective treatment, unethical and/or incompetent colleagues, priorities in treatment, causing pain and discomfort, misleading the patient, and confidentiality as some of the main ethical concerns in fieldwork. Nortje² and Nortje and De Jongh¹³ reported that the three prominent areas where students encountered ethical tensions were in the professional-student relationship, professional boundaries, as well as disclosure of information and keeping information confidential. Clever et al³ additionally report the difficult personalities of team members, professionals of lower hierarchical standing, and team business as a rationale as to why occupational therapists and students are unable to express their concerns in the resolution of ethical tensions. Redman and Fry¹⁴ further suggest that healthcare professionals may not have the necessary skills to resolve ethical conflict and that the persistence of the conflict alludes to the professional not having the decision-making authority to resolve the conflict independently, thus speaking to organisational hierarchies and a conceivable unequal distribution of power. Whilst ethical guidelines recommended by the HPCSA¹⁰ and OTASA¹¹ may support discussions of ethical conflicts, it has been suggested by Brockett¹⁵ and Henry⁹ that these professional bodies and guidelines are ineffective in providing professionals with guidance or clear answers. Ethics education is regarded as a means to enable healthcare practitioners and students to manage ethical dilemmas in practice⁴.

In the Department of Occupational Therapy at a university in South Africa, undergraduate healthcare professional students are exposed to a trimodal ethics curriculum as marked by theory, practical and continual learning consolidation through senior educator guidance. Firstly, students undergo extensive exposure to the theoretical underpinnings of ethics in practice that culminates in ethical decision-making as guided by Sokol's decision-making model⁶. Lectures are interactive and afford opportunities for case discussions with peers and guidance from an experienced ethics lecturer. Additionally, students are invited to participate in an Interprofessional-Ethics World Café (IPEWC) which has been described by De Jongh and Wegner⁷ as a simple, effective, and flexible format for hosting large group dialogue. IPEWC is beneficial in developing an understanding of the different team members' roles and responsibilities and reflecting on the benefits and conflicts that may arise when

working collaboratively as an interprofessional healthcare team⁷. Secondly, students are tasked to implement their learning in practice across 1000 mandated clinical fieldwork hours¹⁶. In addition, students are required to engage in reflective practice through writing reflective journals guided by Kolb's Cycle of Experiential Learning⁸. According to Kolb⁵, experiential learning can be defined as a learning process where knowledge results from the combination of grasping and transforming an experience. This occurs through documenting a concrete experience, reflective observation, abstract conceptualisation, and active experimentation¹⁴. Lastly, students are given opportunities for further consolidation through feedback gained during weekly tutorials with clinical supervisors, lecturers, and fieldwork site clinicians.

Despite exposure to ethics education, occupational therapists and occupational therapy students alike continue to encounter ethical tensions in their daily fieldwork practice. These tensions and the processes that clinicians and students must implement to resolve them are poorly understood. Research is further limited when exploring the context of South Africa. This is noteworthy as research clarifying these tensions and processes could be beneficial in transforming the ethics curriculum into one that is responsive, thus better equipping healthcare professionals with the skills to navigate ethical tensions. Therefore, a study was conducted to explore occupational therapy students' reflections on ethical tensions experienced in fieldwork practice.

METHODS

This study employed a qualitative, descriptive research design to explore occupational therapy students' reflections on ethical tensions experienced in fieldwork practice. Qualitative research describes the systemic inquiry of context-specific phenomena that seeks to describe the 'who, what, and where of events or experiences from a subjective perspective'¹⁹.

STUDY SETTING

Students were registered for their fourth (final) year of an undergraduate occupational therapy programme at a university in the Western Cape, South Africa. During their fourth year, students are required to complete three, six- to eight-week fieldwork placements in diverse practice settings in the Western Cape, including hospitals, clinics, communities, schools, non-governmental organisations, and care homes. Students are required to write a reflective portfolio at the end of each fieldwork placement as part of their assessment. Students select, and write about, three of six topics that include: 1) the impact of pathology on client/group occupational performance, 2) occupational injustices experienced by the client/group, 3) own learning within the occupational therapy process as applied to the client/group, 4) own professional development in the fieldwork placement, 5) ethical principles applied to a situation

experienced in the fieldwork placement, and 6) topic of own choice related to learning in fieldwork.

PARTICIPANT SELECTION

All students registered for the fourth year of the undergraduate Bachelors of Science in Occupational Therapy degree programme at a university in the Western Cape during 2020 and 2021 were eligible to participate in the study. The students were informed about the study, and if they wished to participate in the study, they submitted their portfolios for data analysis. This resulted in a total of 165 reflective portfolios which were available for data analysis. These portfolios were reviewed. For the current study, 35 journals written by 32 students were extracted from these portfolios on the basis that they explored ethics in fieldwork practice. The participating students were all female, with ages ranging from 21 to 26 years, from different geographical locations in Southern Africa.

DATA COLLECTION

Data was collected in April, June, October, and November 2020, as well as November 2021 from the reflective portfolios of the 32 fourth-year occupational therapy students. For the ethics component of their journals, students were required to identify an ethical dilemma experienced during their fieldwork placement, reflect on ethical principles in practice, outline ethical approaches applied to address the dilemma, and explore how they would apply their learning in the future. Students used Sokol's decision-making model⁶ to conceptualise their ethics reasoning, and structured their narrative reflective journals using the four phases of Kolb's Cycle of Experiential Learning⁵ namely: Concrete Experience, Reflective Observation, Abstract Conceptualisation, and Active Experimentation. These narrative reflective journals of the students were used as the data sources for this study.

DATA ANALYSIS

Data analysis was done using Braun and Clarke's six steps of thematic analysis¹⁸. This process started with the review of the students' portfolios in their entirety to identify and extract relevant ethics narrative journals. These narrative journals were imported to an organisational framework. Secondly, initial codes were flagged from the vast amount of data highlighted in the previous step. Codes were clustered based on similar narratives and were organised using a data extraction sheet. Thirdly, codes were further grouped and organised to formulate sub-themes that aligned more closely with the research topic. Themes were then loosely constructed to represent the data housed in each category. Fourthly, themes were reviewed and evaluated based on the coded extracts and full data set and some of the themes were collapsed to streamline the data narrative. Fifthly, themes were named by providing a

description of the narrative represented by the grouping of the sub-themes and supportive data extracts. The final step involved the reporting of the findings, which occurred through analytic narrative supported by data extracts. The three authors closely monitored the process of data analysis ensuring neutrality in the representation of the data.

TRUSTWORTHINESS

Trustworthiness was adhered to by means of ³credibility, transferability, dependability, and confirmability¹⁹. Credibility was ensured through triangulation including multiple data sources, and a team of researchers to substantiate the study narrative²⁰. Transferability was ensured through documenting the study setting and participants²¹. Dependability and confirmability were achieved through the provision of an audit trail.

ETHICS

Ethics approval was obtained from a university in South Africa's ²³Humanities and Social Sciences Research Ethics Committee (ethics clearance number HS19/10/3). Prior to consent, the students were provided with a study information letter. In addition, two of the authors verbally explained the study to the students and answered their questions. Participants signed a consent form voluntarily and were aware that they could ³withdraw from the study at any stage without being penalised. Participants were assigned numbers to uphold confidentiality.

FINDINGS AND DISCUSSION

Data analysis yielded the following themes: (1) Ethics from the perspective of the student, (2) ethical tensions experienced during fieldwork, and (3) how students navigated ethical tensions. Themes comprised thirteen ²⁶sub-themes (Table I).

Table I: Themes and sub-themes

Themes	Sub-themes
Ethics from the perspective of the student	Defining ethics Students' beliefs, cultural views and biases Ethics education and training
Ethical tensions experienced during fieldwork	The sexually disinhibited patient Consent Patients setting unrealistic therapeutic goals Staff mishandling patients Restricted patient choice, autonomy, and dignity Providing patients with gifts and money

How students navigated ethical tensions	Following institutional procedure Knowledge through research Drawing from the “well” of experience Reflection
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Theme One: Ethics from the perspective of the student

In Theme one, the extent of participants’ knowledge and understanding of healthcare ethics and implementation in practice was explored. Findings reflect ethics from the perspective of the student by exploring how participants define ethics, observe their own beliefs, cultural views and biases as impacting upon ethics, and their exposure to and the effectiveness of ethics education and training.

Defining ethics

One of the participants defined ethics as a *“framework designed for healthcare professionals that guides them in what is wrong and right in the treatment of patients”* (P11, June 2020). Ethics was described by participant one as a paramount component of fieldwork practice as it aims to *“protect the rights of patients”* (P1, April 2020).

Ethics was perceived by students to be a mechanism that guided healthcare professionals, including occupational therapy students, during the resolution of ethical tensions experienced in practice by navigating the dichotomy of right and wrong. This aligns with Henry⁸ with reference to his emphasis on acting in a manner that serves the betterment of the patients served. Ethics was highlighted as a significant proponent of fieldwork where the goal of the healthcare professional is to uphold the rights of the patient²². All healthcare professionals registered with the HPCSA across 12 professional boards have a moral and ethical duty to their patients, colleagues, and society⁹. *These duties are generally in keeping with the principles of the South African Constitution (Act No. 108 of 1996)²³ and the obligations imposed on healthcare professionals by law⁹.*

Students' beliefs, cultural views and biases

Participants described ethics as a complex concept that can be influenced by one’s beliefs, cultural views, and biases. Two participants regarded ethics as being a clear cut matter according to descriptions of the guidelines mandated by the HPCSA⁹, OTASA¹⁰, and WFOT¹¹; however, other participants highlighted the role of one’s personal beliefs, culture, traditions, and other idiosyncratic factors as potentially influencing ethical decision making.

“Personal ethics may influence how one reacts to ethical situations”. (P4, April 2020)

Three participants reported that owing to personal biases, one healthcare professional may interpret an experience as conflicting whilst another may dismiss it as customary. An example of this could be seen entrenched in the persisting patriarchal views regarding gender norms and practices rooted in many African cultures. One participant described an experience wherein she felt conflicted in approaching and addressing a group of Pedi (a southern African ethnic group) males as the cultural foundation upon which she was raised was that females should avoid physical or social contact with males as an expression of respect.

¹ *"Growing up in the village, I was taught that a female should address a male with respect which in some cases can be shown by communicating without making eye contact or physical contact". (P6, April 2020)*

Furthering the narrative of a personal or subjective ethical code, it is suggested that it is possible that an individual may interpret and dismiss an event in practice as customary whilst another may interpret it as a conflict requiring action.

"Based on one's personal morals and opinion of right and wrong it is possible that one person may view a situation as ethically correct while another will see it as wrong". (P11, April 2020)

Mofokeng²⁴ in his exploration of the gender role expectations placed upon individuals based on their sex in Lamontville, KwaZulu-Natal Province in South Africa, reports that many of these traditional African views and practices persist today despite attempts to modernise views. It is further suggested that these views and practices may influence various sectors, including healthcare, which assume a more Westernised standing. Whilst moral values are subjective and sculpted on one's personal belief system, culture, spirituality, and other subjective factors, ethics seeks to regulate professional behaviour to safeguard all parties involved²⁵. It is valuable for students to make the distinction between professionalism and ethics as autonomous concepts whilst understanding their interrelatedness for healthcare professionals.

Nortjé, and de Jongh²⁶, p.43 in their exploration of ³ *professionalism – A case for medical education to honour the societal contract*, support an argument by Hillis and Grigg²⁷ in stating that ³ *"professionalism is essentially beyond ethics, values, and beliefs and includes behaviours and attributes which need the mastering of a complex body of information and skills, caring of others, guarantee of competency, truthfulness, unselfishness and the promotion of public good, autonomy, self-regulation and accountability to society"*. This implies that professionalism is rooted in the core values of an individual as owed to their morality, is continually in transformation throughout the individual's life, and regards ethics as informing

the quality of patient care. Furthermore, professionalism influences how healthcare professionals reduce or resolve ethical tensions in fieldwork²⁷.

Ethics education and training

Two participants reported on the ethics education modules they had received as part of the undergraduate programme, and stressed the importance of this teaching in scaffolding their ethical reasoning and performance in practice. The participants reported the effectiveness of the education received to the extent that they felt able to act in accordance with the HPCSA⁹ and OTASA's ethical guidelines¹⁰ subconsciously.

"During fieldwork, I did not consciously follow the HPCSA's ethical reasoning standards, but I relied on what I had learned in class about ethical reasoning. However, because of what we were taught in class, my actions were consistent with the HPCSA's requirements". (P14, June 2020)

Participant five further stressed the importance of ethics education and training in equipping students with essential knowledge and skills to navigate inevitable ethical tensions.

"It is important for students to have ethics education and training so that we can handle ethical dilemmas as professionals." (P5, April 2020)

Participants highlighted the various factors that had the potential to influence ethics in practice. For example, one participant reported a focus on academic prowess as the primary motivator of their decision-making.

"The stress of wanting to get everything right on an academic level sometimes overshadowed what was necessary and therapeutic for my patients." (P1, April 2020)

Ethics education has been highly regarded as a means to aid in the resolution of ethical tensions by equipping healthcare professional students with the necessary knowledge and skills to overcome clinical tensions confidently⁴. This transition from theory into practice, however, was not always seamless as highlighted by the previous participant, who reported her ongoing discourse in valuing academic prowess over what was necessary and therapeutic to patients.

Theme Two: Ethical tensions experienced during fieldwork

In theme two, findings illuminate the ethical tensions experienced during fieldwork including the sexually disinhibited patient; consent; patients having unrealistic treatment expectations, staff mishandling patients; restricted patient choice and autonomy; and providing patients with gifts or money.

The sexually disinhibited patient

This experience occurred when a participant observed: *"a sexually disinhibited patient attempting to have sexual relations with another patient"* (P4, April 2020). The participant intervened, stopped the incident, and reported it to a superior. During a multi-disciplinary ward round, the incident was discussed. Following the ward round, the participant was reprimanded by a senior sister who cautioned the participant that *"if something like this happens it needs to be kept a secret as it just made the nursing staff look bad"* (P4, April 2020). The nursing sister furthered her reprimand by stating: *"what happened is all your fault and you should know your place"* (P4, April 2020). The participant felt perplexed, belittled, and victimised as shown in the quote:

"I was victimised for doing what I have been taught to do. I felt that I was belittled and made to feel bad about doing what was right." (P4, April 2020)

Ethical distress as defined by Kinsella et al¹ and Nortje² occurs when a healthcare professional is cognisant of the correct course of ethical action, however, may feel constrained to act owing to institutional or societal norms. During the above-mentioned interaction with the sexually disinhibited patient, the participant reported assessing the encounter expeditiously and acting instinctively in the protection of the patient to uphold her right to safety and security^{27, 28}. When escalating the incident to the relevant staff members, the participant noted that not all parties were appreciative of her actions and further continuation in raising the incident. The contesting staff appeared to respond defensively and possibly emotionally by reprimanding the participant whilst heavily leaning into institutional hierarchy. This left the participant feeling confused and belittled whilst questioning if her action was warranted and within her scope as a student. Kreindler et al²⁸ and Hall²⁹ propose that healthcare teams are structured by professions and hierarchies that are often associated with varying degrees of organisational importance and subsequent power. This variation in status creates power differentials that further foster climates of professional disregard for the expertise and opinions of those lower on the organisational hierarchy. Bochatay et al³⁰ cited that rigid hierarchies have contributed to negative experiences of conflict in the workplace. The argument of power resonates with the barriers brought forth by Barnitt¹², Clever et al³, and Redman and Fry¹⁴ further validating their report that students and healthcare professionals alike fail to report unethical tensions in fieldwork in fear that it could implicate them or further entrench them in toxic workplace dynamics that often stem from team and organisational hierarchy. Hughes and Fallon³¹ suggest that the inclusion of occupational therapists during team discussions around patient care is instrumental in dissolving professional hierarchy and centralised team or organisation power as it includes all relevant professions in the conversation thus sharing team power.

Consent

In fieldwork, participants are required to obtain consent from patients for videoing treatment sessions for exam purposes. Most notably, *"One of the requirements of fieldwork is to make a video whereby you demonstrate your skills with patients"* (P5, April 2020). One participant assumed that their association with the university will guarantee patient consent at all times.

"I did not expect the nursing sister to deny consent to be filmed". (P9, April 2020)

Participants also reported that consent to participate was utilised by some patients as a leveraging opportunity wherein they could receive something beneficial such as advocacy for their discharge or gifts/incentives.

"The patient said that in exchange for consent to film her for my exam video I should get her discharged or communicate to the doctor on her behalf". (P5, April 2020)

Patients' having unrealistic treatment expectations

Two participants highlighted their experience of patients having unrealistic treatment goals by highlighting the co-existence of various confounding factors such as the patient's acceptance of their adjusted functional prognosis, their families' acceptance of their prognosis, and cultural or spiritual views. The patient presented with paraplegia resulting from a gunshot wound that completely severed the connection between his lumbar spinal vertebrae and brain. Based on prognostic and clinical evidence, the likelihood of regaining functioning to the extent of being able to walk was exceptionally low.

¹
"The patient believed that a miracle could happen and that he could potentially regain function in his lower limbs" (P11, June 2020)

The participant found it challenging to navigate this dynamic as she too was a spiritual individual and of a similar perspective however, had to set her own views aside and focus on her responsibility as a professional. Here we observe an ethical tension between the personal and professional beliefs of a healthcare worker and often having to suspend one's own beliefs, cultural views, and biases in response to patient care whilst being sensitive and respectful to patients' beliefs, cultural views, and biases. The process of separating the personal self from the professional self can often be challenging for a student to navigate as the student can often still be defining their professional identity or learning about who they are separate from their familial context.

¹ "I had to put my religious beliefs which I was raised with aside and only focus on the medical facts" (P11, June 2020)

Goal setting is an integral component of occupational therapy practice and the HPCSA upholds it as one of the outcome measures of the Code of Good Practice⁹. Goal setting is said to enhance patient confidence and motivation, engagement in, and satisfaction with rehabilitation, whilst improving task performance, team communication, and teamwork and, possibly improving recovery, goal achievement, and self-care³². Participant eleven agreed with the significance of goal setting, however, reported on its complexity when influenced by sensitive factors such as spirituality, culture, and traditional beliefs. These factors were reported to pose a challenge as the participant's patients often had unrealistic treatment expectations as fostered on the bedrock of their beliefs or denial of the extent of their prognosis. One participant reported that her patient was optimistic that divine intervention would see a complete recovery to his premorbid functioning. This was concerning as patients displayed disregard for their functional capacity or diagnostic restrictions and over-exerted themselves in hopes of speeding up their recovery. Participant eleven additionally reported that she shared similar beliefs to her patients, however, travelled the conflicting journey of putting their biases aside to act for the betterment of her patients.

Many studies have illustrated the power of spirituality as proponents for better health outcomes including greater longevity, coping skills, and health-related quality of life (even during terminal illness) and less anxiety, depression, and suicide³³. It is fundamental, however, for the clinician to direct these beliefs toward recovery in a manner that is appropriate and constructive^{32, 33}.

Staff mishandling patients

One participant highlighted an incident whereby she and her student peer observed an educator and an educator assistant mishandling children by "shouting at them, mocking them, saying nasty things to them, dragging them on the ground and hitting them" (P13, June 2020). The participant wanted to do something to aid the children, however, was afraid to intervene.

"It was heartbreaking to see this as I would never do that to a child, and as much as I wanted to speak up to them and address the issue, I did not do so" (P13, June 2020)

⁴ The United Nations Committee on the Rights of the Child³⁴ defines corporal punishment as any punishment in which physical force is used and intended to cause some degree of pain or discomfort, however light. Corporal punishment has been prohibited in educational settings, the justice system, and alternate care settings in South Africa^{23, 34}. Children are protected through the implementation of the United Nations Convention on the Rights of the Child (UNCRC)³⁴, the African Charter on the Rights and Welfare of the Child (ACRWC)³⁵ and the

South African Constitution²³ (sections 12 and 28). When the participant observed staff reprimanding children in their classroom through the use of corporal punishment in the form of shouting, mocking, demeaning, hitting, and dragging them around, the participant was concerned for the children's safety, however, felt helpless in doing anything. Nortjé, and de Jongh^{13:188} ameliorate this finding by stating that "students often feel that they do not have the authority to approach a senior staff member (or report them in severe cases) and cannot question the behaviour of qualified therapists, as it could possibly cause tension and even impact negatively on their results/reports". In addition to violating the children's constitutional right to safety and protection against degradation, neglect, abuse, and maltreatment²³, the ethical tension experienced violates the ethical principles of non-maleficence and justice as highlighted by the HPCSA⁹ and OTASA¹⁰.

Restricted patient choice, autonomy, and dignity

A participant noted that: "nurses gave patients maximum assistance in washing, dressing, and grooming. Patients don't decide on the clothes they want to wear even though they have options. Patient privacy is not considered. The patients are expected to take off their clothes in their rooms and then go to the bathroom naked" (P30, November 2020). When bringing the concern to a superior, the participant's views were acknowledged but dismissed due to pre-existing institutional dynamics.

"I asked the clinician about addressing these concerns and she informed me that it is a challenge because of the pre-existing team dynamics" (P30, November 2020)

This participant is reporting the gross removal of participant choice, autonomy, and dignity during basic activities of daily living wherein a state of dependence on care was fostered inadvertently by healthcare professionals. Preservation of human dignity is a core value of healthcare ethos⁴¹ and is fundamentally desired and central to the human experience irrespective of a patient's medical condition^{36, 37}. A patient's right to dignity and autonomy in care is strongly upheld in the Patient's Rights Charter of South Africa²². Studies by Oosterveld-Vlug et al³⁸, Hoy et al³⁹, and Moen and Naden⁴⁰ suggest that the more dependent a patient, the more vulnerable they are to a loss of dignity, whilst independence was a protector of patient dignity. When attempting to address her concerns with a senior clinician the participant reported the incident being reduced to unresponsiveness on account of complex team and institutional dynamics. Clever et al³ reported difficult personalities of the team and professionals of a lower hierarchical standing as a potential rationale as to why occupational therapists and students are unable to express their concerns in the resolution of ethical tensions. Redman and Fry¹⁴ further suggest that healthcare professionals may not always possess the necessary skills to resolve ethical conflict and that the persistence of the conflict

alludes to the professional not having the decision-making authority to resolve the conflict independently.

Providing patients with gifts and money

A central challenge experienced by four participants during fieldwork was highlighted when weighing whether it was right or wrong to provide patients with gifts, money, or other incentives. In most fieldwork contexts, participants worked with diverse patients, many of whom were faced with vulnerabilities such as financial insecurity. The four participants were aware of this vulnerability and all reflected on their degree of privilege as students. In all four cases, this resulted in feelings of guilt that derailed their ethical decision-making process.

"It made me uncomfortable saying no to patients when they ask for money, food, luxuries, or cigarettes" (P12, April 2020)

"I reflected how easily I spend R70 without thinking about it." (P10, April 2020)

One participant's conflict was further compounded when one of her long-stay patients was provided with gifts from her doctor. These gifts included shoes, clothing, toys and snack foods. The patient was medically stable however, was still admitted for social concerns. Considering this context, the participant considered these gifts as a kindness as the patient did not have clothing, shoes or toys to occupy her time in the institution. The participant however, still questioned if providing gifts were considered ethical and if not, what are the parameters that allow healthcare workers provide patients with gifts or basic necessities such as clothing, shoes, toys etc. as an act of care whilst still upholding professional ethics.

"Although I was happy that the patient was receiving these gifts from her doctor, I was unsure if it was ethical for the doctor to be doing this." (P15, June 2020)

Participant twelve reported that patients frequently asked the students for money to purchase luxuries or cigarettes. Participants reflected on how they had to negotiate these type of requests in order to provide all patients with the same incentive so as not to create a dynamic of preferential treatment. Wolinsky⁴¹, contributing writer for MedPage Today, suggested that the act of gift giving, especially when the gift fulfils a basic need, could create an expectation and that the failure to fulfil this need could influence the dynamic between the professional or healthcare team and patient. Nortjé and de Jongh¹³ suggest that in a caring profession – such as occupational therapy – students can often be confronted with diverse patient vulnerabilities that can pose a challenge when distinguishing between professional and unprofessional behaviours. The authors further suggested that students build deeper interpersonal

relationships with patients, thus raising a possible argument about the influence of emotion during the decision-making process in patient care¹³. In addition, the potential for professional boundaries to be blurred as a student is high as they are still learning to create, implement and maintain firm boundaries in patient care whilst remaining therapeutic¹³.

Theme Three: How students navigated ethical tensions

In theme three, the processes students used to navigate ethical tensions during fieldwork are described. This included following institutional procedure; knowledge through research; drawing from the “well” of experience; and reflection.

Following institutional procedure

One participant highlighted the importance of familiarising herself with institutional protocols. This included a summary of systematic steps derived from the HPCSA⁹ and OTASA¹⁰ ethical guidelines. The protocol aimed to provide healthcare professionals with guidance when resolving an ethical tension whilst protecting all parties involved.

“I familiarised myself with institutional protocol” (P4, April 2020)

Another participant stated that following familiarisation with institutional protocol, it is important to document an incident, provide a brief summary in the patient’s medical notes, and when concerned that the patient is injured, seek a medical examination.

“I had to fill out a packet of forms explaining exactly what had happened. I then made a note in the patient’s notes while the doctor checked him out” (P2, April 2020)

Knowledge through research

Participant 2 noted the significance of research in times of ethical tension or uncertainty and highlighted the use of ethical principles and the roles and responsibilities of a healthcare worker as drafted by the HPCSA⁹ as a useful resource. She further sought research on integrating these principles, roles, and responsibilities into practice⁹.

¹
“I had to research the ethical principles that healthcare providers are obligated to implement but also improve my understanding on how to effectively implement these principles within therapy” (P2, June 2020)

Participant 17 highlighted that her experience of an ethical tension during fieldwork reminded her to always seek guidance from evidence-based practice and theory. Her research included the roles and responsibilities of healthcare workers, the rights and responsibilities of patients, and treating patients that you have a non-professional relationship with.

"This experience reminded me to always look to theory" (P17, October 2020)

Drawing from the well of experience

In times of uncertainty, participants reported drawing guidance from others with knowledge and expertise. This included clinicians, fieldwork supervisors, lecturers from their university, peers and friends, family, and past students who are working as occupational therapists.

"It is beneficial to seek advice from block peers, clinicians, supervisors, lecturers, and friends that are qualified occupational therapists" (P12, April 2020)

Reflection

Participants highlighted the importance of being reflective in practice.

"I spent a lot of time reflecting on the ethical dilemma" (P20, October 2020)

"I often journaled about how I felt instead of speaking to others" (P3, April 2020)

Based on the findings of this study, when confronted with an ethical tension, participants tend to adopt either an active or passive role. In an active role, participants benefit from a robust support structure provided by clinicians, which includes open communication, compassionate teaching, and proactive engagement in learning. Conversely, participants in a passive role are more likely to encounter institutional or clinician-imposed constraints when attempting to address their ethical tensions. They often feel unsupported during on-site ethics learning. The findings further suggest that participants in an active role respond promptly to ethical tensions by reporting and consulting senior staff members for guidance and appropriate steps to take. In contrast, participants in a passive role tend to internalize the incident, assuming blame and responsibility while planning how to handle similar ethical tensions in the future when they possess more power or decision-making authority.

Despite the categorical differences in participants assuming a more passive or active role, the study's findings indicate more similarities than disparities. All participants recognise the importance of planning and taking action based on research and evidence-based practices. They also seek consultation from various sources, such as peers in the fieldwork, clinicians (if available), clinical education, university lecturers or tutors, and qualified occupational therapists, to enhance their knowledge in resolving ethical dilemmas.

All participants additionally made use of reflective practice through the use of journaling as guided by Kolb's Cycle of Experiential Learning⁵. Journaling was found to be a helpful tool in providing participants with an opportunity for introspection and systematic planning. An article published by the University of St. Augustine for Health Sciences exploring the benefits of

journaling reports that journaling is beneficial to students as it improves ¹² mental health, encourages self-confidence, boosts emotional intelligence, helps with achieving SMART goals, enhances critical thinking skills, heightens academic performance, and strengthens communication and writing skills⁴².

The classification between the role of active or passive participant indicates a potential need to foster soft skills such as teamwork, critical and creative thinking, decision-making, and communication that will encourage students to maintain a more assertive position in the health team⁴³. Additionally, this distinction alludes to a need to strengthen the collaboration between universities, the clinical educator, the site clinician, and the student to ensure that all students are provided with a comparable support structure and opportunity for learning. Each role-player's duties and responsibilities should be systematically outlined and should be transparent as this will allow an easier resolution of ethical tension or other challenges experienced during fieldwork.

Findings additionally indicate a need in ethics education to explore the concept of professionalism and its interrelatedness to ethics in fieldwork^{28, 29}. This is significant as the findings illustrate how interchangeably these two concepts are understood and subsequently implemented whilst navigating ethical tensions. Occupational therapy curricula could build on students' introspection of how their varying views and biases may influence their professional self and how in turn, this could influence their ethical decision-making¹⁷ on a conscious and subconscious level. This is important in the context of South Africa when considering the wide array of individuals, genders, cultures, traditions, and beliefs that co-exist. This is beneficial when considering that healthcare should be accessible and inclusive to all^{9, 10, 11, 23, 26}.

The study findings align with the argument made by Atwal and Caldwell⁴ in demonstrating that ethics education is paramount in mitigating the effects of ethical tensions experienced in fieldwork. Participants were able to identify an encounter as an ethical tension, understood the theory underpinning the experience, and were able to derive an appropriate plan of action regardless of whether or not it was implemented at the time of the encounter. To further strengthen the ethics education curriculum, consideration could be given to implementing simulated ethical tensions in the form of role-playing²⁵.

Future research could ¹⁶ explore occupational therapy students' understanding and experiences of ethics education or ethical tensions experienced or observed during fieldwork. Additionally, future research could explore site clinicians' experiences of supporting students when an ethical tension is encountered during fieldwork.

Limitations

One limitation of this study is that a small portion of ¹⁶ occupational therapy students at a university in South Africa elected to reflect on ethical tensions encountered during their fieldwork. Although occupational therapy students are provided with six profession-specific questions for their end-of-rotation portfolio, they are only required to explore three. This suggests that the remaining occupational therapy students may not have experienced an ethical tension, could have had difficulty recognising or identifying such tensions during their fieldwork, may have lacked interest in exploring the ethical question, or possibly felt uncomfortable delving into their ethical tensions.

CONCLUSION

This study provided an insight into occupational therapy students' reflective learning as acquired through exposure to ethical tensions during fieldwork. This was achieved through the expression of three themes: (1) Ethics from the perspective of the student, (2) ethical tensions experienced during fieldwork, and (3) how students navigated ethical tensions. Ethics was defined by students as a framework that guides healthcare workers including occupational therapy students, during the resolution of ethical tensions. Students experienced varied ethical tensions during fieldwork including the sexually disinhibited patient, consent, patients setting unrealistic therapeutic goals, staff mishandling patients, restricted patient choice, autonomy, and dignity, and providing patients with gifts and money. Students navigated these ethical tensions by following institutional procedures, acquiring knowledge through research, drawing from the "well" of experience, and reflective practice. The study further offered a narrative for encountering and resolving an ethical tension during fieldwork in an active or passive role. The main distinction between the two classifications persists when reviewing the support given to the participant who has been empowered to resolve the ethical tension whilst receiving consultation from their site clinician and the institution. Findings lastly inform healthcare educators and clinicians regarding students' perceptions about ethics education and the tensions experienced during fieldwork.

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