Research Article

Navigating Ethical Tensions When Working to Address Social Inequities

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Importance: When providing services, occupational therapists encounter social inequities that affect the health and well-being of their clients and create ethical tensions.

Objective: To develop an understanding of the ethical tensions encountered by occupational therapists working with clients experiencing social inequity and how such tensions are navigated.

Design: This qualitative study used an interpretive description methodology.

Setting: Community and tertiary health settings.

Participants: Fifteen occupational therapists who identified as working with clients experiencing social inequity.

Outcomes and Measures: Semistructured interviews were used to explore participants' practice experiences. Data were analyzed using thematic analysis.

Results: Two themes were identified in relation to participants' experiences of ethical tensions: (a) perpetuating inequities and (b) experiencing conflicting values. A further three themes were identified in relation to how participants identified and navigated these tensions: (a) taking action, (b) seeking support, and (c) ensuring integrity and accountability.

Conclusions and Relevance: Ethical tensions frequently emerged when systemic health contexts were not responsive to social inequities or created barriers to health care access. Occupational therapists felt a sense of responsibility to take action to address inequity, which led them to stretch boundaries and roles. Having informal and formal supports, and confidence in the scope of their practice, helped the occupational therapists to navigate ethical tensions with integrity and accountability. Increased avenues for support that incorporate reflexivity offer an opportunity for occupational therapists to engage in dialogue about social inequities and ethical practice.

What This Article Adds: This article explores the types of ethical tensions occupational therapists experience when addressing social inequities and provides insights into how such tensions are managed.

McArdle, H., Barlott, T., McBryde, C., Shevellar, L., & Branjerdporn, N. (2023). Navigating ethical tensions when working to address social inequities. *American Journal of Occupational Therapy, 77,* 7701205160. https://doi.org/10.5014/ajot.2023.050071

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There has been a gradual shift in occupational therapy practice to move beyond the individual, consider the societal context of occupation, and respond to *social inequities* (Gerlach et al., 2018): avoidable disparities that unfairly disadvantage certain groups of people by precluding their participation in or access to resources in society (Arcaya et al., 2015; Braveman et al., 2011). Examples of social issues that may result in social inequities include marginalization, discrimination (e.g., through racism, sexism), poverty, unemployment, incarceration, and human displacement (i.e., in the case of refugees and asylum seekers; Malfitano & Lopes, 2018).

Although occupational therapy is considered a holistic profession that acknowledges the transaction between people and social context (see Law et al., 1996), practice varies considerably in terms of how practitioners attend to social contexts and social determinants of health (Hammell, 2020). Occupational therapy models of practice tend to "focus primarily on the individual or micro, without accounting for impacts of broader socio-historical, political, and economic contextual factors on occupational engagement" (Irvine-Brown et al., 2021, p. 313). Gerlach et al. (2018) highlighted how individualism is a pervasive assumption in the global Northern and Western

societies (e.g., Canada, the United States, and Australia) and can limit the degree to which occupational therapists recognize and address social issues in their practice. In response to the underlying cultural influence of individualism in Northern and Western practice, there has been a social turn in occupational therapy (Gerlach et al., 2018), with a renewed emphasis on addressing global population inequities stemming from social structures. For example, some areas of practice have been guided by frameworks such as the participatory occupational justice framework (Whiteford et al., 2017), which foregrounds the social context. Other examples include social occupational therapy, which emphasizes addressing the social conditions that shape everyday lives with a view to enacting social change (Malfitano & Lopes, 2018), and the International Social Transformation through Occupation Network (Rudman et al., 2018), which seeks to change social processes and structures through an occupational lens (see Farias & Rudman, 2019a).

Working to address social inequities through occupational therapy practice can pose ethical challenges. Codes of conduct identified by professional bodies (e.g., those provided by the American Occupational Therapy Association or Occupational Therapy Australia [OTA]) provide a starting point and guide for professional behavior; however, ethical practice can become less clear in the face of complex social inequities (Shevellar & Barringham, 2016). An *ethical tension* is a "decision-making situation that necessitates choosing between two or more moral imperatives, neither of which is unambiguously satisfactory or preferable, and where obeying potentially results in transgressing another" (Kaye et al., 2019, p. 1). For example, encountering resource limitations can pose an ethical tension, in particular when limited staff, funding, or equipment make it difficult to effectively support clients who experience disadvantage (Bushby et al., 2015; Durocher et al., 2016). A tension may occur when a practitioner is aware that a client would benefit from services but they cannot (or are not permitted to) provide these services because of structural limitations. Restrictive practice conditions, such as working in a fee-for-service model (where only those with financial resources can access services), or when systemic factors pose barriers to access for clients (e.g., ineligibility for access because of one's visa status), have also been identified as sources of ethical tension (Bushby et al., 2015; Durocher et al., 2016).

Consistent with calls across the profession to explore ethical issues specific to social inequities (Bushby et al., 2015), in this study we aimed to explore the ethical tensions experienced by occupational therapists when encountering social inequities in the course of their work. Moreover, we sought to understand how practitioners navigate these tensions in their work with people who experience social disadvantage. Our project was guided by the following two research questions:

1. What are the ethical tensions occupational therapists experience when they encounter social inequities in their practice?
2. How do occupational therapists navigate these ethical tensions?

Method

Research Design

In this qualitative study, we used an interpretive description (ID) research methodology (Thorne, 2016). ID embraces the disciplinary lens that researchers bring to the research process with an emphasis on interpretations of data that have practice outcomes (Thorne, 2016), in this case, for the field of occupational therapy. Rather than focusing on theoretical understandings or general qualitative descriptions, ID explores clinical and context-specific applications (Thorne, 2016). Ethical approval from The University of Queensland Institutional Human Research Ethics Committee (Approval No. 2020000163) was obtained before the study commenced.

Participant Selection and Recruitment

Participants were recruited through purposeful sampling via the OTA's (2020) Mental Health Special Interest Group and convenience sampling through the research team's professional networks on social media. The inclusion criteria for this study were that participants (a) were an occupational therapist with current Australian Health Practitioner Regulation Agency registration, (b) self-identified as having encountered social inequities through their practice (the definition was provided to participants during recruitment; see the Appendix), and (c) were not working in a primarily academic role. Participants were not remunerated for their participation.

Data Collection

Semistructured interviews were conducted from May to September 2020. All interviews were conducted and recorded via videoconferencing and ranged from 29:35 to 53:45 min (*Mdn* = 45:33) in duration. Consent was obtained at the beginning of each interview. All interviews were transcribed and deidentified before analysis. All participants were provided with an opportunity to review their transcript and nominate a pseudonym. Before their interview, participants were provided a copy of the interview schedule (see the Appendix). Although this study focused on ethical tensions, the interview also explored occupational therapists' understanding of social inequities and how they address them in their practice. These findings will be reported in a separate article. Consistent with an ID approach, interview questions focused on participants' real-world experiences in their practice contexts (Thorne, 2016) and were broad in nature, to evoke explorations of their understanding of social inequities

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and ethical practice. For example, interview questions included "Can you tell me a story of a time when you experienced an ethical tension in your work which attends to social inequities?" and "Tell me about how you navigated this tension."

Data Analysis

Data analysis was conducted using thematic analysis (Braun & Clarke, 2006). Analysis began during the transcription phase, in which Hannah McArdle undertook multiple readings of the interview data. Members of the research team met at each stage of thematic analysis to compare and contrast interpretations of the data. All members of the research team agreed on preliminary codes before determining patterns and initial themes. Emergent themes were discussed in multiple meetings by the research team, and a final set of overarching themes was determined.

Trustworthiness of the analysis was achieved using analyst triangulation, with all members of the research team systematically examining and reaching a consensus on the findings. The research team was representative of a variety of disciplinary backgrounds (social science, behavioral science, and occupational therapy) and professional expertise in a range of sociopolitical contexts (e.g., academia, hospital, government departments, community, and volunteer organizational contexts). The diversity of personal experience, and of professional orientation, enabled a broad analysis of the data and encouraged diversity of interpretation and theoretical perspective. The research team kept a detailed audit trail throughout research activities and engaged in reflexive discussions to consider how their own assumptions, beliefs, and positions might influence the research process.

Results

Study participants were 15 female occupational therapists working in varied practice settings, including mental health (inpatient, forensic, and community based), refugee settlement, pediatric, home-based therapy, age care, Aboriginal and Torres Strait Islander health, and assistive technology. Participants' years of practice experience ranged from 3 to 40 ($Mdn = 15$).

Our findings are organized according to the two guiding research questions, each with interrelated themes. The two themes of occupational therapists' experiences of ethical tensions included (1) perpetuating inequities and (2) experiencing conflicting values. The three themes addressing how practitioners identified and navigated these ethical tensions included (1) taking action, (2) seeking support, and (3) ensuring integrity and accountability.

Ethical Tensions

Perpetuating Inequities

A common type of ethical tension described by participants related to feeling obligated to address inequities generated by the systems in which they worked. Participants reported a sense of responsibility beyond their typical role, such that if they did not act to address inequity, they feared they would perpetuate it. Taylor detailed the conflicts associated with service delivery under a punitive model based on her experiences of working in an institutional prison environment:

> A prison isn't designed to be rehabilitative . . . it's designed to be corrective or punitive . . . knowing you're working in a system that's perpetuating these disadvantages is really difficult, you . . . often feel powerless.

Despite Taylor's desire to promote recovery and improve the everyday lives of their clients, she described being a "part of the system" that holds people back.

Participants discussed the dilemma of whether they should follow organizational rules and deny services (which disadvantages their clients) or provide services and disobey organizational rules. When reflecting on her work in a pediatric practice setting, Kristy provided an example of a client who could not access public health services because of their refugee status:

> Families with a refugee background . . . certainly need prioritization. . . . We know what service they need, but they can't access [them]. . . . There becomes an ethical dilemma of, are we going to provide service or not? And if we can't refer them correctly anywhere else, what do we do? So, the ethical dilemma becomes, do I continue [to provide services]?

Kirsty went on to discuss the conflicts experienced when working in a service with policies and processes that are not responsive to the inequities experienced by the client group: "[I was] sitting there at my desk and [clients were failing to attend and] activity-based funding is measured by face-to-face appointments. [I remember thinking] . . . something needs to change."

Experiencing Conflicting Values

The second set of ethical tensions participants identified related to conflicting values among their personal life, professional life, and the values of other team members. These value conflicts often occurred in the context of feeling a personal duty to address the inequities experienced by clients. For example, Miranda reflected on her experiences of time-limited, intercultural service provision in a region that typically lacks access to occupational therapy services. Miranda described how she felt "impelled" to provide impromptu services to assist a family that was not funded by the organization she worked for, knowing they would have no access to other services for at least 12 mo: "I had the skills, and I could help . . . it was outside of the scope, it was outside of the hours." Miranda elaborated on how her duty to act was based on both personal values—"I am someone that probably has pushed the boundaries over time . . . it's just the

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[need] to do things for people"—and professional values as an occupational therapist: "We want them to have the best opportunity to participate and be functional within their lives." Miranda further reflected on these practice dilemmas, acknowledging that because of the context in which she was working (i.e., with time restraints causing reduced capacity for comprehensive assessment), the quality of her intervention would likely be impacted: "Some of my recommendations were a bit more on the fly; [I didn't know] the total situation."

Bianca detailed instances in her mental health work setting when the treating team pushed for referrals to sheltered employment or discouraged clients from pursuing higher education, despite being contrary to the client's goals: "It's definitely tense when you've got members of the treating team who are really pressuring you to make this referral or go down this certain path." In these situations, participants who promoted client choice and autonomy risked conflict with others on the treating team.

Navigating Ethical Tensions

Taking Action

Participants detailed how ethical tensions often reflected the systemic barriers in their workplaces. A common response to address these barriers was to take action. There were three ways in which this occurred: (1) covert practice, (2) working outside of organizational role expectations, and (3) engaging in advocacy.

Covert practice included exaggerating during report writing and keeping actions secret with the aim of maximizing funding or support. This was described by Nicole when writing reports to funding bodies with the aim of promoting outcomes for her clients: "So, I might be describing a client's worst-case scenario and a worst-day experience rather than an average-day experience [in order to maximize their funding]."

When responding to differing perspectives and values on the treating team, Mona disclosed the need to practice covertly to respect the wishes of a terminally ill client who wished to return home. Fearing the broader treating team might disapprove, Mona shared discharge accommodation details only with those necessary: "We certainly let the treating team and medical director know, but I didn't advertise it too much because I think it would have got a lot of disapproval."

Similarly, Bianca described how, when responding to inequity and differing values in the treating team (e.g., the treating team discouraging clients pursuing open employment or higher education), she would "bend the rules a bit . . . to promote equality." After unsuccessfully attempting to advocate for the client and challenge the stigmatizing beliefs of members on the treating team, Bianca disclosed acting in solitude:

> It should have been a team approach . . . but [I just had to] go ahead and do it . . . afterward [I was able to discuss with team], and say "Look, see . . . this was the right thing."

Another way participants navigated ethical tensions was by covertly working outside of organizational role expectations and engaging in advocacy for clients who experience inequities. Sue described working with a palliative care client who was having difficulty accessing financial and social services in the community:

> I was going outside of the scope of my practice . . . I did a [home] visit . . . I didn't need to actually do anything to do with [occupational therapy] . . . [and] I was [contacting] other professionals more than I would with other clients.

To address access barriers, Miranda occasionally provided interventions free of cost: "They can't afford to actually access the clinic . . . so, they will ask [our] advice and you give it of course." Miranda felt a sense of duty and responsibility to support clients experiencing inequities, at times stretching organizational policies, saying "We can't not [provide a necessary service]."

Practitioners often engaged in advocacy on behalf of clients, seeking to overcome barriers to access. This included appealing to people in power, as described by Nicole: "It's a lot of advocacy, so [we try] to find the person who is the decision-maker higher up in an agency or an organization and appealing to them." Advocacy was a way for participants to manage and act on feelings of powerlessness in the systems they worked in. Taylor reported:

> You often feel powerless because you don't make the decisions . . . but there are some small things you can do to advocate for people, and you have to hold onto those things because there's a lot you can't control.

Seeking Support

A common strategy identified by participants when navigating ethical tensions included seeking support from coworkers and supervisors. Nicole commented, "[I've] learned the importance of teamwork . . . your colleagues . . . help you debrief the tensions and . . . also hand over those tensions, 'cause you can't carry them all . . . it's burdensome." Megan addressed a value conflict with a client's family (specifically, the family's choice not to proceed with treatment) by engaging in supervision with her team leader:

> I talked to the manager and let her know of the situation and my unease with it . . . I can speak up, I can report; if I don't have a resolution with a direct supervisor, I am aware of different avenues that I can take now.

Fatima stressed the importance of "working around people that are lateral thinkers and champions of the profession . . . [so you are] well supported and able to navigate the ethical issues that surround some of the work." Participants reported the value of working

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collaboratively with colleagues and supporting each other through ethical issues that are interrelated with broader social issues.

Ensuring Integrity and Accountability

Participants highlighted the importance of integrity, transparency, and accountability when responding to ethical tensions. Measures used to achieve this included outlining clinical reasoning in documentation, transparently acknowledging systemic barriers, reflecting on and upholding personal and professional values, and having confidence in the occupational therapy role. Participants highlighted the importance of completing documentation that articulates clinical reasoning and decision making. When responding to the denial of access to emergency mental health services based on a client's refugee status, Ayah emphasized the importance of documentation: "We had to assess the risk and document, document, document and . . . then address [the issue] with strong advocacy afterwards [to pursue policy change]."

Having open and transparent conversations with clients or colleagues that acknowledge systemic barriers was a common response from participants. In Megan's role liaising with refugee services, she recalled a client who was denied equipment because of their visa status. Megan believed the equipment was necessary; however, she was unable to proceed after management advised her she was working outside of organizational role expectations. To uphold her personal and professional values, Megan transparently reported the issue to the refugee service care coordinator:

> I was unable to help him . . . I had to communicate back . . . "This is the situation . . . I would recommend that if you wish to try and get a wheelchair for this man that you go through these other avenues. But I am unable to, for these reasons."

Participants emphasized the value of workplace culture for fostering transparent conversations with clients about the limitations of systems. Rebecca experienced an ethical tension when completing mandatory child safety notifications that she believed would further perpetuate the inequities experienced by her clients:

> My team leader is a big believer in having [transparent] discussions . . . [they would say] "[Our clients] are up against a system, if we keep throwing systems at them nothing is going to stick . . . if you can get buy-in and say to them "This is why I'm doing this" [and you let them know] the system doesn't have to be enemy; we can all work together."

Rebecca further commented on how these conversations increased her satisfaction as a clinician and led to beneficial therapeutic outcomes.

Numerous participants highlighted the importance of reflective practice, in relation to their personal values, the systems in which they work, and the social inequities experienced by their clients. They described how an awareness of their values helped improve their confidence and clinical reasoning, as Kristy commented:

> I think your worldview and your belief system can really come into your clinical reasoning about what you do in these situations . . . so, understanding that in your beliefs, if you value things like equality and equity, you think like that when you work.

Reflecting on their assumptions and considering their increased confidence in their occupational therapy identity over time helped participants navigate ethical tensions by addressing social inequity. Janelle reflected on her transition from new graduate to an experienced clinician:

> [As a new graduate] I tended to follow the rules rather than questioning the rules . . . [I have] become a lot more comfortable in . . . my role as an occupational therapist [and I'm able to] look at things with a critical eye and not just accept things as they are.

Sally also reflected on the development of her personal and professional identity:

> At the start . . . I would definitely err on the side of caution . . . [I didn't] want to unsettle the water . . . [now] if I do identify social inequity, . . . I have an obligation to advocate.

In contrast, Miranda detailed how experience taught her to be more circumspect, ensuring she is more reflective, to balance her own personal values of addressing injustice while also upholding the autonomy and wishes of her clients: "Being a younger therapist, I was a bit more [overly enthusiastic], if I saw something that I could fix, I would do it in any way I could . . . [But now, with more experience] I am more reflective."

Discussion

In light of recent literature highlighting the importance of acknowledging and acting on social inequities in occupational therapy practice (see Hammell, 2021), our study sheds light on the ethical tensions that practitioners navigate when working with clients experiencing inequity and the ways occupational therapists responded to these tensions. A prevalent source of ethical tension described by occupational therapists in our study was a sense of duty to overcome the failures of the health systems in which they worked. The notion of seeing themselves as complicit in perpetuating inequity by being "part of the system" offers empirical support for concerns raised by other occupational therapy scholars (see Bailliard et al., 2020; Farias & Rudman, 2019b). Participants' sense of complicity with inequities was interconnected with their obligation to act, and our findings highlight some of the actions that emerged from ethical tensions, including covert practice and seeking support.

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When occupational therapists lacked a supportive working environment, they engaged in covert practice and advocacy in response to feeling an ethical obligation to address perceived inequities. This is consistent with the concept of "underground" occupational therapy (Irvine-Brown et al., 2021; Stouffer, 2016) and the "exercise of discretion" (Aldrich & Rudman, 2020, p. 139), in which occupational therapists transcend (or transgress) institutional expectations or rules to be responsive to specific clients' needs and contexts. Our findings are unique in identifying that these strategies are used by occupational therapists deliberately in the context of ethical decision making. Similarly, our findings indicate that occupational therapists may stretch boundaries and practice outside of organizational role expectations to fulfill their perceived duty to address social inequities. The consequence of acting covertly and stretching professional boundaries is that these actions may threaten job security and reputation (Shevellar & Barringham, 2016; Topor et al., 2006). In their work on the compatibility of community development and occupational therapy, Irvine-Brown et al. (2021) suggested explicitly bringing underground work above ground through professional dialogue and by developing frameworks that prepare occupational therapists "to work across micro-, meso-, and macro-levels of society" (p. 313). This suggests that bringing to light underground practices, through the development of explicit frameworks and guides, may support occupational therapists in navigating ethical tensions as they address social inequities through their work.

Our findings also highlight the significance of formal and informal support to navigate ethical tensions, by sharing the burdens with colleagues and actively seeking supervision (VanderKaay et al., 2019). Without support, practitioners may feel powerless and experience moral distress, increasing the likelihood of staff turnover and burnout (Rivard & Brown, 2019). These notions of powerlessness may be particularly prevalent as practitioners work in systems that are increasingly under fiscal restraint, resulting in barriers to service access, a common source of ethical tension in occupational therapy (Bushby et al., 2015; Durocher et al., 2016) and evidenced in our study. Participants drew our attention to the developmental aspects of ethical decision making and how new graduate occupational therapists may feel unequipped to act on social inequities (and respond to corresponding tensions). Hazelwood et al. (2019) emphasized the importance of creating systems of support for new graduates so that they can feel more prepared to navigate ethical issues, and we add that these systems of support should offer space for dialogue about social inequities encountered in practice. Critical reflexivity may be a useful tool for integration into support systems and mentorship as practitioners consider systemic issues, their personal values, and methods of action.

Critical reflexivity offers a process for occupational therapists to navigate ethical tensions and address social issues (Farias et al., 2016; Phelan, 2011). Reflexivity includes thinking critically about the systems of which we are a part and how our own personal beliefs and assumptions shape our practices (Farias et al., 2016). Our findings suggest that the practice of critical reflexivity enables practitioners to be more aware of underlying social inequities, to be more likely to experience ethical tensions related to a reluctance to perpetuate inequity, and to feel an associated duty to respond. Taking a reflexive posture can bring underlying assumptions to the surface (McCorquodale & Kinsella, 2015; Phelan, 2011)—and although this may produce ethical tensions it also evokes a sense of ethical responsibility and affective impulse to act in alignment with one's personal and professional values. Bringing reflexivity into support systems and mentorship can offer an opportunity to engage in collaborative dialogue about social inequities, ethical tensions, and modes of action while also promoting professional accountability (see Arczynski & Morrow, 2017; Fickling et al., 2019).

The findings from this study contribute novel understandings of the ethical tensions experienced by occupational therapists attending to social inequities. Although the diverse cross-section of participants was useful for understanding the broad experiences of occupational therapists in Australia, a country with a universal health insurance system, it could also be considered a limitation given that context-specific challenges were not explored in depth. Future research that explores the nature of ethical tensions and their navigation in other health care systems may provide a more comprehensive understanding of context- and system-specific challenges. Exploring how critically reflexive informal and formal support networks help practitioners practice ethically in their work would also be valuable.

Implications for Occupational Therapy Practice

The promotion of supportive workplaces, including critically reflexive formal and informal mentorship, is vital for supporting occupational therapists as they traverse the ethical landscape of addressing social inequities through occupational therapy practice.

Conclusion

Systemic barriers that perpetuate inequities for clients represent a common source of ethical tension among occupational therapists who encounter social inequities through their practice. Occupational therapists navigate these tensions by taking action and seeking support to ensure their professional integrity and accountability. Creating systems of formal and informal support that incorporate critical reflexivity may enable occupational therapists to effectively navigate

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the complex social dynamics of their clients and the associated ethical tensions.

Acknowledgments

We express our gratitude to those who participated in our study and thank them for generously offering their time and expertise and for their commitment to practices that act on social inequities.

References

Aldrich, R. M., & Rudman, D. L. (2020). Occupational therapists as street-level bureaucrats: Leveraging the political nature of everyday practice. *Canadian Journal of Occupational Therapy, 87,* 137–143. https://doi.org/10.1177/0008417419892712

Arcaya, M. C., Arcaya, A. L., & Subramanian, S. V. (2015). Inequalities in health: Definitions, concepts, and theories. *Global Health Action, 8,* 27106. https://doi.org/10.3402/gha.v8.27106

Arczynski, A. V., & Morrow, S. L. (2017). The complexities of power in feminist multicultural psychotherapy supervision. *Journal of Counseling Psychology, 64,* 192–205. https://doi.org/10.1037/cou0000179

Bailliard, A. L., Dallman, A. R., Carroll, A., Lee, B. D., & Szendrey, S. (2020). Doing occupational justice: A central dimension of everyday occupational therapy practice. *Canadian Journal of Occupational Therapy, 87,* 144–152. https://doi.org/10.1177/0008417419898930

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77–101. https://doi.org/10.1191/1478088706qp063oa

Braveman, P. A., Kumanyika, S., Fielding, J., Laveist, T., Borrell, L. N., Manderscheid, R., & Troutman, A. (2011). Health disparities and health equity: The issue is justice. *American Journal of Public Health, 101*(Suppl. 1), S149–S155. https://doi.org/10.2105/AJPH.2010.300062

Bushby, K., Chan, J., Druif, S., Ho, K., & Kinsella, E. A. (2015). Ethical tensions in occupational therapy practice: A scoping review. *British Journal of Occupational Therapy, 78,* 212–221. https://doi.org/10.1177/0308022614564770

Durocher, E., Kinsella, E. A., McCorquodale, L., & Phelan, S. (2016). Ethical tensions related to systemic constraints: Occupational alienation in occupational therapy practice. *OTJR: Occupation, Participation and Health, 36,* 216–226. https://doi.org/10.1177/1539449216665117

Farias, L., Laliberte Rudman, D., & Magalhães, L. (2016). Illustrating the importance of critical epistemology to realize the promise of occupational justice. *OTJR: Occupation, Participation and Health, 36,* 234–243. https://doi.org/10.1177/1539449216665561

Farias, L., & Rudman, D. L. (2019a). Challenges in enacting occupation-based social transformative practices: A critical dialogical study. *Canadian Journal of Occupational Therapy, 86,* 243–252. https://doi.org/10.1177/0008417419828798

Farias, L., & Rudman, D. L. (2019b). Practice analysis: Critical reflexivity on discourses constraining socially transformative occupational therapy practices. *British Journal of Occupational Therapy, 82,* 693–697. https://doi.org/10.1177/0308022619862111

Fickling, M. J., Tangen, J. L., Graden, M. W., & Grays, D. (2019). Multicultural and social justice competence in clinical supervision. *Counselor Education and Supervision, 58,* 309–316. https://doi.org/10.1002/ceas.12159

Gerlach, A. J., Teachman, G., Laliberte-Rudman, D., Aldrich, R. M., & Huot, S. (2018). Expanding beyond individualism: Engaging critical perspectives on occupation. *Scandinavian Journal of Occupational Therapy, 25,* 35–43. https://doi.org/10.1080/11038128.2017.1327616

Hammell, K. W. (2020). Action on the social determinants of health: Advancing occupational equity and occupational rights. *Cadernos Brasileiros de Terapia Ocupacional, 28,* 378–400. https://doi.org/10.4322/2526-8910.ctoARF2052

Hammell, K. W. (2021). Social and structural determinants of health: Exploring occupational therapy's structural (in)competence. *Canadian Journal of Occupational Therapy, 88,* 365–374. https://doi.org/10.1177/00084174211046797

Hazelwood, T., Baker, A., Murray, C. M., & Stanley, M. (2019). New graduate occupational therapists' narratives of ethical tensions encountered in practice. *Australian Occupational Therapy Journal, 66,* 283–291. https://doi.org/10.1111/1440-1630.12549

Irvine-Brown, L., Ware, V. A., Malfitano, A. P. S., & Di Tommaso, A. (2021). Re-engaging in our role with communities: The coupling of occupational therapy and community development. *Australian Occupational Therapy Journal, 68,* 308–316. https://doi.org/10.1111/1440-1630.12728

Kaye, D. K., Chongwe, G., & Sewankambo, N. K. (2019). Ethical tensions in the informed consent process for randomized clinical trials in emergency obstetric and newborn care in low and middle-income countries. *BMC Medical Ethics, 20,* 1–8. https://doi.org/10.1186/s12910-019-0363-0

Law, M., Cooper, B., Strong, S., Stewart, D., Rigby, P., & Letts, L. (1996). The Person-Environment-Occupation Model: A transactive approach to occupational performance. *Canadian Journal of Occupational Therapy, 63,* 9–23. https://doi.org/10.1177/000841749606300103

Malfitano, A. P. S., & Lopes, R. E. (2018). Social occupational therapy: Committing to social change. *New Zealand Journal of Occupational Therapy, 65,* 20–26.

McCorquodale, L., & Kinsella, E. A. (2015). Critical reflexivity in client-centred therapeutic relationships. *Scandinavian Journal of Occupational Therapy, 22,* 311–317. https://doi.org/10.3109/11038128.2015.1018319

Occupational Therapy Australia. (2020). *Special interest groups.* https://otaus.com.au/tags/special-interest-groups

Phelan, S. K. (2011). Constructions of disability: A call for critical reflexivity in occupational therapy. *Canadian Journal of Occupational Therapy, 78,* 164–172. https://doi.org/10.2182/cjot.2011.78.3.4

Rivard, A. M., & Brown, C. A. (2019). Moral distress and resilience in the occupational therapy workplace. *Safety, 5,* 10. https://doi.org/10.3390/safety5010010

Rudman, D. L., Pollard, N., Craig, C., Kantartzis, S., Piškur, B., Algado Simó, S., . . . Schiller, S. (2018). Contributing to social transformation through occupation: Experiences from a think tank. *Journal of Occupational Science, 26,* 316–322. https://doi.org/10.1080/14427591.2018.1538898

Shevellar, L., & Barringham, N. (2016). Working in complexity: Ethics and boundaries in community work and mental health. *Australian Social Work, 69,* 181–193. https://doi.org/10.1080/0312407X.2015.1071861

Stouffer, S. S. (2016). Living and working as an underground occupational therapist/scientist in Los Angeles. In D. Sakellariou & N. Pollard (Eds.), *Occupational therapies without borders: Integrating justice with practice* (2nd ed., pp. 220–227). Elsevier Science.

Thorne, S. (2016). *Interpretive description: Qualitative research for applied practice* (2nd ed.). Routledge.

Topor, A., Borg, M., Mezzina, R., Sells, D., Marin, I., & Davidson, L. (2006). Others: The role of family, friends, and professionals in the recovery process. *American Journal of Psychiatric Rehabilitation, 9,* 17–37. https://doi.org/10.1080/15487760500339410

VanderKaay, S., Jung, B., Letts, L., & Moll, S. E. (2019). Continuing competency in ethical decision making: An interpretive description of occupational therapists' perspectives. *Canadian Journal of Occupational Therapy, 86,* 209–219. https://doi.org/10.1177/0008417419833842

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Whiteford, G., Townsend, E., Bryanton, O., Wicks, A., & Pereira, R. (2017). The participatory occupational justice framework: Salience across contexts. In D. Sakellariou & N. Pollard (Eds.), *Occupational therapies without borders: Integrating justice with practice* (2nd ed., pp. 163–174). Elsevier.

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Appendix. Semistructured Interview Guide

Definition
Social inequities are avoidable disparities between groups of people, unfairly disadvantaging certain groups of people from participation or access to resources in society (Arcaya et al., 2015; Braveman et al., 2011). To illustrate, someone who is homeless may have a more difficult time finding work than someone who has a fixed residential address (and be more likely to remain in poverty), in part because of not having access to professional clothes, unreliable access to a computer/the internet for job searching and application, lack of home address on a résumé, inability to get a full night's sleep before an interview, and so on. The social issue of homelessness and resulting social disadvantage could be an example of a social inequity. Other examples of social issues that may result in social inequities include homelessness, poverty, unemployment, racism, sexism, marginalization, incarceration, and human displacement (i.e., refugees, asylum seekers).
Questions
1. Tell me about your practice background.
2. Can you tell me about how your work responds to social inequities?[a]
3. Can you share an example of how you have identified, and responded to, social inequities in your work?[a]
4. What does it mean to be ethical in practice or practice ethically?
5. Tell me a story of a time when you experienced an ethical tension in your work which attends to social inequities.
6. Tell me about how you navigated this ethical tension.
7. What advice would you give your early self? Looking back, what would now tell yourself?

[a]This research question does not relate to this article and its research questions. It will be used in a future research article.

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