JOB SATISFACTION:
VIEWS OF PHYSICAL ACUTE CARE
OCCUPATIONAL THERAPISTS

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ABSTRACT

Job satisfaction and dissatisfaction has been a subject of debate in determining the reasons for attrition within the general occupational therapy profession. However, minimum research on the subject has been done and published in New Zealand in the area of physical acute care occupational therapy practice. The purpose of this study was to explore physical acute care occupational therapist’s perceptions on factors influencing their job satisfaction and dissatisfaction. It also sought to explore their perceptions of the strategies that could be used to address their job dissatisfaction. The questions that guided the study were:

- What meaning do the research participants attribute to job satisfaction or dissatisfaction?
- What key issues do the participants attribute to their job satisfaction or dissatisfaction?
- What strategies to rectify job dissatisfaction do the participants suggest?

The study utilized an exploratory interpretive inquiry, where focus group interviews with twenty therapists were used to collect data. The interpretational analysis was used to categorize and draw themes from the data. The themes identified teamwork and nature of occupational therapy practice such as fast pace of work, high caseloads and working in isolation as key issues impacting on therapists’ job satisfaction and dissatisfaction. The main findings emphasize the importance of understanding the political environment in which the physical acute care occupational therapists practiced as well as the maintenance of occupational therapy teams as a form of support for the participants.

Key skills such as teamwork, self-management, quick clinical decision-making, wide knowledge base about various medical conditions and ability to prioritize work were recommended as vital to ensure effective discharge of physical acute care occupational therapy services. In view of these practice demands, the study made a further recommendation to define the work setting as a specialty area because of the fast nature of the work and practice demands for the above skills.
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CHAPTER ONE

INTRODUCTION

The New Zealand health sector has undergone several changes and reforms in the past two decades that have impacted on acute care services. The changes have occurred at two levels. Firstly changes to the structure of the health sector politically imposed by reform minded governments and secondly changes that happened as a result of the changes occurring in the rest of the developed world. These changes according to Tuohy (1999) can be understood by considering the structural and constitutional dimensions related to the balance of influence across the state, the medical profession and the private finance sector. Policy-shifts in the health sector in New Zealand occur when there is change in governments (Gauld, 2001). The significant changes noted in the health sector in New Zealand according to Gauld (2001) are:

- Health reforms unveiled in 1991 by the National government commencing operation in 1993
- Health re-reforms prompted by problems with the health sector and the founding of the National-led coalition government in 1996
- The emergency of the District Health Boards system introduced by the Labour government in 1999 to present day.

During the above changes, micro changes in management systems and service delivery continued to be implemented. The main focus of the District Health Boards (DHBs), unlike previous reforms, is on determinants of health and illness with the aim of improving people’s quality of life as well as reducing health inequalities among New Zealanders (King, 2000). The main roles of the DHBs include the
promotion, effective coordination, protecting, conserving the public health and providing the health services. They have also been tasked to establish and maintain an appropriate balance in the provision and use of the resources on population-based public health services and health management services.

The population health approach under which the District Health Board system operates requires new thinking about the roles of those involved in the governance, management and delivery of services. According to Hornblow (2003), the demand is on how to network resources and health workers are required to work in teams. The ultimate objective of the new challenge is to provide a safe, high quality, integrated and well-managed care that utilizes available community-based resources. The population health approach places a demand on all health practitioners to be accountable for their actions. This demand has an impact on the way health practitioners are trained and work.

In the District Health Board system, health delivery is through a multidisciplinary team comprising the medical professionals and allied health professionals all working together to ensure a coordinated, efficient and quality service delivery to the consumers (Opie 1998). The allied health professionals include nurses, occupational therapists, physiotherapists, speech and language therapists, social workers and dieticians. Every team member has a discipline-specific role to play in the team. The multidisciplinary team that executes its functions in the acute care settings of the hospital is referred to as the front-line service provider (Backman, 2000). The team provides the initial service to the patients once admitted to the wards and the team’s overall role is to ensure an early and effective intervention with the aim of implementing a safe discharge of patients to their original environments with full or optimum independence with life tasks (Backman, 2000).

Acute care, as defined by Anderson, Anderson and Glauze (2002) is “a pattern of health care in which a patient is treated for a brief but severe episode of illness, for the sequelae of an accident or other trauma, or during recovery from surgery” (p.32). The micro-changes in the health sector delivery and management discussed above have also impacted on the functions of the acute care settings. Kendall (1994) indicates that the budget conscious health system has imposed a huge demand for
clinicians, including occupational therapists, to be more accountable for their services. They account for this by providing a quality service to their clients in a timely and cost saving manner despite operating within a very restricted budget. In addition to monitoring of resource usage, occupational therapists in the acute care settings are required to maintain their standards by participating in supervision and are involved in professional goal setting using key performance indicators. More so, their productivity is monitored and maintained at a high level in order to keep the acute care service cost competitive.

Another effect of the health sector changes, in the acute care setting is the reduced length of bed stays for patients in hospital (Griffin, 1993). The financial pressures and cost cutting measures introduced into the health sector has affected the health service delivery. There is a huge demand on the acute care doctors to discharge patients quickly to ensure a fast turnover and to reduce waiting lists, owing to spiralling bed costs. This in turn has placed constraints on the nature of the occupational therapy service that can be provided for patients who may only be in hospital for a few days.

It is equally important to discuss the newly shaped role of the acute care occupational therapist in the budget conscious health system. Griffin (1993), basing findings from the investigation of the Australian acute care occupational therapists, defined the new role as having been reduced to simply assess and discharge planning. Kendall (1994) citing the New Zealand experience of acute care occupational therapists adds that the new role of acute care occupational therapists is firmly on appropriate management of presenting problems followed by a timely discharge. This is in sharp contrast to the more holistic traditional rehabilitation practices, which are based on the assessment, intervention and discharge planning. The occupational therapy service is valued for its role in assessment and discharge planning, which enables the District Health Boards to achieve their goal of cost-cutting and increasing gains more effectively. There is a striking similarity in the health care changes that happened in New Zealand and Australia in the area of acute care, with specific focus on the occupational therapy services, therefore the role of acute care occupational therapists will be defined in the above two contexts (Craig, Robertson & Milligan, 2004; Fish & Rudman, 1998; Griffin, 1993, 2002; Kendall, 1994). The most common assessment
tool used by acute care occupational therapists was found to be the initial interview and the most common intervention used in the same setting was education with self-care as a major client-need that was addressed (Griffin, 2002). This was appropriate given the limited time patients stay in acute care settings, as there was simply no time to address issues pertaining to patients’ leisure and work. Important skills required in order to work effectively as an acute care occupational therapist are time management, quick clinical reasoning, stress management, ability to set limits and conflict resolution skills (Griffin, 1993).

Griffin (1993), citing Australian acute care occupational therapists’ experiences, identified that acute care occupational therapists enjoyed and expressed a positive attitude towards their work when working in interdisciplinary teams as compared to multidisciplinary teams. The reason was that professionals working in interdisciplinary teams understood their occupational therapy role better than professionals in multidisciplinary teams.

There is an increased demand in health care services in New Zealand. Occupational therapists working in the acute ward settings have a role of providing a link between the hospital setting and the community. They can only achieve this task after successfully assessing a patient’s needs (Maloney & Kasper, 1991). In addition to the above, they have a task of ensuring that patients attain optimum independence and are safe for an effective discharge planning, despite a high turnover of patients (Fish & Rudman, 1998). The pressure is on acute ward occupational therapists to reduce long hospitalization of patients, prevent readmissions or failed discharges, thereby ensuring that patients continue to lead autonomous and productive lives in their communities (Cardol et al., 2002). It is therefore essential to focus on perceptions of occupational therapists working in the acute ward settings on predictors of job satisfaction, since good morale is essential for a quality service delivery (Coile, 2001).

**Statement of the Research Problem**

There is a strong indication in New Zealand that the role of occupational therapists working in the acute ward settings is discharge specialists (Craig et al., 2004;
They provide a safe link between the hospital setting and the community, thereby preventing hospital readmissions (Maloney & Kasper, 1991), which is a role consistent with the New Zealand health strategy (King, 2000). However, indicators point to the issue of high occupational therapist turnover in the above mentioned work setting that could indicate lack of satisfaction. As Hornblow and Barnett (2000) state, the recruitment and retention of staff is an expensive exercise for New Zealand hospitals. Therefore the issue of occupational therapists’ perceptions of factors influencing their job satisfaction, job dissatisfaction and possible strategies to address job dissatisfaction are important issues in New Zealand that will be explored in this study.

**Justification of the Research**

The role of occupational therapy in acute wards in physical medicine has been described as critical and pivotal in the health service delivery (Griffin, 1993; Joe, 1996). Yet little has been researched and published in New Zealand about this area of work. One recent study by Craig et al. (2004) that explored this area noted that effective team communication is integral to a positive working environment. It also identified occupational therapy as primarily providing a service that ensured effective discharge planning. A further study, although not directly related to the current study, was on the topic of burn out prevention where the focus was on occupational therapy managers (Hocking, 1988). Also, the researcher as part of the physical acute care occupational therapist workforce has witnessed over a two-year period a high staff turnover in the area of practice. Attracting occupational therapists in this area of practice has also been a problem as the researcher has witnessed job advertisements seeking acute wards occupational therapists being re-run in the press at national level. According to Norman (1999), high staff turnover has a negative effect on ensuring a continuous service delivery. Furthermore, participants’ perceptions on the job satisfaction is important as it can provide information to employers and occupational therapists relevant to their recruitment and retention.
Research Questions

1. What meaning do the research participants attribute to job satisfaction or dissatisfaction?

2. What key factors do the participants attribute to their job satisfaction or dissatisfaction?

3. What strategies to rectify job dissatisfaction do the participants suggest?

Purpose of Study

1) To explore factors influencing job satisfaction as well as job dissatisfaction for New Zealand registered occupational therapists working in acute physical ward settings in public hospitals.

2) To make information available to occupational therapists and employers, relating to job satisfaction that could impact on occupational therapists’ recruitment and retention.

Thesis Outline

In this chapter the topic of the thesis has been introduced and a background of the New Zealand Health Care System with a particular focus on acute care practice has been provided. The thesis then proceeds through the usual stages of research to first of all consider the relevant literature in the field followed by the research methods and the data analysis. The final chapters present a discussion of the findings, the limitations of the study and the implications of the study for occupational therapists and employers.
CHAPTER TWO

LITERATURE REVIEW

Staff satisfaction is an issue of concern for health organizations nationally and internationally. It affects service provision, quality of patient care and professional growth. Job satisfaction greatly influences an individual’s decision to remain in his or her work situation. It is therefore essential for researchers to investigate the factors influencing job satisfaction if issues of recruitment and retention are to be addressed (Tovey & Adams, 1999). The bulk of literature on job satisfaction in healthcare comes from Australia, the United States of America, Canada and Britain. The following literature review has captured the themes from these studies.

Recruitment and Retention

Research into occupational therapists’ job satisfaction has largely been driven by concerns regarding their recruitment and retention (Freda, 1992). In the United States of America, Freda (1992) carried out a study to explore factors that influenced the retention of 55 occupational therapists working in rehabilitation settings in the Metropolitan Philadelphia area on job satisfaction. Aspects explored included rewarding, stressful aspects of their jobs as well as professional or personal reasons they would consider as reasons for leaving their jobs. Responses were grouped by the therapists’ years of experience as a framework for drawing conclusions. The results showed that years of experience affected what was considered of value to their jobs as shown by those who had seven years experience and those with one-year experience. In general the most rewarding aspect of an occupational therapist’s job was seen to be patient care and paperwork as the most stressful. Occupational therapists who were deciding to leave the profession were surveyed. They rated salary, productivity, expectations, professional growth opportunities, peer
relationships with other occupational therapists and vacation time as highly important.

Bailey (1990), in a related study, carried out an exploration study of the reasons for attrition of 696 occupational therapists in America. The study examined the reasons given for leaving the profession of occupational therapy. The reasons given by respondents were childbearing and child rearing, geographical relocation and subsequent inability to find a job, excessive paperwork, desire for increased salary and promotional opportunities, high caseloads, stress and burnout. In addition to the above factors, the actual practice of occupational therapy, bureaucracy, the chronicity and severity of clients’ illnesses and an inability to find part-time work were also cited as reasons for attrition among American occupational therapists. Most of the therapists who left the profession did not return to practice because they felt they were out of date and unable to compete with younger therapists. The above two studies done in America suggested patient care, opportunities for professional development and positive working relationships as factors that influenced therapists’ job satisfaction. The nature of occupational therapy practice, bureaucracy, excessive paperwork, high caseloads, low salaries, lack of opportunities for promotion and stress was also cited as factors that influenced their job dissatisfaction. However, it is interesting to note that the study did not clarify the details about occupational therapy practice or the stresses that were stated as sources of job dissatisfaction in the study.

Mills and Millstead (2001) conducted a study on ten occupational therapists’ experiences of rural practice in Western Australia. The focus was on factors that influenced the retention of rural occupational therapy practitioners. A number of themes emerged regarding the participants’ experiences from the time they first considered rural practice to reflections following their departure. One of the themes identified personal reasons that included moving into the city, travel plans and missing family for leaving rural practice. The second theme cited professional reasons for abandoning rural practice. These reasons were: keenness to experience more professional development, seeking support of an occupational therapy department and formal supervision. There were social reasons that pushed occupational therapists to leave rural practice such as the negative publicity perceived
to be associated with rural practice, general reluctance to settle down and lack of academic opportunities for children in rural areas. The study managed to capture key sources of job dissatisfaction associated with rural occupational therapy practice. This information provides a useful framework for occupational therapists and employers when making decisions on issues of recruitment and retention.

Jenkins (1991), in trying to identify problems of recruitment, carried out a survey of all occupational therapists who were employed by a certain Health Board in Northern Ireland. The study highlighted a number of factors, which contribute to the problems of recruitment and retention. The degree of satisfaction among occupational therapists was regarded as fundamental to occupational therapists staying in post. The survey established four specific factors of job satisfaction, which were, multi-professional teamwork, adequate staffing, further training/retraining and involvement in decision-making. Reasons for leaving and deterrents from applying for jobs were viewed together as factors, which take or keep occupational therapists out of posts. High weightings were given to lack of resources, unrealistic workload, personal reasons and lack of professional status. The attractive features of occupational therapy that were noted included variety of work, good working relationships and the challenge of the work. In this section factors influencing job satisfaction and dissatisfaction were identified as significant issues that impact on occupational therapists’ recruitment and retention. Geographical location, inter-professional working relationships, nature of work and professional standing within teams participants practiced were suggested as affecting participants’ job satisfaction.

In a similar study, Greensmith and Blumfield (1989) investigated all occupational therapists who were practicing in Leicestershire, United Kingdom on the possible reasons they would consider when leaving employment. The study identified reasons similar to those cited in Jenkins’ study. However, in this study career change, increased workloads, lack of resources, lack of professional status and disillusionment were rated as the most likely reasons to leave employment. Greensmith and Blumfield also concluded that there was a significant discontent among occupational therapists in the way their role and contribution was perceived within the multidisciplinary team. If role perception was an issue, then one might
imagine that staff rotation, which is a commonly used strategy to encourage new graduates into a work environment, might also raise issues of roles not being clearly defined with therapists working in posts for short periods of time. However, literature provides a broader perspective for such rotational posts and its implications for occupational therapists’ job satisfaction.

Staff Rotation

Taylor, Andriuk, Provost and Langlois (1995) carried out a study on job satisfaction of Canadian occupational therapists working in occupational therapy departments of tertiary care hospitals in Montreal on the implications of staff rotation on occupational therapists’ job satisfaction. The occupational therapy departments had perennial problems with staff rotation. Changes in staffing and staff’s needs resulted in rotation becoming an important issue within departments. The study identified the pros and cons of rotation and non-rotation of occupational therapists across Montreal, Canada. Staff rotation was found to lead to generalist level of practice; disruption of patient care and in situations where the clinical area is not of choice could lead to job dissatisfaction. Positive factors cited about rotation were the potential to allow for easier staff coverage during vacation periods and various learning opportunities for new graduates. In addition, rotation provided an opportunity for participants to experience a diverse clinical setting that was seen as a positive career advantage for staff as it could increase their marketability. Non-rotational schemes on the other hand were hailed for increased opportunities for therapists to specialize, provide optimum care and reducing supervision and orientation time. Therapists also identified the opportunity to become acknowledged and valuable team members in non-rotational schemes. In contrast, becoming specialized was viewed as negative in that it reduced their marketability. A key factor to note about this study is that seventy three percent of the total participants rated quality of care, teamwork and interprofessional communication as important for their job satisfaction. They also identified a non-rotational system as a way to achieve the above goals.

Ryrie, Williams, Wamsley and Dwyer (2000) in a British National Health survey of basic grade occupational therapists’ involvement in a community rotation scheme,
investigated the participants’ perception of the issue of rotation as a component of job satisfaction. A semi-structured questionnaire was administered to elicit their views on role clarity, multidisciplinary working practices, access to professional support, levels of occupational stress and job satisfaction. The findings indicated a number of benefits from community rotation-schemes such as development of autonomous practice and the varied nature of work was noted as a source of job satisfaction.

One further issue that relates to job dissatisfaction is differences between genders. According to Fraser (2002), male occupational therapists in New Zealand constitute less than five percent of the total number of occupational therapists practicing in public hospitals. In view of this, the following section identifies themes cited in studies conducted on male occupational therapists that influenced their job satisfaction or dissatisfaction.

**Gender**

Occupational therapy is a female-dominated profession. Hughes (1945) argued that gender specific occupations have resulted primarily because “people carry in their minds a set of expectations concerning the auxiliary traits properly associated with many of the specific positions available” (p.354). The literature agrees that males have some reluctance to enter female-dominated professions (Rider & Brashear, 1988; Brown, 1991). In response to this, males may decide to leave the non-traditional professions or seek out specialized areas within the profession, referred to as “islands of masculinity” (Kadushin, 1976). These are defined by Kadushin as areas which are more appropriately gender-typed when employed in a profession inappropriately gender-typed, for example a male in a female dominated profession. The reluctance of males to enter female-dominated professions is particularly evident in occupational therapy (Madill, 1987; Posthuma, 1983; Rider & Brashear, 1988). Men who do become occupational therapists tend to stay in the profession for short periods of time (Brown, 1991; 1995; Madill, 1987) and may perceive the profession as a stepping-stone to medicine or other health fields (Janzten, 1973; Taylor et al., 1990).
In an attempt to address the issue of gender, Turgeon and Hay (1994) carried out an investigation on job satisfaction of eighty-two male occupational therapists who were practicing in Ontario, Canada using questionnaires. The study addressed several factors pertaining to job satisfaction and other work related issues. The respondents perceived gender discrimination, lack of personal gratification, lack of opportunities to advance, gender-hindered practice, experience gained as having an effect on their job satisfaction. Less experienced occupational therapists were less satisfied and more likely to leave the profession.

In a related Canadian study, Posthuma (1983) carried out a survey of thirty-three (response rate of 89.2%) male occupational therapists who had graduated from the University of Western Ontario between 1974 and 1977, on their job satisfaction. Sixteen occupational therapists responded to the survey questionnaire, only ten of the sixteen were still working. Six respondents had already left the profession. Posthuma (1983)’s findings were similar to those cited in Turgeon and Hay (1994)’s study. Reasons cited by the six respondents who had left the profession were low salaries, few or no opportunities for advancement and lack of professional status.

Brown (1995) conducted a questionnaire survey of the 199 male occupational therapists who were members of the Canadian Association of Occupational Therapists during 1990-1991 and only 165 responded. Specifically, five job satisfaction factors (work, pay, co-workers, supervision and promotional opportunities), work environment traits and the demographic characteristics of male occupational therapists in Canada were examined. In terms of job satisfaction, male occupational therapists indicated that they were very dissatisfied with their work, pay, promotional opportunities, supervision and co-workers as a group. Moderate levels of community role strain, colleague role strain and patient role strain, as well as moderate levels of role conflict, and role overload, but a low level of role ambiguity were also reported. Reasons they cited as factors influencing their career choice were similar to those by Rider and Brashear (1988). Their level of job dissatisfaction was greatly influenced by pay scale, lack of opportunities for advancement within the profession, lack of standing of the profession within the healthcare and lack of knowledge about what occupational therapists can offer to other professionals and to
the layperson. These factors agree with Posthuma (1983)’s findings as discussed previously.

Taylor, Madill and Macnab (1990) carried out a matched peer survey of 55 male and 55 female occupational therapists in Canada in order to examine the level of value endorsement and job satisfaction. Respondents were matched according to position, educational level, years since graduation, marital status, and area of residence. Data from Life Roles Inventory (LRI) was analyzed using discriminant analysis, results showed that males endorsed risk and advancement more strongly than their female cohorts, while females endorsed social relationships at a higher level than males. Males viewed studying as more important than females did in terms of participation, commitment and role value. Data from the Minnesota Job Satisfaction Questionnaire (MSQ) was analyzed using a t-test and results showed there was no difference between the two groups in relation to their level of job satisfaction. The research finding on gender comparison strongly matches Green, Ross and Weltz (1999)’s study on job satisfaction of American health care workers where no significant differences in gender were discovered. However, Green et al. (1999) noted that women valued interesting work and social rewards whereas men valued self-direction, autonomy and extrinsic rewards.

In a similar study, Rider and Brashear (1988) sent out a survey questionnaire to all male occupational therapists in the United States of America in 1979, 1982 and in 1985 on work related issues with an attempt to determine factors influencing their job satisfaction. The male occupational therapists were found to be younger and had more postgraduate degrees. Respondents rated working with people as the most attractive aspect of occupational therapy. Job security and availability, opportunity to assume leadership roles and autonomy were also highly regarded. However, high salaries, flexible hours and high status were not cited as key determinants for their career choice.

In a British study, Parish, Carr, Suwinski and Rees (1990) reported concerns of male occupational therapists regarding the inadequacy of facilities within their clinical settings (washrooms, change rooms, and locker rooms). Dissatisfaction with salaries
was also noted. In an attempt to remediate their dissatisfaction, male occupational therapists were reported to search for personal interests, a sense of achievement, and financial rewards by obtaining managerial positions.

Common themes cited on studies of male occupational therapists on factors influencing job satisfaction were, autonomy, opportunities for advancement in the profession, promotional opportunities and job security (Brown, 1995; Posthuma, 1983; Rider & Brashear, 1998 Taylor et al., 1990) while salary, lack of professional status within the healthcare and lack of advancement within the profession were factors cited as possible sources of job dissatisfaction (Brown, 1991; Greensmith & Blumfield, 1989; Madill, 1987; Parish et al. 1990; Posthuma, 1983; Rider & Brashear, 1988; Turgeon & Hay, 1994; 1995).

The next section will identify studies that have explored occupational therapists’ career expectations and their impact on job satisfaction.

**Career patterns Related to Job satisfaction**

Career expectations play a significant role in determining occupational therapists’ job satisfaction. A failure to meet these can result in their job dissatisfaction. Nordholm and Westbrook (1986) carried out a survey to establish career patterns of 73 occupational therapists who had graduated from the Cumberland college of Health Sciences in Australia in 1979, 18 months after graduation. The study explored their plans for future work, study and specialization to determine their perceptions of the importance of and their satisfaction with various aspects of work as well as those aspects of work respondents found as most stressful. Aspects of work which were considered most important were, opportunities to develop skills, chances to do something worthwhile and the friendliness of co-workers. Work aspects, which were considered to be of least importance included factors such as pay, physical surroundings and promotional opportunities. The most stressful aspect of work was dealing with other health professionals who were perceived as confused about the role of the occupational therapist.
According to Bush, Powell and Herzberg (1993), career expectations contribute to job satisfaction, which ultimately affects personnel retention. Bush et al. (1993) reviewed literature on carrier self-efficacy, judgment about the efficacy of one’s carrier choice and adjustment. The focus of the investigation was on career self-efficacy, judgments about the efficacy of one’s career choice and adjustment. Career efficacy was considered relevant to the profession of occupational therapy in that occupational therapists are considered to be leaving the profession because of unmet career expectations. Bush et al. (1993) explored Bandura (1982)’s self-efficacy theory (the basis of career self-efficacy) and discussed Banduras’ experience in clinical practice and education relating the application of career self-efficacy to occupational therapy. Suggested methods for enhancing career self-efficacy include the implementation of a professional development course based on Bandura’s self-efficacy theory, incorporation of self-efficacy content into the professional theory and practice courses, clinical supervision that creates realistic self-perceptions or performance during the fieldwork experience.

Sutton and Griffin (2000), elaborated on the need for development of a more robust theoretically sound methodologies for the investigation of job satisfaction within the profession. Job dissatisfaction was identified as a significant cause of attrition in the occupational therapy profession (Bailey, 1990; Freda, 1992; Mills & Millstead, 2001). 295 Australian occupational therapists were investigated immediately prior to graduation with respect to their expectations about working as an occupational therapist, their work values and work preferences. A personality profile was also administered. The findings indicated that students hold inflated expectations about their first job and retain traditional occupational therapy work values.

In the above three studies on career patterns, no common issues came out as in previous themes discussed mainly because the studies, although they were on career patterns, focused on different aspects of occupational therapy. Theorists have suggested a different argument to explain the subject of job satisfaction. Studies below explore some of the theories and the explanations attached to job satisfaction.
The Dual-Factor Theory

House and Wigor (1975) presented a different approach to the search for factors determining job satisfaction among occupational therapists. They argued that there are no specific factors attributed to job satisfaction as argued by Vroom (1964). Their school of thought was based on the Herzberg’s dual-factor theory (Herzberg, 1974) that asserts that factors, which determine job satisfaction, are different from those, which determine job dissatisfaction. The major factors, which were sources of job satisfaction, were labelled as ‘motivators’ whilst those determining job dissatisfaction were called the ‘hygienes’. Herzberg (1974) defined motivators as “a man’s relationship to what he does: his job content, achievement on a task, recognition for a task achievement, the nature of the task, responsibility for a task and professional advancement or growth in task capability” (P.74). The ‘motivators’ include factors such as the work itself, responsibility, recognition, achievement and advancement. The "hygienes" which were regarded as work design factors included company policies, working conditions, interpersonal relations, supervision and salary. Herzberg (1974) defined hygienes as “the kind of administration and supervision received in doing the job, the nature of interpersonal relationships and working conditions surrounding the job, and the effect of salary.” (P.75).

House and Wigor’s discussion on the Herzberg’s dual factor theory was used by Burley de Wesley and Clemson (1992) to investigate job satisfaction using the focus group interview. Burley de Wesley and Clemson involved 26 members of an occupational therapy department in a focus group. The motivators identified in the study included factors such as interpersonal relationships in multidisciplinary teams, patient relationships, work itself, department identity, professional autonomy, recognition, informal networking and relationships within the department. Themes consistent with hygienes included working conditions such as an unpleasant physical environment, office disruptions, uniforms, rotation, fluctuating caseloads, organizational problems, lack of support for professional development, lack of quality supervision, lack of career advancement and low pay. Overall, job satisfaction was found to be positive although working conditions posed some challenges. However, it
should be noted that rotation that was cited in this study as a source of dissatisfaction was also identified previously as a motivating factor towards job satisfaction (Ryrie et al., 2000).

**Extrinsic and Intrinsic Rewards on Job satisfaction**

According to Painter (1994), extrinsic and intrinsic factors are two distinct constructs that constitute work rewards. In view of this, Painter carried out a study on 311 full time registered American occupational therapists who were practicing in ambulatory care settings to determine the predictive power of extrinsic and/or intrinsic rewards as determinants of their overall job satisfaction. The study findings suggested that intrinsic factors had a significant contribution on their perceptions of job satisfaction when compared with extrinsic factors. The intrinsic factors cited in this study were task involvement and autonomy whilst salary, supervision and co-worker support were identified as extrinsic factors.

Common themes can be identified between Painter’s study and Herzberg (1974)’s dual-theory on job satisfaction. Both classified predictors into two main components, Painter preferred using the terms intrinsic rewards and extrinsic rewards whilst Herzberg used the terms motivators and hygienes to refer to the same concepts. Both themes also employ the same method of interpreting the research findings. The intrinsic factors, which Herzberg referred as motivators were independent variables, more internalized aspects of the occupational therapists’ work, a source of their professional identity and were not dependent on prevailing external conditions. Painter cited task autonomy and task involvement as the intrinsic factors whilst in Herzberg theory study, the motivators were work itself, professional autonomy, department identity and recognition. Both studies suggested general working conditions, salary, supervision and co-worker support as external factors that influenced the participants’ job satisfaction.

The following section identifies available literature on physical acute care occupational therapy practice in New Zealand. It also outlines the findings of a survey conducted on occupational therapists in a three-year period.
New Zealand Literature

There has so far been a lack of literature published on job satisfaction among the occupational therapists working in physical acute care settings in New Zealand. In spite of this, recruitment and retention is a major issue nationally and internationally especially in the public sector. This is particularly so among occupational therapists who have a long-standing reputation of being hard to recruit (New Zealand Health Workforce, 2001). Several District Health Boards in New Zealand have reported difficulties with recruiting and retaining occupational therapists especially those working in acute settings in physical medicine. The reasons for health professionals leaving their jobs cited by Hornblow and Barnett (2000) include student loan commitments influencing occupational therapists to seek jobs overseas, poor remunerations, high workload and poor working conditions. The Ministry of Health in New Zealand has published three occupational therapists workforce surveys in years 2000, 2001 and 2002 (Fraser, 2002).
<table>
<thead>
<tr>
<th>Year</th>
<th>APC</th>
<th>POT</th>
<th>DHB</th>
<th>OTs in Acute Wards</th>
<th>POT</th>
<th>NR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total Male Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>1372</td>
<td>808</td>
<td>464</td>
<td>42.5% 2.5% 97.5%</td>
<td>4.0%</td>
<td>94.8%</td>
</tr>
<tr>
<td>2001</td>
<td>1391</td>
<td>835</td>
<td>474</td>
<td>22.8% NR NR</td>
<td>4.7%</td>
<td>94.7%</td>
</tr>
<tr>
<td>2002</td>
<td>1535</td>
<td>1100</td>
<td>568</td>
<td>22.5% NR NR</td>
<td>6.0%</td>
<td>92.5%</td>
</tr>
</tbody>
</table>

**KEY:**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>OT</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>APC</td>
<td>Annual Practicing Certificates purchased</td>
</tr>
<tr>
<td>POT</td>
<td>Practicing Occupational Therapists.</td>
</tr>
<tr>
<td>DHB</td>
<td>OT employed by District Health Boards</td>
</tr>
<tr>
<td>Acute Ward</td>
<td>Refers to the medical, surgical and paediatrics wards</td>
</tr>
<tr>
<td>NR</td>
<td>Not Reported</td>
</tr>
</tbody>
</table>

In the 2000 survey a total of 1372 occupational therapists purchased annual practicing certificates between March and September 2000. 808 were working occupational therapists who responded to the survey and 464 worked for District Health Boards. In this survey 197 occupational therapists worked in the medical, surgical and paediatric ward settings in physical medicine representing 42.4% of the total workforce working in District Health Boards. Only 5 were male occupational therapists working in the medical, surgical and paediatric wards whilst 192 were females. In 2001 a total of 1391 occupational therapists purchased annual practicing certificates and 835 were practicing, 474 of the 835 occupational therapists were working in District Health Boards, representing 56.8% of practicing occupational therapists. 108 occupational therapists out of those employed by DHBS worked in the medical, surgical and paediatrics wards representing 22.8% of occupational therapists employed by DHBS. Gender differences in this setting were not reported.

In a related survey carried out in 2002, a total of 1535 occupational therapists purchased annual practicing certificates. 1100 were practicing occupational therapists who responded to the workforce survey and 568 worked for district health boards.
representing 51.6 % of the active occupational therapists. In the same survey a 22.5% of the active occupational therapists worked in the medical/surgical and paediatric work setting in physical medicine. There was an increase of 20 in the number of occupational therapists working in the medical/surgical and paediatric wards from the 2001 figure. However, there was an overall drop of 69 from the 2000 figure. In the 2002 survey, gender proportions were not reported for the population working in the medical/surgical and paediatric ward settings.

It can be summarized from the above survey that there was a significant drop in the number of occupational therapists working in the acute ward setting in physical medicine. Specific reasons were not given but the ministry of health went on to cite possible reasons as increased workload, poor remuneration and travelling overseas in order to offset the student loans. In the two and a half years the researcher has been working in the acute care setting, the above trend has been witnessed despite lack of statistical support to base the argument. The specific reasons for physical acute care occupational therapists’ attrition are not known although evidence from the researcher’s experiences and national press advertisements suggest a high staff turnover in the acute care setting. More so, there is a lack of published research in New Zealand on physical acute care occupational therapists’ job satisfaction needs and strategies for addressing their job dissatisfaction.

Summary

The review of the literature indicates that job satisfaction was a major factor that impacted on occupational therapists’ recruitment and retention at an international level. Occupational therapists who participated in the selected previous studies identified problems with working in health care teams (Bailey, 1990; Jenkins, 1991; Madill, 1987; Mills & Millstead, 2001; Posthuma, 1983), the restricted nature of occupational therapy practice (Bailey, 1990; Brown, 1991; 1995; Jenkins, 1991; Taylor et al., 1995;) and fluctuating workloads (Bailey, 1990; Burley de Wesley & Clemson, 1992; Madill, 1987). However participants did not expand on the aspects of their practice they found dissatisfying. Other factors cited as contributing to job
dissatisfaction were linked to organizational problems such as low pay (Bailey, 1990; Brown, 1995; Nordholm & Westbrook, 1986; Parish et al., 1990), red tape (Bailey, 1990; Greensmith & Blumfield, 1989), rotational schemes (Burley de Wesley & Clemson, 1992; Taylor et al., 1995) and poor funding for occupational therapy professional development (Brown, 1995; Burley de Wesley & Clemson, 1992; Parish et al., 1990; Posthuma, 1983; Turgeon & Hay, 1994).

Occupational therapists also identified factors they perceived as satisfying in their jobs such as patient care; opportunities to advance in the profession and autonomy were identified as key sources of their job satisfaction (Burley de Wesley & Clemson, 1992; Freda, 1992; Painter, 1994; Rider & Brashear, 1988; Ryrie et al., 2000). Literature search failed to identify any evidence of published studies on occupational therapists’ job satisfaction in New Zealand except for a report presented on a survey conducted on the occupational therapy workforce (Fraser, 2002).

The current study seeks to fill this gap and will explore occupational therapists’ perceptions of their job satisfaction, job dissatisfaction and strategies to address their job dissatisfaction. It is hoped that the study findings will help to inform other occupational therapists and their employers on issues relating to their recruitment and retention.
CHAPTER THREE

METHODOLOGY

Qualitative Research

Strauss and Corbin (1990) defined qualitative research, as any kind of research that produces findings not arrived at by means of a statistical procedure or other means of quantification. It accepts the complex and dynamic quality of the social world (Cronbach, 1982). Qualitative methods can be used to better understand any phenomenon about which little is yet to be known, gain new perspectives on things about which much is already known or gain more in-depth information that may be difficult to convey quantitatively (Strauss & Corbin, 1990).

The current study explored the perceptions of acute care occupational therapists working in physical medicine in New Zealand’s public hospitals on factors influencing their job satisfaction, job dissatisfaction and likely strategies to rectify the issue of their job dissatisfaction. It is a new area for research for the particular population in New Zealand and hence a qualitative approach is best suited for the inquiry. In addition to the above, the qualitative approach was chosen because it produces detailed, rich data and gives insights into participants’ experiences of their world (Stake, 1978), thereby meeting the purpose of the inquiry.

Qualitative Design

Methodology has been described as the theory of knowledge and framework that guides a particular inquiry (Harding, 1987). The particular design of a qualitative study depends on the purpose of the inquiry, what information will be most important
and what information will have the most credibility (Patton, 1990). The researcher sought to explore the issue of job satisfaction, dissatisfaction and likely strategies to rectify job dissatisfaction from the acute care occupational therapists’ perspectives. According to Bryman (2001) in order to understand social actions, researchers must grasp the meaning that actors attach to their actions. Thus to gain understanding, Bryman points that the social scientist must “gain access to people’s common-sense thinking and interpret their actions and their social world from their point of view” (P.14).

This research adopts the interpretive paradigm in its approach. Geertz (1973) defined this paradigm as “a statement of what meaning particular social actions have for the actors whose actions they are…. demonstrates about the society in which it is found and beyond that about social life as such” (P.118). Cohen and Manion (1994) argue that the social world can only be understood from the perception of the individuals who are part of the ongoing action being investigated. The researcher was involved in the focus group discussions and captured the participants’ experienced contributions through tape-recording and use of an assistant researcher to observe and record all the non-verbal interactions, which could not be captured through tape recording. The assistant researcher also took notes on key issues as they came out during the discussion. When using the interpretive paradigm meanings are never predetermined but are socially established based on cultural patterns of a particular group (Geertz, 1973, 1983). In other words, meanings attached to certain actions or perspectives depend on the context, the professional orientation of the group and culture of the group (expected norms and values)(Durkeim, 1961; Heritage, 1984). The group representations help people make sense of every day life and human reason is organized and expressed through processes of institutional thinking (Douglas, 1986). Durkeim (1961) referred to institutions as social reforms such as religion, home, family and community. Douglas (1986) suggested “an answer is only seen to be the right one if it sustains the institutional thinking that is already in the minds of the individuals as they try to decide” (P.4).

Culture of a particular group plays a pivotal role in shaping meaning and interpretation of everyday life (Denzin, 2001; Denzin & Lincoln, 1998) and
contextually defined meanings form local cultures (Sacks, 1974). According to Sacks ‘a culture does not, so to speak, merely fill brains in roughly the same array, it fills them so that they are alike in fine detail” (P.7). The researcher adopted the interpretive inquiry to study selected populations of acute care occupational therapists’ interactions in a focus group discussion and explored the meanings they attached to their professional lives. The researcher involved only occupational therapists working in the area of acute care at that particular time, in physical medicine in New Zealand’s public hospitals. The occupational therapists shared a similar professional background and a similar work area. The issue of context as explained by Sacks was also considered since only those occupational therapists working in the defined area of practice were selected for the study. During the focus group discussions participants’ comments and decisions were influenced by the counsel and advice given by other participants, an issue consistent with Geertz (1973)’s finding that meanings are constructed based on cultural patterns of a particular group and Douglas (1986)’s suggestion that an answer is only seen to be right if it sustains the institutional thinking that is already in the minds of the individuals as they try to decide. Participants were drawn from three different institutions and all belonged to the same professional background. The institutional cultures and/or professional culture therefore influenced the participants’ interpretation of the research inquiry (Geertz, 1973). It can therefore be concluded that the interpretations they gave regarding issues of their job satisfaction, dissatisfaction and strategies proposed were a representation of their cultures and were local interpretations.

The interpretive approach assumes that we do not simply live out our lives in time and through language, rather we are our history. The fact that language and history are both the condition and limit of understanding is what makes the process of meaning construction unique (Denzin & Lincoln, 1994). In agreement with the above school of thought, Geertz (1973) put forward a suggestion that there is no world of social facts “out there” waiting to be observed, recorded, described and analyzed by the inquirer but the inquirer constructs meanings from the people he or she studies. Interpretations are always grounded and local to the particular population being studied. The interpretive approach, according to Denzin and Lincoln, is concerned
with matters of knowing and being, not method per se. Focusing on methods and techniques for analyzing and gathering data are unremarkable in the interpretive inquiry because they mask a full understanding of the relationship between method and inquiry purpose. Various methods can be used to attend to the details, complexities and situated meanings of everyday life world (Denzin & Lincoln, 1994). Interpretive inquirers in their approach watch, listen, ask, record and examine data. How this is employed, depends on the inquirer’s purpose of doing the study, purpose also depending on the relationship between the inquirer and phenomenon under study and methodological commitments (Erickson, 1986; Wolcott, 1988, 1992).

The interpretive inquiry and focus group method were chosen because they allowed the participants to work collaboratively with the researcher in collecting data. Bird, Nicholls and White (1995) supported the idea in their analysis of research methods. Bird et al (1995) emphasized that “…. since a wide variety of methodological approaches are available to the researcher, it is important that the chosen method should not only compliment the research questions asked but be sensitive to the needs of the participants” (P.112). In addition to the issue of method sensitivity, Robinson and Sullivan (1987) claimed that the activity of interpretation is not simply a methodological option open to the social scientist but rather the very condition of human inquiry itself “the interpretive term is not simply a new methodology but rather a challenge to the very idea that inquiry into the social world and the value of understanding that results is to be determined by the methodology” (P. 20). A partnership role was established between the researcher and the participants, the former consolidating knowledge in a qualitative approach while the participants had an avenue to air out their views on an issue critical to their professional practice.

The study aimed to present a systematic view of the perceptions of acute care occupational therapists working in the New Zealand physical health sector on predictors of their job satisfaction, job dissatisfaction and strategies to rectify job dissatisfaction. There has not been any formal study in this area and subject in New Zealand.
Selection of participants

Purposive sampling method was used to select participants. According to Patton (1990), the logic and power of purposive sampling lies in selecting information-rich cases for study in depth. Information rich cases are cases from which one can learn a great deal about the phenomenon under study. Patton further classified purposive sampling method and the specific sampling method used in this inquiry was the criterion sampling. When using this method all cases that meet some criterion are included. Miles and Huberman (1994) and Patton (1990) further explained that the logic of its use is to review and study all cases that meet some predetermined criterion of importance. The current study adopted this method when it targeted acute care occupational therapists that were working in New Zealand’s physical public hospitals at the time of data collection. The criterion was predetermined and only those participants meeting the above criterion were selected to participate in the focus group discussions. In as much as the researcher wished to have equal gender representation he was limited by the shortage of practicing male occupational therapists. In this study eighteen of the participants were females (90%) and only two were males (10%), figures representative of the active occupational therapist population (Table 1).

Another factor considered in the selection process was the proximity of the participants to each other as a cost cutting measure. Participants included in each of the four focus groups worked for the same organization hence had knowledge about each other. Stewart and Shamdasani (1990) argued that familiarity among participants could significantly reduce warm up time. They further defined warm up time as the time when participants get to know each other to facilitate interaction thereby enabling the researcher to quickly focus on the interview. Evidence indicates that there is greater diversity of ideas in single sex focus groups than in mixed sex groups (Stewart & Shamdasani, 1990). The mixed sex group tends to be more conforming because of the social interaction between males and females. Both groups tend to “perform” for each other. The majority of the participants knew each other quite well. This helped in reducing the amount of time spent on initial introductions and allowed an early start to the discussions. The researcher being male and an
occupational therapist who had once worked in the area under inquiry set aside personal biases during focus group interviews, referred to by Bryman (2001) as bracketing. The researcher made every effort to avoid personal perspectives and interests from spilling into the discussions by not asking leading questions. Personal bias was also avoided by consistently consulting with the supervisor and assistant researcher on content and progress of the data collection process.

**Recruitment**

Four major occupational therapy departments, in hospitals in the north island in New Zealand were chosen as possible sources of participants for the study. They were chosen because of their proximity to each other and each employed a sizeable number of physical acute care occupational therapists to enable running of a focus group interview. The researcher contacted the team leaders of all the four hospitals by both telephone and letters. Request letters, as well as a package of information that would be sent to the participants were sent to each of the team leaders. The package consisted of the information sheet with details about the study (appendix B), a supporting letter from the project supervisor, nine open-ended research questions used in the focus groups (appendix C), an ethical approval letter from the Otago Polytechnic and a consent form (appendices D & A). The request letter sought permission for the release of acute care occupational therapists in their respective departments to engage them in focus group discussions at a time coinciding with working hours. A request for allocation of a venue for the interview and identification of potential participants was made in the same letter. A specific request was made to the team leaders not to include anyone who the participants could view as holding a position of authority, a caution suggested by Krueger (1994) to enable a free and non-threatening discussion. A follow up telephone call was made to each of the four-team leaders a week after the request letters were posted.

The team leader of the first focus group reported having met with the staff and that all the five physical acute care occupational therapists working in that hospital had agreed to take part. They had agreed on a date and time, which fell into their working times and had allocated a room for the interview. The team leader identified the
names of the potential participants to the researcher and individual invitation letters and the packages as described above were sent out to each of the participants.

The team leader for the department, which provided participants for the second focus group, responded promptly by email. The team leader reported that all five acute care occupational therapists agreed to participate in the study. They had agreed on a date, which was a week away, and on a time that fell within their working times. A suitable venue had been identified for the discussion as well. The team leader identified the names of the potential participants. The team leader had distributed a copy of the consent form to each one of them and all had signed it and sent back to the researcher. The interview was carried out as scheduled.

The third team leader sent out an email informing the researcher that she had left her position but had discussed the issue with the potential participants at a departmental meeting. She forwarded the name and contact details for the new team leader. The researcher contacted the new team leader three days latter via email requesting if she was aware of the pending data collection request. She had not received this information so the package was sent to her directly. A response was received three days latter, which indicated that all the ten acute care occupational therapists working at that hospital, had agreed to take part. A date was given for the two focus group discussions, which was only three days away. The two focus groups were carried out on the same day, focus group three in the morning and focus group four, three hours latter in the afternoon and used the same venue. An assistant researcher was used in all the four interviews to capture the non-verbal communications and observations.

**Inclusion Criteria**

Participants were required to be current practicing occupational therapists working in the area of acute care in physical medicine in three New Zealand public hospitals in the city chosen. All those qualifying for the above were included in the study despite gender, cultural, age or differences in work experiences. A range of perspectives was essential for the balance of results (Mason, 1998).
Exclusion Criteria

Managers were excluded from the study even if they met other criterion. Managers hold positions of influence and their presence was suspected to influence the contributions of the other participants possibly through fear of being reprimanded after the interviews. The researcher excluded them in order to create non-threatening and open group interviews. Occupational therapists who had previously worked in the acute care area but were not practicing in the area on the time of data collection were also excluded.

Sample Size and Justification

Purposive sampling method was employed to select the participants. All the occupational therapists who met the set criteria were included in the study for each of the three hospitals studied. The criterion sought to select all occupational therapists working in the area of acute care in the area of physical medicine in three New Zealand major public hospitals, all drawn from one city. Each of the four focus groups had five participants, which is consistent with Morgan (1998)’s suggestions to have four as the smallest number and twelve as the biggest number for any particular focus group. In as much as the researcher wanted to have a larger sample, he was limited by a shortage of occupational therapists working in the area of acute care, as it came out that each therapist was covering more than one ward. There were advantages to smaller numbers of participants per focus group. The study was purely explorative and smaller groups demanded a greater contribution from each participant meaning a dynamic of higher involvement in the life of the group. Morgan (1998) further clarified the above issue, “when the researcher desires a clear sense of each participant’s reaction to a topic, small groups are more likely to satisfy this goal” (P.43). The above argument is consistent with the interpretive approach used in this study where participants were expected to define the phenomenon (job satisfaction) from their own experiences and according to their contextual environments (Geertz, 1973). The number of focus groups needed was not predetermined as explained on
the recruitment subsection. Data collection ceased when additional data collection was not adding any new understanding on the above phenomenon.

**Data Collection**

Data were collected in the form of four focus group interviews and observed data, which was recorded by the assistant researcher. The focus group interviews were conducted at the participants’ places of employment on the request of the researcher. The request for the venue was made as a measure to cut cost for hiring one and it enabled interviews to be carried out during working times. Participants were given nine open-ended questions well in advance to use as a guide (appendix C). The discussions lasted between one hour and one hour and fifteen minutes and were carried out on dates as indicated in Table 2 below. The participants, researcher and assistant researcher completed consent forms prior to commencement of all the four interviews.

Each interview began with the researcher explaining the aims of the session, the role of the assistant researcher and clarifying the audio-recording procedures such as, participants were told to speak clearly, one at a time and that there was going to be a pause when the tape needed to be turned over. Before each session, the researcher reiterated to the participants their right not to answer any specific question(s) if they wished so. The researcher moderated the focus group interviews by asking open-ended questions to explore issues acute care occupational therapists perceived as important. However, there were times when he needed to deviate from the planned open-ended questions to more specific ones in order to gain a detailed understanding of a participant’s interpretation of phenomena. At the end of the discussions, the researcher thanked the participants for their contributions and emphasized that he was going to distribute the overall results of the study to them and the occupational therapy team leaders. Issues of confidentiality and anonymity were briefly explained. In all the four interviews, the researcher and assistant researcher met immediately after the discussions to identify key issues from the discussions. This was important as they still recalled the events of the discussion.
The assistant researcher was used during the data collection process to help with arranging refreshments, setting up and monitoring the audiotape recorder. He also recorded all the non-verbal interactions such as head nods, eye contact between certain participants or clues that indicated level of agreement, support or interest and took notes on well said quotations illustrating some key issues and providing feedback to the researcher on analysis. Observation was conducted to gain insight into the interaction patterns between participants themselves and between participants and the researcher. It also sought to record critical and sensitive issues as they came out during the interviews. The assistant researcher was not involved in the discussions.

Table 2 below summarizes the participants’ ranges of work experience, period during which data was collected, the gender differences as well as the total number of participants selected for the study.

**Table 2: The Structure of The Four Focus Groups**

<table>
<thead>
<tr>
<th>Focus Group</th>
<th>Date of interview</th>
<th>Number of Participants</th>
<th>Years of experience</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>1-3</td>
<td>4+</td>
</tr>
<tr>
<td>1</td>
<td>20.11.03</td>
<td>5</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>03.12.03</td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>12.12.03</td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>12.12.03</td>
<td>5</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>20</td>
<td>18</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 2 above shows that twenty participants were selected for the study, two of these had more than four years of work experience in the area of acute care and eighteen participants had work experiences ranging between 1 and 3 years. Data was collected over a period of three weeks, with a fortnight’s interval between focus group interviews 2 and 1 and more than a weeks’ interval between interviews 3 and 2. Third and fourth group interviews were carried out on the same day and venue and participants were selected from the same place of employment. The researcher consulted with the supervisor on issues pertaining to data collection during the above
in-between interview intervals. Participant from focus group 2 who had more than 4 years of physical acute care area work experience pulled out of the discussions thirty minutes into the interview and returned when the interview was completed. Data collected from the fourth interview did not provide any new understanding and it was therefore concluded that data saturation (Morgan, 1997) had been achieved. After consulting with the supervisor and assistant researcher data collection was terminated at this stage. The researcher transcribed all tape-recorded data.

Data Analysis

Data analysis is an ongoing cyclical process integrated into all phases of the research that begins with data collection (McMillan & Schumacher, 1997). It consists of examining, categorization, tabulating or otherwise recombining the evidence to address the initial propositions of a study (Yin, 1984). In a qualitative inquiry, there are agreed upon methods for data analysis in the sense of drawing conclusions and verifying their strength (Patton, 1990). Patton went on to suggest that there are no absolute rules except for researchers to do their best to represent the data and communicate what the data revealed given the purpose of the study. The current study explored perceptions of acute care occupational therapists on factors that influenced their job satisfaction, dissatisfaction and strategies they felt could be implemented to rectify job dissatisfaction. The study also sought to make information available to occupational therapists and employers relating to job satisfaction that could impact on occupational therapists’ recruitment and retention.

In order to provide findings to the above inquiry, the researcher used interpretational analysis (Gall, Gall & Borg, 1989 cited by Tesch, 1990), which involves preparing a database containing all the data (field notes, observational notes, transcripts) collected during the study. Similar codes are sequentially coloured in the text using the same ink. The text is then divided into meaningful segments and each segment is coded. All the segments that have been coded by a given category are put together in a pile to develop themes. The different themes are constantly compared and contrasted over a long period. This is done to identify any relationships or differences that exist.
between categories. During this process new themes are created, existing themes combined or discarded (Gall et al., 1989, cited by Tesch, 1990).

In this study analysis began in the field when the researcher discussed the main themes that appeared to merge with the assistant researcher immediately after each focus group but the overall analysis was done after all data was collected and transcribed. The results of the analysis done during data collection did not influence subsequent data collection process. The purpose for the ongoing data analysis was to determine the stage at which data collection was to be terminated. The researcher transcribed the audio-recorded data and the assistant researcher compiled the notes obtained from the field. The analysis followed Gall et al. (1989 cited by Tesch, 1990), McMillan and Schumacher (1997) and Miles and Huberman (1994)’s coding and classification process. Kvale (1996) referred to this classification as meaning categorization. The thrust in this analysis was in organizing data into categories and identifying patterns or relationships among categories. The categories emerged from data and were obtained by constantly comparing and contrasting gathered data (Appendix E).

After all the data had been collected, the researcher familiarized himself first with the data by reading several times all data collected from the field by the assistant researcher and all the transcribed copies of data as well as listening to the audio-tapes. This practice gave the researcher a holistic perspective of the data. Merriam (1988) described this stage of analysis as “one of holding a conversation with the data, asking questions of it (sic), making comments and so on” (P.151).

The stage that followed was to code the data. Miles and Huberman (1994) defined codes as tags or labels for assigning units of meaning to the descriptive or inferential information compiled during the study. The initial coding involved writing a descriptive word or phrase next to a given excerpt in order to summarize what the excerpt was about. The codes (broad names or phrases) were then grouped and used to create categories. The different categories were then colour coded by use of different ink colours, each colour represented a different category. The colour coding was done on a computer. The researcher then printed out two copies of the transcripts.
(written data) with categories colour coded already. The transcripts were cut up and organized into respective piles of the same category. The second printed copies of the transcripts were retained to enable the researcher to identify the original sources of the different categories, which was vital in the interpretation of the data. The piles of different categories were displayed on a long table in the researcher’s private study room that was kept locked to avoid interruption of the data.

Each pile of each category was analyzed again and compared with other data to form bigger categories. The researcher took several days studying, comparing and contrasting the different categories. The time frame allowed the researcher to familiarize with the categories in order to create relationships. Relationships between categories were identified and connections were made. As original categories changed, combined or discarded, new relationships were found and new categories generated. After the establishment of new relationships between categories, overall themes were identified. The themes allowed the researcher to draw conclusions from the data, determine the implications of the findings and to make recommendations in line with the purpose of the study (Appendix E).

**Rigor**

Krefting (1991) defined rigor in a qualitative inquiry as the assessment of trustworthiness. According to Bryman (2001), trustworthiness is a set of criteria advocated by some writers for assessing the quality of qualitative research. The following are strategies used by the researcher to ensure the worthiness of the current study.

**a). Supervision**

The researcher had regular supervision over the phone and through emails from the beginning of the study until its completion. The supervision provided guidance to the researcher at every stage of the study. Supervision is a crucial part of the research project especially at the beginning of the study (Jerkins & Staker, 1998).
b). Member checking

Member checking can increase credibility of data in a qualitative inquiry. During the process of member checking the researcher takes the data back to the participants to confirm if the findings are consistent with their perception of the data (Krefting, 1991). The researcher distributed the results of the study to all the participants before the final draft of the project was written to check with the participants if the study’s findings were consistent with their perceptions. A ninety percent respond rate was obtained and all respondents agreed with the findings.

c). Adequacy and appropriateness of data

Adequacy in qualitative research refers to the amount of data collected rather than to the number of subjects selected (Denzin & Lincoln, 1994). Adequacy according to Denzin and Lincoln (1994) is attained when sufficient data have been collected that saturation occurs and variation is both accounted for and understood. Appropriateness refers to selection of information to the theoretical needs of the study and emerging model (Denzin & Lincoln, 1994). In qualitative research, sampling occurs purposefully and the investigator samples until repetition from multiple sources are obtained (Denzin & Lincoln, 1994). In this study participants were purposefully selected using the criterion method. Participants who possessed the qualities to contribute meaningfully in the focus group discussions were selected for the study. They were selected based on their professional background and their work experiences. Data collection was terminated when saturation was attained.

d). Triangulation

Triangulation is the use of a variety of data collection methods to strengthen the credibility of the data gained (Bryman, 2001; Krefting, 1991; Patton, 1990). Patton (1990) identified four different types of triangulation, which are data triangulation, investigator/analyst triangulation, theory triangulation and methodological triangulation. The researcher used the data and investigator triangulation to strengthen credibility of the data gained. Patton further defined data triangulation as
the use of a variety of data sources in a study and investigator triangulation as the use of several different researchers or evaluators. In this study, data triangulation was employed when the researcher used the assistant researcher to record the non-verbal interactions and physical observations as they naturally occurred during the discussion. The observed data was analyzed and compared with the transcribed interview data. This comparison led to a single consistent interpretation of the inquiry. In cases where inconsistencies were found in the data collected reasonable explanations were given and this contributed significantly to the overall credibility of the findings.

In addition to the data triangulation, the investigator triangulation was used when he involved the assistant researcher and the supervisor to independently analyse the same data and then compared their findings. The supervisor and assistant researcher analysed the transcribed data independently. The results of the above analysis were compared and contrasted with those of the researcher to ensure that no major themes were missed or that unwanted information was included. There were no major differences in the categories developed from the data and after consulting the project supervisor all the parties came to an agreement on themes.

**Ethical Considerations**

Addressing ethical issues, which may arise as a result of research, is part of the research process. Ethics is defined as “the study of the code of moral principles derived from a system of values and beliefs and concerned with rights and obligations” (Brooker, 2002 P.121). When research involves human participants ethical approval must be gained from an ethics committee of the institution involved and informed consent must be gained from participants involved (Pollit & Hungler, 1997). The research proposal for this study was submitted to the Otago Polytechnic Ethics Committee and approval was given on September 24, 2003 (appendix D).

All major ethical principles according to the above committee were applied. The contents of the Otago Polytechnic Ethics Committee were consistent with the
guidelines outlined by National Commission for the protection of Human Subjects of Biomedical and Behavioral Research (Woods & Catanzaro, 1988). The guidelines, according to Woods and Catanzaro (1988) emphasize respect for a person as an autonomous agent, maximizing benefits and minimizing harm and the equitable sharing of burdens and benefits of research by the population. The subject of inquiry was regarded as a sensitive one as it was possible that participants were going to share with the researcher some employment contract issues that many organizations regard as private and confidential. Accessing participants, informed consent, potential harm of the participants, confidentiality, anonymity issues and use of the information were addressed as part of the research process.

a). Access to participants

The principle of justice (Sieber, 1992) was applied, which states that researchers should ensure reasonable, non–exploitative and carefully considered procedures and their fair administration to potential participants. Names and telephone numbers of participants were obtained by contacting team leaders of occupational therapy departments of three major referral hospitals in the north island of New Zealand. Personal invitation letters and telephone calls were made to individual participants. Participation was voluntary. An information sheet with aims and details about the study was part of the invitation package. Follow up telephone call reminders were made to participants a few days before the focus group interviews. In each of the four focus group interviews, the researcher started by explaining the aims and objectives of the study, addressed anonymity and confidentiality issues as well as offering the opportunity for voluntary participation.

b). Informed Consent

In light of being a potential participant in a research study, individuals require sufficient information to enable them to make an informed decision on whether to participate or not. According to Sim (1986), informed consent is “the voluntary and revocable agreement of a competent individual to participate in a therapeutic or research procedure based on an adequate understanding of its nature, purpose and
implications” (P.584). In this study, the principle of mutual respect (House, 1990) and the Privacy Act (1993) was applied in seeking participants’ consent. It is important for researchers to understand others’ aims and interests, to be careful not to damage self-esteem and to respect participants (House, 1990). It can be argued (Eisner, 1991; Wax, 1982) that truly informed consent is impossible in qualitative studies because events in the field and the researcher’s actions such as following up new and promising leads cannot be anticipated. Informed consent therefore is considered to be an ongoing negotiated process. Initially potential participants must consent to being involved in the study. The consent must be voluntary and freely given. Consent forms (Appendix A) were signed on the day of the interview after the researcher had explained the aims of the study and explained the potential participants’ involvement in the study. Participants read the information sheet and had questions answered to their satisfaction prior to signing the consent forms. The information sheet (Appendix B) and consent forms stipulated that participants had the right to refuse to answer any particular questions during the interview by remaining silent or withdraw from the study without giving any reason. However, participants could not retract the information if they chose to withdraw.

**c). Anonymity and confidentiality**

Roberts and Taylor (1998) suggested that the researcher should build appropriate procedures to protect the anonymity of the participants and protect data from unauthorized access. The principle of respect (Sieber, 1992) was applied with the aim to protect the autonomy of persons. Pseudonyms replaced participants’ real names throughout all written and reported documentation. Tapes and transcripts are kept in a locked cabinet and will be destroyed after a period of five years from the date of approval of the research. Only the researcher, assistant researcher and the supervisor had access to them. At the end of the study, all raw data with personal information about the participants will be destroyed. Collecting information that would potentially identify the participants, such as their ages and the District Health Board names, was avoided. Both the researcher and assistant researcher signed the consent forms and abided by the contract.
d) Potential harm to participants

It is important to think of variations in vulnerability to harm (Sieber, 1992) and it is wise to assume that the chances of some type of harm are better than none and to consider in advance, ways of reducing that likelihood (Erickson, 1986). If any harm is expected in a study, access to data and its quality may suffer (Miles & Huberman, 1994). No physical harm was expected in this study. However as explained above procedures to protect the privacy and anonymity of the participants were explained to those taking part in the study in order to allay any fears of being identified. As Reiss (1979) says, “The single most likely source of harm in social science inquiry is the disclosure of private knowledge considered damaging by experimental subjects” (P. 73). Should the researcher wish to disclose information outside the signed contract he will seek approval of the participants.

e) Participants’ right to decline

The principle of non-coercion and non-manipulation was applied (House, 1990). Participants had the right to decline to participate without any disadvantage of any kind or withdraw from the project at any time without giving any reason. One participant who responded to a phone call during the second focus group interview exercised this.

f) Arrangements for participants to receive information

The researcher promised to answer all questions asked by participants to their satisfaction as provided in the consent form. The information sheet provided contact details for the supervisor and the researcher and instruction that they could be contacted without any hesitation, should participants wish to ask any questions. A summarized copy of the results was promised to be sent to the participants and details as to how to access the final copy of the study at Otago Polytechnic Library was promised to all the participants.
g) Use of the information

It is the responsibility of the researcher that the information is used based on the pre-study agreements between the researcher and participants (Mathieson et al., 1992). The principle of ‘beneficence’ and ‘humanity’ was applied by making information available to occupational therapists that can impact on their recruitment and retention. The purpose of the information gathered during the course of the research was to produce a thesis, a requirement for the Master of Occupational Therapy degree. It was also stated that results of this project may be published or presented at academic conferences but any data included will in no way be linked to any specific participant without prior consent. A copy of the thesis will be put in the Otago Occupational Therapy School Library and the Bill Robertson Library for general reading. It is anticipated that the information will be a useful guideline to occupational therapy managers when addressing occupational therapists’ recruitment and retention issues.

h) Researcher Bias.

The researcher in qualitative research is the primary research tool; therefore personal aspects of the researcher impinge on the interview relationship. Halloway & Wheeler, (1996) argue that researcher’s own subjectivity becomes an analytical tool and consequently becomes part of the research. The researcher had worked as an occupational therapist in the area of physical acute care setting prior to the study so this was already an area of interest to the researcher. There was potential to create a conflict of interest so to avoid this, peer review was an important part of the design. It is vital for the researcher to acknowledge his own subjectivity since bias cannot be eliminated. An assistant researcher and my academic supervisor were consulted throughout data collection to get a balanced opinion as a way to monitor the bias and ensure confirmability. The researcher was professional when collecting data by bracketing the bias. That is, as said before the researcher sets aside the preconceptions emanating from previous experiences and attends to the participants’ interpretations.
Summary

In this chapter the researcher’s rationale for the use of the interpretive approach as a methodology and the method of using focus groups to generate in depth data was described. Ethical considerations were also described and the rigorousness of the research was addressed through expert checking, member checking, data and investigator triangulation and supervision.
**Key to abbreviations of the data chapters**

The following abbreviations are used in the study in chapters four, five, six and seven, which discuss the analysis of the data.

( ): Figures in brackets Focus Group number, the participant’s pseudonym and page number of the transcript. For example, Focus Group 2, participant M and quote found on page 2 would be recorded as (F2: M: 2).

Indent: Signifies quotes from the participants
Analysis of data in an interpretive study leads to the generation of themes. The themes are not discrete entities and can have some overlaps (Denzin, 2001). The purpose of the study was to explore meanings attributed by participants to aspects of their job satisfaction, job dissatisfaction and strategies aimed at rectifying job dissatisfaction or maintaining job satisfaction. The themes capture the personal experience of the participants in order to give a more comprehensive insight into the job satisfaction phenomena. Analysis of data from the study generated eight themes attributed to job satisfaction, ten themes attributed to job dissatisfaction and seven themes attributed to strategies aimed at rectifying job dissatisfaction or maintaining job satisfaction. Some themes related to all four focus groups and others were peculiar to a specific group(s).

Chapters four to six will address themes relating to job satisfaction, job dissatisfaction and strategies aimed at addressing job dissatisfaction or maintaining job satisfaction respectively.
CHAPTER FOUR

THEMES RELATED TO JOB SATISFACTION

1. Support from the occupational therapy and multidisciplinary teams

Satisfaction was expressed in relation to the support given by the occupational therapy team. The support was both formal and informal. Formal support related to work/ward cover when absent from work, professional advice when they encountered any work difficulties, formal supervision, receiving appropriate referrals from the team and having senior occupational therapists working alongside them. Informal support included social gatherings or events with other occupational therapists, working alongside other multidisciplinary team members such as social workers, physiotherapists and speech language therapists, sharing workloads and going out for lunch together.

a) Supportive nature of the occupational therapy team

Participants across all four focus groups expressed great satisfaction with the support they gave each other as acute care occupational therapists. They felt that the support was unique to their particular team and other organizations didn’t have that level of support as expressed by one participant.

F4: S: 11 // I realized that other occupational therapists from other hospitals are shocked by the support we give each other because they don’t have it at their places. Even when you are overwhelmed, other occupational therapists just pop in to help with the workload and I am overwhelmed by such support. //
b) Working alongside senior occupational therapists

Participant K viewed the acute care work area as a traditional training ground for new occupational therapy graduates that was shunned by more experienced occupational therapists. She gained satisfaction from opportunities she had of working alongside senior occupational therapists.

F3: K: 9 // Its good to see seniors like C working alongside us. Traditionally acute care has been the training ground for junior occupational therapists so we need all the senior occupational therapists to come and work in our area. //

c) Supervision

Acute care occupational therapists from the four focus groups valued the supervision they got from the senior occupational therapists at their organizations. Participants Ly and E defined supervision in terms of its frequency and the structure respectively.

F4: Ly: 4 // We actually get good supervision. When you start off here you get weekly supervision and then move to fortnightly supervision. //

F3: E: 2 // Supportive team in terms of supervision. The supervision is formal and structured. I like that. //

d) Working alongside other multidisciplinary team members

It was satisfying for participants to work alongside supportive multidisciplinary team members such as social workers, speech and language therapists. Participant E gave the supportive nature of multidisciplinary team as the reason for staying long at her workplace.
2. Well structured working times

Participants were satisfied with regular working times for example working Monday to Friday and being away from work during weekends and having fixed working weekdays working hours, starting from 7am and finishing not later than 5pm. Participants felt this allowed them to balance their work and social demands.

F2: M: 8 //.. I like to have a life myself. I start at 8 am and finish at 4:30pm then I can do what I want after work. I love OT but it’s not my whole life. //

F2: Al: 8 // I think Monday to Friday is good. I like my weekends. //

b) Work environment

Participants valued working in a hospital setting because they regarded it as well structured. One participant singled this as the main reason for working in a hospital setting.

F3: K: 2  // Hospital is a good structured environment, good for occupational therapists to work. That was the major reason for me to come and work in a hospital environment. There is formal supervision and little chances to go wrong. //

Another participant from the same group went further and compared the acute work setting with the community work setting
3. Patient contact.

It was satisfying for participants across all four focus groups to meet and work with new patients. Also, receiving appreciation and being involved in their discharge planning was cited as satisfying.

a) Meeting new patients

The fast pace in the acute care area as a result of high patient turnover enabled participants to meet new patients regularly. Meeting new people presented new challenges to participants, an aspect satisfying to participants in all the focus groups as quoted from one participant.

F2: Sc: 9 // I like the variety that we get in acute care and the distinctive nature of the patients we get everyday. That really keeps me going. Meeting different kinds of patients, different kind of conditions that we studied in the past, so that’s really exciting. I like the fast pace, different kind of conditions. That’s kind of challenging. //

b) Appreciation

Getting positive feedback from patients even on trivial interventions was satisfying to participants.

F3: C: 4 // Giving people different options is quite helpful, sometimes when they come to hospital they think that’s the end of it. But when you show them how to get into the shower, use the toilet and they appreciate it. //
c) Involvement in discharge planning

It was satisfying to the participants to be involved in discharge planning of their patients by taking a broad overview as their approach to ensure that patients were safe. One therapist gave a brief description of their interpretation of the discharge-planning role.

F4: S: 5 // I think also our involvement in discharge planning. We see things using a big picture and we can easily pick up if something is not right and then we make recommendations on safety. I think that’s satisfying as well. //

4. Occupational therapy role in acute care

Participants defined the role of acute care occupational therapists in terms of discharge planning, home safety assessment and teamwork. They felt that occupational therapists are good team builders, team building regarded as essential for teamwork. They enjoyed the holistic approach they used in managing their patients and the above roles, which were exclusive to occupational therapy.

The role of acute care occupational therapists was defined by one participant from one focus group as being around patient safety especially for discharge purposes.

F2: C: 6 // The team’s understanding of role of occupational therapy is around safety. So we are often asked if someone is safe to go home and we make decisions. //

Participants from one focus group also regarded themselves as good team builders. They attributed this quality to their professional training. Good team building enabled participants to be effective team members of the multidisciplinary team.

F3: S: 3 // We are very well trained in team building. Occupational therapists are known for good team building. //
5. Education opportunities

Working in acute care area provided occupational therapists with good learning opportunities as reported by participants from all four focus groups. Multidisciplinary team members were open and willing to help and teach whenever it was necessary. Secondly, the nature of work in acute care was described as fast and busy. The high patient turnover enabled the occupational therapists to encounter a variety of patients with various medical conditions. They felt as if they were studying the conditions they had theoretically learnt in school in more depth. Participants from one group expressed that they also shared relevant research articles amongst themselves to help keep abreast of current practice requirements. In addition, participants also expressed satisfaction with the available internal and external courses at their places of employment and one participant valued available opportunities to educate student doctors on the role of occupational therapy.

a) Good learning environment

Acute care’s work was interpreted as fast and busy due to the high patient turnover and reduced patient bed stays. This created plenty of opportunities for participants to work with people presenting with various medical conditions. All groups regarded these opportunities as good for their professional development.

F4: C: 5 // In acute care occupational therapy one thing I really enjoy is that you get to see so many people, lots of conditions, learn lots from these and I can’t imagine how much knowledge I would have missed if I had moved to a specialized and specific area as a new graduate. I wouldn’t have the knowledge I have now. It’s awesome. //

b) Internal and external courses

Participants from one focus group valued sharing professional reading materials amongst themselves as well as the increased opportunities to attend internal or external courses.
6. Pace of work

Therapists from one group reported a high patient turnover, which kept them busy. The busyness meant they were not bored, that is, had enough challenges to problem solve that made their work interesting.

F1: FM: 4 // Its just an influx, we have to guarantee that they are discharged with full supports and some external supports as well as ACC or homecare. The minute they are discharged the bed will be filled then you meet someone completely different. There is also the issue of financial pressure even though they are not medically fit for discharge. There is a bit of pressure to guide them and get discharge because the bed needs to be allocated to someone else. That’s the way it is, that’s how I see it in orthopaedics, it’s busy. //

F1: K: 4 // When I said fast pace, I meant just seeing patients one after another. I like being busy, I don’t like sitting around doing nothing, yeah getting busy although it can be busy sometimes. //

7. Variety

Variety was defined in two ways. Firstly, it was defined in terms of the high patient turnover in acute care that resulted in meeting people with various presenting conditions.
F4: C: 5 // In acute care occupational therapy, one thing I really enjoy is that you get to see so many people, lots of conditions, learn lots from these and I can’t imagine how much knowledge I would have missed if I had moved to a specialized and specific area as a new graduate. I wouldn’t have the knowledge I have now. It’s awesome. //

Variety was also defined in terms of work settings. Rotation gave acute care occupational therapists opportunities to learn to practice in different areas of specialization such as orthopaedics, medical, renal and paediatrics.

F1: FC: 3 // I guess for me, I have a permanent position in orthopaedics now but have had a chance to work in acute medical which is good for me. The hospital setting has several work settings hence it provides us with the opportunity to try elsewhere. //

8. Autonomy

Participants reported that they had a responsibility to manage entirely more than one ward. Working in isolation was satisfying to occupational therapists because it offered them opportunities to make decisions independently. The following were participants’ perceptions on autonomy:

F2: AM: 8 // I like the way you make your own decisions, manage your own workload. //

F2: M: 10 // The ability to problem solve, sometimes depending on where you are working, there is an opportunity to problem solve on your own. //

Key issues identified as satisfying to therapists in the study related to the nature of their practice, that is, the fast pace of work and high caseloads, relationships with co-workers and working conditions. In addition, participants worked in isolation, which allowed them to make independent decisions on patient management. The
Increased patient turnover provided variety to their work as well as increasing the participants’ opportunities to meet new people. Also, participants enjoyed the support they got from both occupational therapy and multidisciplinary teams. Lastly, it was satisfying for participants to work in well-structured settings like a hospital in which they had regular working times.
CHAPTER FIVE

THEMES RELATED TO JOB DISSATISFACTION

1. Lack of understanding of occupational therapy role

Participants were dissatisfied with lack of knowledge about their role by some multidisciplinary team members. The doctors were singled out during the discussion for sending inappropriate referrals and sending referrals when patients were about to leave the ward. It was felt by many participants that doctors, some members of the multidisciplinary team and patients, misunderstood their role.

a) Doctors

Participants were dissatisfied with receiving inappropriate referrals which they interpreted as lack of knowledge about occupational therapy by the doctors and just ensuring they didn’t get fined for mishaps.

F2: Sc: 14  // …also inappropriate referrals, sometimes you get patients who do not need occupational therapy input at all and they just document that they have referred the patient to occupational therapy and are safe to go home, just to cover themselves. Doctors sometimes do these referrals. //

b) Role Overlap

Social workers and nurses were singled out as members of the team who prescribed equipment to be issued on the referrals they made to occupational therapists. Role overlap was perceived as an issue because nurses and social workers got similar
information from patients and on their referrals chose to ask occupational therapists to issue specific equipment.

F2: Sc: 13 // In orthopaedics, there is a lot of role overlap with social workers and nurses so during the assessments, they may identify some equipment patients require and on the referrals they send to occupational therapists they may specify the equipment the latter need to issue out. I don’t really like that…………
May be its lack of time, lack of knowledge about occupational therapy or probably do not want to learn what occupational therapists do. Some of the professionals in the ward really think that occupational therapists just give out equipment. Its bad to think that that’s all you have to do a degree for. I got to apply my knowledge, if I don’t apply my knowledge, I don’t like it. //

c) Patients

Participants did not like their role being confused with that of physiotherapists or nurses. They blamed role confusion on the fact that they treated the same patients using the same treatment area as physiotherapists hence faced difficulties in projecting their professional identity to patients. Two participants from one focus group summed up the above perceptions as:

F2: Al: 16 // Its quite often the physiotherapist has seen the patients first and does something with them, you visit them after and you hear them saying “I have already seen you today”. //
F2: Am: 17 // Some of it has to do with assessments we do, bedside assessments. It’s different from taking them down to the kitchen and asking them to make a cup of tea rather than bedside assessments. //

It was also noted that the role confusion was due to the memory loss often associated with old age.
F1: AE: 8 // Lack of knowledge by patients themselves as well. A lot of them are old people and quite often you are called a nurse. I think that’s lack of knowledge, I think that’s what they see us all as. //</n
2. Lack of professional status

It was felt that there is lack of respect for the occupational therapy profession by the doctors and management. For example failure by doctors to take up recommendations on patients’ care and management and they do not consult occupational therapists. However, some participants reported that they had made some inroads in making influential decisions in their areas of practice on specific areas such as head injuries management.

a) Doctors

There was lack of value of occupational therapy role on safety issues and doctors acknowledged physiotherapists’ role ahead of that of occupational therapists.

F1: FC: 7 // I don’t think that doctors do not know what we do, they do, but they do not put any importance on our role than they do with physiotherapists. //</n
F2: M: 17 // One thing frustrating is that you recommend that its unsafe to discharge the patient but doctors discharge them anyway, when I know very well that the issue of safety is entirely my responsibility. I find that quite frustrating. //</n

Participant Sc summed up their perceptions on lack of professional recognition by doctors as follows:

F2: Sc: 13 // I find it frustrating that occupational therapy is considered equal to issuing out equipment which is quite frustrating. //
b) Organization management

Low pay and lack of consultation was dissatisfying to participants as they attributed the issues to lack of professional recognition by management. Low pay was directly related to lack of value of their role as expressed by the following participants:

F4: S: 18 // The issue of pay. We had to fight to have it reviewed. I don’t like that; we just need to be valued. //
F2: Am: 20 // I think we are very underpaid and I think its lack of incentive. //
F2: Sc: 20 // Although you enjoy your job you need to be valued. //

Participants also strongly felt that management was not consulting them on key issues directly affecting them professionally. They interpreted this as mere lack of appreciation of their profession.

F4: C: 10 // What frustrates me the most is the hierarchy of the whole system. Throughout all these changes happening there is no consultation made to us, decisions are just imposed on us; we don’t have enough space for our offices and treatment, yet ten floors are being allocated to the university for teaching. //
F4: K: 10 // Lack of consultation equals lack of value. //

3. Communication Obstacles

There is lack of effective communication regarding patients’ care between occupational therapists and the doctors. For example it was noted that some referrals received for patients to go home were a waste of time as most of these patients ended up referred to a rehabilitation service.

The following precepts highlight the participants’ level of dissatisfaction with the poor communication that existed between themselves and the doctors.
F3: S: 12  // You get a patient initially planned to go to rehab and all of a sudden there is change in discharge plan and patient is suddenly for discharge to home environment. That’s a worry too and it looks like it’s a trend. //
F1: FC: 6  // Sometimes I get quite frustrated because of the turnover, sometimes I get people needing to go home and the team only informing me when they are due to leave. I will hurriedly send out all paperwork to ACC, equipment suppliers only to be told last minute that the patient is going to rehabilitation instead. Down there they have all the luxury to do all paperwork because patients will be there for a very, very long time. So I get so frustrated because I think it’s not necessary. It looks like it’s a waste of time. //

4. Lack of staff

Participants reported a lack of locum staff to cover for absentees which resulted in them covering for these occupational therapists in addition to their existing workloads. Absenteeism was associated with working mothers by one group, when they unexpectedly took leave to attend to their un-well families.

F1: FM: 10 // Another thing which is tough in the medical side is that three of the staff have young kids, so when the kids are unwell they take time off and a lot of pressure goes to the likes of AE, its something unplanned but getting a call saying I’m not coming AE can you deal with it, which is unfortunate, so that’s tough. //

Shortage of staff was also attributed to the high occupational therapy staff turnover in the area of acute care. Participants also felt that it was a trend to have high OT staff turnover in acute care, a factor they considered so dissatisfying that they were thinking of leaving too.

F3: C: 11 // Staff turnover. People don’t stay for too long. It’s different now but when people leave, they do that at once. You just feel like this kind of change is going to happen any time. //
F2: Am: 20  // The fact that there is high staff turnover in acute care area doesn’t motivate you to stay either. So people end up moving after staying for one or two years because that’s what everyone does. //

5. Organizational Issues

A range of organizational problems such as lack of adequate funding to cater for all the patients’ equipment needs, lack of adequate affordable parking space for staff, politics of the public health system and failure to recruit key staff such as charge nurses and senior occupational therapists were identified.

a) Bureaucracy and red tape

Participants from one group found dealing with bureaucracy and red tape on issues relating to equipment funding frustrating and thought that organizations put priorities on making profits at the expense of quality patient care. The most dissatisfying issue was the politics involved in the whole health system and funding system as expressed by one therapist:

F1: FC: 9 // One big thing has to do with politics in the health system and funding. Families are hard on your back expecting you to meet their relative’s needs even if they don’t meet the criteria and all that kind of stuff. //

b) Occupational therapy staff cuts

Participants reported a reduction in the overall occupational therapy staff working in acute care area. The staff shortages resulted in mounting pressure on the remaining acute care occupational therapists to deal with an increased patient turnover. They felt that the quality of their work was reduced to mere basic assessments due to the increase in demand of their services against an acute shortage.
F3: Ly: 11// Case loads. Recently we have had numbers of acute care occupational therapists cut yet we are seeing the same number of patients or more. The management expects us to carry out safe discharges yet we can only do basic assessments. It’s impossible for us to do functional assessments. //

c) Shortage of adequate staff vehicles parking space

It was dissatisfying for participants from two groups from the same organization, for organizations not to provide adequate and affordable parking space. Participants were therefore forced to come to work earlier than their normal starting times in order to find free parking space. Readily available parking space at their organizations was considered too expensive and beyond reach of participants as two participants put it:

F3: E: 13 // Its not part of the pack. You have to pay for parking or else you come early. My day starts at 6 am. That’s my choice but the car parking here is expensive. It was okay if we could get public transport. //
F4: Ly: 18 // Its hard finding parking here. We start at 7:30 am and we get here when all parking is filled. We have to park away from hospital and walk long distances. //

6. Pace of work

While the pace of work was a positive factor as already discussed, it was also seen as negative. High patient turnover in acute wards put a lot of pressure on occupational therapists, as they had to ensure that patients were safely discharged against a background of patients’ short bed stays. Closely linked to the issue of fast pace was a reduction in the quality of their service which participants felt had been reduced to simply, discharge planning. Participants expressed the amount of commitment they gave to ensure that work was done. The sacrifices they made included missing out on meal breaks such tea and lunch breaks.
7. Limited occupational therapy role

The scope of occupational therapy practice was reported to be limited in the acute care area. The reason stated was the medical model of approach used in acute wards. This was interpreted as a model that focuses on disability rather than a holistic approach one that favoured occupational therapy practice.

Participants felt that the medical model used in the acute care did not allow them to focus on function because patients are discharged as soon as their medical conditions improve. Doctors were singled out as mainly focusing on medical condition and disregarding patients’ function. The following were therapists’ perceptions and interpretations of the medical model:

F3: Kt: 11// Yeah, I think with people using the functional model such as occupational therapists when working with say neurological conditions, doctors focus on the disability and totally disregard function. The hospital clearly operates along the lines of disability rather than function. //
F2: Am: 13  // Because we do work on a medical model really in acute, patients are there for a short time then we end up looking at the patient from a medical model point of view, not the whole person. //

Occupational therapy role was also limited by the multidisciplinary team approach used in acute care areas. Participants interpreted the multidisciplinary team approach as having rigid inter-professional boundaries, maintaining specific professional activities and allowing little interchange of information between professions.
F2: M: 14 // It has to do with the functions of a hospital where specific roles are assigned to particular professions like doctors look at drugs, surgeons at operations, physiotherapists walking patients, social workers organizing supports, so occupational therapists are left with nothing else except equipment. //

Participants went further to define the broader occupational therapy role in acute care:

F2: Am: 15 // Its around function, for example shortness of breath and how they function with activities of daily living. I don’t get that time to look at the patient holistically, the social and home environment, home visit and appropriate equipment. //
F2: Sc 16 // … I view occupational therapy role as client centered, do rehab and make recommendations, housing modifications, not just equipment. //

8. Resources

Participants were dissatisfied with lack of specifically allocated treatment areas for them in acute wards. This lack of treatment space resulted in participants carrying out bedside assessments and treatments as compared to more functional assessments and treatments such as kitchen tasks and self-cares. A shortage of occupational therapy staff against a high patient turn over was reported as having reduced their work to just equipment provision.

a) Shortage of treatment space

Shortage of adequate treatment space such as consulting rooms and therapy kitchens in acute wards had forced participants to share bedsides as treatment areas with physiotherapists, which was regarded as creating role confusion for patients. The participants suggested the use of occupational therapy specific assessments such as kitchen tasks and self cares.
b) Shortage of human resources

Reductions in overall acute care occupational therapy staff against a background of increased patient turnover was interpreted as having reduced the quality of occupational therapy practice

F4: C: 14 // The organization by cutting down on acute care occupational therapy staff, it has reduced our work to simply equipment people because of the increased workload and reduced patients’ hospitalization. //

9. Limited patient contact

High patient turn over and reduced bed stays in acute care meant that participants had limited knowledge about their patients due to short time frames. Another concern was that there was no follow up for patients discharged from the wards.

a) Short bed stays

Participants reported a reduced time allowance for them to see patients due to early discharges. They found it difficult to get to know their patients well enough to effect change in patient’s functional status.

F1: AE: 9 //.. The fast pace and high turnover, you don’t come to know your patients very well but in rehabilitation you get to know your patients very well. Just in 20 minutes you have to do everything, you don’t have to know what really happens and no idea how they cope once discharged. //
F1: K: 9 //… sometimes when we send out paperwork for equipment we do not really know whether they have received the equipment or not. Lack of feedback makes it hard to know. //
c) Safety

Participants felt it was their responsibility to ensure a safe discharge for patients despite early discharges. Participants ended up following up patients on their own time.

F1: FC: 12 // Its an issue when they go home. It’s a big responsibility on our shoulders especially if something happens at home. They are just pushed out too quickly and on certain times you will have to go outside the circle to contact them on your own time to ensure that they are safe at home. //

10. Pay

Participants reported low pay among acute care occupational therapists as a source of dissatisfaction. Low pay was interpreted as lack of value of their role by management and created no incentive for occupational therapists to continue practicing. Participants were still paying back student loans and hence the money was not enough to meet other life demands.

F4: C: 19 // You know these student loans are horrendous, and we are just not paid enough. //
F4: S: 9 // Yeah, its an issue especially with student loans, renting is very expensive and the money is not enough. //

There were different rates of pay even for people who had similar experiences.

F2: Am: 21 // Even among the occupational therapists the difference in pay is phenomenal depending on the job you got. I think we are underpaid and I think its lack of incentive. //

However, even though low pay was listed in most group discussions at the end, it can be concluded from the above participant’s perceptions, that it was a topical issue and
highly dissatisfying. The participants related low pay to lack of recognition of their services by their employers, which can be a possible factor for attrition.

Main issues identified as dissatisfying to participants related to scope of their practice and working in multidisciplinary teams. They expressed dissatisfaction with the reduced scope of their practice that was due to increased patient turnover and organizational policies that emphasized cost containment. In addition, cost containment resulted in low salaries and cuts in occupational therapy staff numbers. Also, there were problems with working in teams such as communication obstacles, lack of professional recognition and role ambiguity whilst working in multidisciplinary teams.
CHAPTER SIX

STRATEGIES TO RECTIFY JOB DISSATISFACTION

The third research question sought to explore the participants’ perceptions on strategies that could be implemented to address aspects of their job dissatisfaction or maintain their job satisfaction. The following summarizes the participants’ interpretations of possible strategies.

1. More staff

Participants felt that increasing occupational therapy staff numbers had the potential to reduce the pressure of work. Increasing staff also meant occupational therapists will manage their work more effectively as they will have manageable caseloads. Increasing acute care staff was suggested as having the potential to improve the quality of the participants’ service. More time will be allocated to individual patients and opportunities to carry out functional assessments would enormously increase. The following were therapists’ suggestions:

   F3: S: 14 // With more staff you start getting more time to work with patients and some rehab and not just discharge. Start to make use of the skills learnt in school. //
   F1: K: 16 // The more staff we get then the more time we will have to do functional assessments. //

2. Broaden nature of practice

Acute care occupational therapists suggested use of more holistic approaches in acute care to replace the medical model approach. The approach suggested was the Model
of Human Occupation, which participants felt that it allowed them to carry out a holistic approach when carrying out functional assessments and treatments.

Acute care wards were blamed for employing the medical model of approach in the management of patients. Participants disliked this model because it focused on the patient’s impairments. Many therapists felt the Model of Human Occupation (MOHO) suited their practice since it addresses patient’s function. Participant F3 gave a close analysis of the strategy:

F3: Kt: 14 // We would like to use the Model of Human Occupation which is more holistic than the medical model, so with more staff we will be able to do that. We can show what we can actually do as occupational therapists. Show the managers that this is what occupational therapists do in addition to discharge planning. I think we have a lot of equipment thing but OT is changing and the perspective is changing. //

3. Role clarity

There was a strong perception that acute care occupational therapists needed to take a proactive role towards educating doctors, patients and other members of the multidisciplinary team on the occupational therapy role in acute care. In order to clarify their role, occupational therapists need to use assessments and treatment approaches which are distinct and not overlapping with any other profession’s role.

a) Clarifying occupational therapy role to patients

F2: Sc: 18 // . and making ourselves distinct by doing things others do not do like transfers where we work with physiotherapists and people end up thinking that we are physiotherapists. But we become distinct by doing things like kitchen assessments, activities of daily living assessments, we will make our profession distinct, “like this is our role”. I think that helps. //
b) Clarifying the occupational therapy role to members of the multidisciplinary team

F3: S: 15 // Taking full control of what we do, being clear of what we do as well as implementing the occupational performance model. //
F1: AE: 16 // If nurses refer a patient for a walking frame, you tell them straight away that you don’t do that. //

c) Clarifying occupational therapy-physiotherapy boundaries

Participants felt strongly that they were loosing a lot to physiotherapists in terms of professional recognition, which was blamed on blurred boundaries between the two professions. They suggested that occupational therapists needed to continuously educate physiotherapists about their scope of practice as a way of clarifying practice boundaries that exist between the two professions. Participants gave their experiences and initiatives they had adopted in their work places to clarify their frames of practice.

F4: S: 14 // We are going to have combined in service training with physiotherapists just to highlight the issue of boundaries and find out which way we are going as occupational therapists. //

It was vital to the participants to explore other therapists’ opinion on their role in acute care area, on equipment issues, models of practice and professional practice boundaries between occupational therapists and physiotherapists.

F3: C: 16 // One of the things we are doing together with E is trying to gather information on the role of occupational therapy and try to clarify what we do, the issues surrounding equipment and all the models of practice we use and all issues pertaining to doubling up by physiotherapists doing the same thing. So we are trying to find strategies to run away from that. //
4. Ongoing education

a) This referred to taking learning opportunities such as attending external or internal courses or refresher courses as a way to keep informed with current trends and demands of the occupational therapy practice. Rotation was also suggested as a good learning strategy. Participants recommended that this should extend to areas such as community occupational therapy and rehabilitation other than just acute wards as was the case in their work areas. Extension of the rotation will broaden their knowledge to more specialized practice areas. The therapists felt the onus was on them to initiate and take up learning opportunities to keep pace with changes happening in the acute care area. This was possible because of increased opportunities to attend courses.

F2: Sc: 10 // Ensuring that we take opportunities to learn more that helps you keep pace with the work and change in the work area and also you keep learning more. //
F4: C: 8 // The chances to attend courses has significantly improved in the last two years. //

Rotation was recommended as a good learning opportunity for participants who wished to cover not only acute wards but also areas such as community and rehabilitation. Therapists felt that rotation had the potential to broaden the base of occupational therapy knowledge.

F2: Sc: 11 // Rotation, which doesn’t happen here, but if that happens it will be interesting like moving from medical to orthopaedics because of differences in work. Not only rotation in the wards but working as community occupational therapists and the like, rehab. Introducing those kind of rotations could be beneficial. It will give us opportunities to learn about what’s happening in other settings. //
F2: M: 11 // The rotation will definitely increase our base of occupational therapy knowledge by experiencing challenges on other settings. //
b) More Funding

Participants acknowledged that public hospitals were poorly funded but emphasized the importance of making educational opportunities available to participants to enable them to gain knowledge on specific areas.

F2: Am: 12 // More educational opportunities, I know the public health system does not have a lot of money to splash around but it will be nice to get opportunities to enable us to gain knowledge about specific areas. //

5. Self-management

Participants recommended self-management as a strategy to overcome or avoid the stress that was associated with working in the physical acute care setting. This included, time management, taking breaks or holidays; socializing techniques such as going out for lunch as a team and being assertive with the supervisors regarding the amount of workload one can manage.

a) Time management

Good time management was interpreted as taking breaks, holidays and prioritizing tasks. It was suggested as a strategy to rectify job dissatisfaction or maintain job satisfaction

F3: S: 7 // Making sure you take your breaks. //
F1: JW: 14 // Make time available for everything. //

b) Team building

This involved going out for lunch as a team, buying each other presents as well as helping each other with caseloads.
F3: E: 6 // You find out that there may be someone really busy and 3-4 wards being quiet. We just turn up in large numbers and bless that ward by helping out, so that by the end of the day they feel relieved. That’s where the issue of priority also comes into place. You will only see high priority ones. We sort of know what happens in all the wards due to the rotation so it’s easy to help out. //

c) Stress management

It involved knowing how to identify and deal with stressful situations or stressed members of the team. The symptoms of stress as mentioned by participants included staying away from group lunches, becoming grumpy, not answering locators and not taking breaks. Strategies participants used or suggested involved informal counselling amongst themselves, seeking help from others and start of day meetings meant to review each therapist’s workload for that particular day.

F3: K: 6 // If a team realizes that someone is stressed, we will have a chat, talk about it and you may realize that its nothing serious. //
F2: Am: 10 // Being honest with the professional leader and if you are not happy you can tell her. The professional leader is there so that you can find someone you can turn to. //
F3: C: 6 // Every morning we have meetings where we try to catch up with everyone and that’s where people can open up. //

6. Occupational therapy promotion

Promotional opportunities for the occupational therapy profession included advocacy through setting up an annual national occupational therapy day, having an effective team leader, providing in-service training to other multidisciplinary team members and being distinct in terms of using specific occupational therapy tools for assessments and treatments.
a) Advocacy day

Marketing of occupational therapy profession requires a national approach to it. One suggested strategy was the national occupational therapy day annual commemoration. Participants felt setting aside such a day will enable them to educate people at a nation wide level.

F4: S: 15 // Have an occupational therapy day where we talk about occupational therapy to many people, advocating for the good of our profession. It promotes the profession. We also talk in health education seminars and we also educate them. //

b) Case by Case Approach

Educating people as therapists encounter people without knowledge about occupational therapy was suggested as an effective strategy. Two therapists gave details of their experiences in particular situations.

F3: C: 17 // Like a few weeks ago, a patient was sent home before myself and physiotherapist saw the patient. I made a follow up phone call to the patient only to discover that the patient was not managing at all at home. The patient ended up being readmitted to the ward. That was great. //
F2: Sc: 18 // Embark on promotional opportunities for OT (occupational therapy) whenever we get a chance. Like last week I attended a seminar and was asked to talk about OT and what we do, I really liked it because sometimes people don’t know what we do and its not their mistake, maybe they have not been told and I think its our job to tell them. //

c) Team Building

Interpreted by one therapist in terms of educating doctors and other allied health workers on the role and value of occupational therapy in order to foster understanding and co-operation from them.
F3: 5: 10 // ……previously I worked with junior house surgeons when they were just starting, I always explained to them the value and role of occupational therapists whenever an opportunity arose. I managed to mould them, some of them, and now some are nearing consultancy level. This applies to junior and new nurses coming to the ward through creating a good rapport with them and explaining the occupational therapy role and you end up getting appropriate referrals. //

d) Effective Occupational Therapy Department team leader

According to participants the value placed on each department depends on the effectiveness of the team leader in management issues. It was therefore recommended for occupational therapy teams to have effective leaders in order for the occupational therapy profession to earn any recognition.

F4: C: 8 // Leadership is vital; it makes us what we are. We are valued depending on the leader we have. It has been difficult having a supervisor and manager being the same person because it’s difficult to separate the two roles. The situation ends up being stressful. //

e) Assertiveness

Acute care occupational therapists have to take full control of their roles and employ an occupational performance model in their work. Participants felt that the respect or treatment received from their work colleagues was a result of how they presented themselves to the rest of the team. The value attributed to them was a mirror of the contributions they made to their work.

F4: Ly: 15 // It has much to do with what we want as occupational therapists and then stick to it. A lot of it is how we present ourselves. //
f) Incident and accident reports

Completing incident and accident reports for every patient sent home without input from occupational therapy when there was need to do so, was put forward as an effective way to attract the management’s attention into participants’ plight. It was seen as having a potential to reflect to management about occupational therapists as worthy members of the team.

F3: E: 17 // Incident reports and accident reports for patients who go out of the ward and we haven’t been involved even if there was need. Incident reports to try to push it a little bit more. The more we do this the more they become aware of our plight. //

7. Funding

Increasing occupational therapy budgets to cater for adequate equipment provision and improving occupational therapy salaries was perceived as a strategy that could improve acute care occupational therapists’ job satisfaction.

a) Addressing patients’ needs

The bureaucracy and red tape within the public health sector was very frustrating to participants as they found it difficult to meet all their clients’ needs. There were set criteria for getting equipment for patients and found relatives of patients not cooperating with them if they did not meet the criteria. Participants felt that the hassles were going to be reduced by making more money available to cater for all patients’ needs without following an inclusion or exclusion criteria.

b) Increase salaries

Participants suggested they were getting poor salaries, not enough to cater for their student loans, parking and expensive rentals. Participants regarded good salary as essential for their morale and as an OT retention strategy for use by employers.
F3: Kt: 17 // Increase pay to keep us happy. That’s why we are working//
F2: Sc: 21 // I think the hospital needs to increase pay for acute care occupational therapists and work towards specialization opportunities if they want to retain therapists. The hospital needs to show the therapists that “this is their future”. //

It can be concluded from the above precepts that low pay was directly related to low morale and regarded as major source of attrition for occupational therapists working in acute care area.

The main recommendations made to address the participants’ job dissatisfaction were directed at the occupational therapists, their current and future employers. The strategies that participants thought could be addressed by occupational therapists were, clarifying their role in physical acute care setting, promoting the profession of occupational therapy and participating in professional development courses to enhance their practice skills. Self-management skills such as time, stress and team building skills were identified as essential for occupational therapists to practice in the acute care setting. Employers were also urged to increase budgets for occupational therapy activities such as professional development, salaries to make their job more attractive and as a form of professional recognition and increasing the numbers of occupational therapy staff in the acute care. Increasing occupational therapy staff was perceived as having the potential to allow them to implement learnt practice models in their practice.

**Summary**

It was clearly demonstrated that teamwork and the nature of occupational therapy practice were key issues that impacted on job satisfaction and job dissatisfaction. Also, the strategies that were recommended to address job dissatisfaction were mainly aimed at improving occupational therapists’ capacity to work in multidisciplinary teams and expanding the scope of physical acute care occupational therapy practice. It was evident that patient care, the fast pace of work, autonomy and support received from some members of the multidisciplinary and occupational
therapy teams were key factors that influenced the participants’ job satisfaction. The structured working times and environment was also a positive impact. Major sources of discontent included multidisciplinary teams and the nature occupational therapy practice. The multidisciplinary teams were identified as a place characterized by inter-professional communication obstacles, competition for professional recognition and role ambiguity. Furthermore, health care policies such as reduced in-patient bed stays and cost containment reduced the scope of occupational therapy practice and implementation of the traditional occupational therapy models of practice.

The participants expressed strong views on what they viewed as pivotal ways to address problems they encountered in the multidisciplinary teams and to overcome the limitations in their practice. There was a general consensus that participants needed to clarify and execute their role clearly and effectively within multidisciplinary teams as a way to promote the profession. In addition, self-management skills such as team building, stress, time and work prioritization were identified as important to ensure an effective discharge of physical acute care occupational therapy services. The same skills were also identified as vital for teamwork. It was clear that participants needed to broaden their practice by undertaking professional development courses in order to acquire skills needed to keep pace with the fast changing trends in their practice. Overall, teamwork and the expectations the team had of the occupational therapy role were the main factors that influenced the participants’ practice.
CHAPTER SEVEN

DISCUSSION

The data analysis has revealed the importance of two key factors that impact on occupational therapy practice in acute care. The factors are: working in multidisciplinary teams and occupational therapists’ expectations of their own professional practice. This chapter will discuss teamwork and occupational therapy practice with reference to the study findings and evidence from previous literature.

Teamwork

In this study, teamwork was a major factor that contributed to a satisfactory work environment for occupational therapists. Their ability to offer effective health care services was influenced by their ability to work in such an environment.

According to Wilcock (1998) teams came into existence in health care settings because of a desire to modify the hierarchical medical model that was in existence during the 19th century. In the hierarchical system, the doctor was in control of patients’ management, made all the important decisions and decided which therapist was to be involved in care on a case-by-case basis. There was a need to address the impact of the illness experience on a patient’s occupational performance because occupation was considered to be central to human functioning (Wilcock, 1998). It therefore made sense to incorporate all disciplines whose care was vital in addressing the multiple problems patients presented with. Medical input into rehabilitation planning can be a relatively minor part of the overall picture and as a result there was a strong desire to reduce the medical role in controlling decisions (Wilcock, 1998).

Teamwork recognizes that patient’s needs cannot be addressed adequately by one discipline (Opie, 1998). In principle, the team becomes the place where a more holistic perspective about a patient’s needs are reached through inter-professional
collaborative pooling of information as well as information gathered from the patient or family. Consistent with this view of merging of complimentary skills Baldwin (1919, cited in Muller (1989)) defined teamwork as a ‘special form of interactional – interdependence between health providers, who merge different but complimentary skills or viewpoints whilst providing service to the patient, in search of a solution to his or her health problems’ (p.122). Teamwork is valued for its ability to increase professional accountability through joint work, contribute to greater job satisfaction (Clark, 1998; de Silva, 1992; Jenkins, 1991; Nordholm & Westbrook, 1986; Solomon & Mellor, 1992; Taylor et al., 1995), reduce errors (Poulin, Walter & Walker, 1994), respond to complex and interdependent tasks (Shortell & Kaluzny, 1997; 2000) and contribute to greater creativity in developing care plans through sharing of discipline specific knowledge about a patient (Toseland et al., 1986). More so, there has been a demand to network resources and for health workers to work in teams in order to ensure a provision and delivery of quality health care (Hornblow, 2003). However teamwork needs to be nurtured by involving multiple stakeholders such as patients or family, health care professionals and employers.

According to Opie (1997), failure to safeguard operations of teamwork can result in inter-professional conflicts that can significantly undermine organizational objectives. Previous studies conducted on occupational therapists elsewhere have identified inter-professional communication obstacles as an example of conflicts that can arise in teams (Brown, 1995; Jenkins, 1991; Nordholm & Westbrook, 1986). Participants in this study also shared these views when they recommended the need for an active involvement of employers, therapists themselves and other health care professionals such as doctors and physiotherapists in safeguarding healthy working environments through participating in team building. They suggested recognition of every profession’s contribution, respect for professional practice boundaries and effective inter-professional communication as vital to team building. Ideally there is disciplinary equality and not the privileging of input of dominant disciplines, for instance doctors as reported in the current study.

Participants in the current study identified that they worked in both occupational therapy and multidisciplinary teams. They reported significant satisfaction working
with the occupational therapy team and some selected members of the multidisciplinary team such as social workers and speech and language therapists. However some professional misunderstandings existed between occupational therapists and doctors or / and physiotherapists. Physiotherapists were reported to be trespassing on occupational therapists’ professional practice boundaries and doctors were blamed for failing to recognize occupational therapists’ contributions towards patient care. The role of an occupational therapist as indicated by Kielhofner (1999) involves addressing the impact of the patient’s illness experiences through use of purposeful occupations rather than illness itself. In the study doctors were considered to be focusing on the medical condition and disregarding the impact of the illness on occupational performance. This difference in orientation between occupational therapists and doctors can be a possible reason for doctors failing to appreciate occupational therapy practice in acute settings. Previous literature supports the interprofessional misunderstandings that exist between occupational therapists, physiotherapists or doctors (Atwal, 2002; Brown, 1995; Fortune, 2000; Golledge, 1998; Griffin & McConnell, 2001; Hagedorn, 1997; Nordholm & Westbrook, 1986).

Mandy (1996) classified teams found in health care settings as either multidisciplinary or interdisciplinary teams. Although available evidence indicates that teams operating in acute physical health care settings are multidisciplinary teams (Atwal, 2002; Craig et al., 2004; Griffin, 1993; Griffin & McConnell; 2001), it is useful to define what the two types of teams mean, as there is confusion as to their definitions. An interdisciplinary team can be defined as a group of persons who are all trained in the use of different tools and concepts (Luszki, 1958). The discipline-specific boundaries are relaxed and there is easy transference of knowledge contributing to the creation of new team knowledge. Team members understand each other’s role and often recognize areas of overlapping roles. Understanding of each team member’s role helps members to tolerate different perspectives and where conflict arises resolution is achieved through role negotiation.

A multidisciplinary team can be defined as a group of health professionals from different disciplines who meet together to discuss the management of clients that they treat individually (Semlyen, Summers & Barnes, 1998). It is characterized by
discipline-specific goals and measures and professional autonomy. There is usually an unwritten understanding of what activities are owned by which discipline with no transference across discipline boundaries. The concept of a multidisciplinary team is rigid in the sense that each member of the team is required to assess every client prior to a management plan being agreed upon. The multidisciplinary team is the standard team structure in health care settings (Semlyen, Summers & Barnes, 1998).

A close analysis of the multidisciplinary team concept reveals that it is flawed because each individual remains discipline-specific and team members may therefore fail to see important synergies and efficiencies through co-operation with different disciplines. The different professions operate in parallel lines rather than intersecting points where there is a transfer of knowledge. According to Deber and Leatt (1986), a common source of misunderstandings in multidisciplinary teams is a mismatch between expectations of team members regarding equal participation in the team and the reality of unequal status. This mismatch creates a sense of role deprivation for some members with accompanying implications for job satisfaction. Furthermore, previous studies suggest that occupational therapists leave the profession because of unmet career expectancy (Bush et al., 1993; Nordholm & Westbrook, 1986; Sutton & Griffin, 2000). To add on, Bush et al recommended the incorporation of self-efficacy content into professional, practice courses and clinical supervision in order to create realistic self-perceptions during students’ fieldwork experiences.

There is an extensive literature in the field of occupational therapy, of both inter- and intra-professional rivalry for example conflict of jurisdiction, unequal power–relationships, communication barriers, differences in professional status and role ambiguity (Atwal, 2002; Fossey, 2001; Golledge, 1998, Jenkins, 1991; Maskill, 1995). Inter-professional working can be constrained by unequal power relations between professions and this can have a direct effect on service delivery. Opie (1998) described teams as possible sites of disciplinary contests and power struggles conducted across personal and professional planes. In her conclusion, Opie (1998) stated that teams are divided and fragmented by disciplinary power, knowledge claims and the desire to protect their professions.
In the current study participants reported working in multidisciplinary teams and indicated that doctors had a significant status in the teams. This inequality in power resulted in lack of recognition of therapists’ recommendations on the care and discharge planning of patients. Conflict of jurisdiction is common in multidisciplinary teams when there are no clear professional boundaries between different professions. Previous studies and the current study point to blurring of boundaries between occupational therapists and physiotherapists, social workers and nurses (Atwal, 2002; Golledge, 1998; Hagedorn, 1997). Physiotherapists were pointed out as the biggest threat to occupational therapy existence because participants reported them to be incorporating concepts such as use of functional activities in their practice, which is regarded as being central to occupational therapy practice. Previous studies (Finlay, 2000; Griffin, 1993; Mandy, 1996; Opie, 1998) and current findings suggest multidisciplinary teams can be battlegrounds identified by inter- and intra-professional rivalry, supremacy of individual professions and role ambiguity. According to Shortell and Kaluzny (2000), problems in teams are natural and can never be avoided and if not addressed can have a negative impact on organizational performance.

Part of the health care changes demand that health professionals re-define their roles in order to sustain their existence. Shortell and Kaluzny (2000) argued that there is high demand for flexibility in professional teams and at the same time a greater need to protect professional boundaries by redefining their practice jurisdiction. There is evidence to suggest that occupational therapists lack a clear role in multidisciplinary teams (Maskill, 1995; Snell, 1997). In multidisciplinary teams, members jostle with each other for professional recognition in order to justify their existence especially when operating under restricted budget systems. It is under these circumstances, that occupational therapists feel threatened with extinction or being absorbed by other professions (Clemence, 1998; Feaver & Creek, 1993; Hagedorn, 1997; Johnson, 1995). Findings from the current study also suggest strained working relationships in some teams where participants were dissatisfied with lack of professional recognition from other team members.
Mandy (1996) discussed the issue of professional misunderstanding from two main causes: conflict of jurisdiction and status. According to Mandy (1996), each profession has its activities under jurisdiction for instance, in acute care occupational therapy activities such as self-cares, household task management and cognitive interventions provide the cultural machinery of jurisdiction (Craig et al., 2004). This is how professional practice boundaries are established. After defining its boundaries, ideally, a profession asks society to recognize its exclusive rights to an area of knowledge and expertise. These claimed rights may include absolute monopoly of practice, control of professional training and licensing. An example is the New Zealand Occupational Therapy Board that is entitled to oversee the licensing, practicing and training of occupational therapy in New Zealand. Conflict occurs between professional groups when they claim similar areas of jurisdiction. The claim may be done indirectly with the intention to help the client. A lack of understanding of the nature of education and practice between health professionals perpetuates the problems of professional boundaries and inter-professional suspicion (Mandy, 1996).

Foto (1998) stated that changes that occur in the health care sector modify professional boundaries and suggested that the changes should benefit the clients being served. She urged both occupational therapists and physiotherapists to compliment each other and thus enhance overall rehabilitation services. While, the ideal is that people share their professional expertise for the benefit of the client, the reality is that teams are social constructions where intra-professional and inter-professional issues need to be managed carefully to ensure effectiveness. This focus deviates teams from their primary purpose and goals. Opie (1998) in her investigations of multidisciplinary teams in different settings in New Zealand found problems in teams, which related to a lack of inter-professional, trust and complicated power relations between professions. Problems also related to a lack of clear structures, directions and goals both for the team and service users, dominance of certain professions in defining patients’ needs and lack of continuity of members.

There are different approaches taken to the issue of lack of status in teams. Maskill (1995) and Gooder (1997) advocated for occupational therapists to take a more robust protectionist approach by openly challenging those trespassing on their practice
boundaries. On the other hand Creek (1999) argues that articulating the occupational therapy role is not necessary because the history of its existence in the health sector is enough to justify its usefulness to service consumers, thus the occupational therapy profession remains in existence because of being useful rather than powerful. A strategy consistent with proving worth is for occupational therapists to apply their unique and core skills with the utmost expertise for the benefit of the patients (Golledge, 1998; Mattingly & Fleming, 1994). Foto (1998) and Clemence (1998) also urge that the differences that exist between the occupational therapy and physiotherapy create value and quality of care to their clients. They urged both occupational therapists and physiotherapists to reject any external influence aimed at blurring what they described as clear inter-professional boundaries based on a historical perspective of the two professions. In addition, they recommended that both professions should safeguard their practice by making the client the centre of their decision-making because both professions owe their existence to providing services to clients.

Brown and Greenwood (1999) suggested that trends indicated increasing role overlap between physiotherapy and occupational therapy. The reasons cited for the inevitable role overlap between the two professions were that both professions share a common knowledge base in anatomy, physiology, human growth and development, biomechanics and ergonomics. Despite this biomechanical perspective of similarities, occupational therapy and physiotherapy are different in their practice. Occupational therapy practitioners recognize the importance of engaging clients in meaningful and relevant occupation-based activities to facilitate health and wellness whereas physiotherapists, Sherer (1997), focus on the human trunk and lower limbs and use physical modalities such as electrotherapy and exercises to enhance well-being.

It is important to note the discrepancy that exist between the demand for flexibility in health care teams and the recommendation made by Maskill (1995) and Creek (1999) for both physiotherapy and occupational therapy to protect their boundaries. Also, there is an increasing trend of role overlap between occupational therapy and physiotherapy (Foto, 1998), which further complicates the idea of professional protectionism. Flexibility in practice is consistent with the trend towards role overlap between the two professions.
Inequalities in professional status were cited in the study as a cause for the communication barrier that existed between doctors and occupational therapists. One therapist summarized her perception of the relationship that existed between occupational therapists and doctors:

// I don’t think that doctors do not know what we do, they do but they do not put any importance on our role more than they do with physiotherapists (sic). // (F1: FC: 7)

This participant perceived her status as being lower than that of physiotherapists and indicated that doctors were viewed as being the most powerful members of the team as shown by the jostling for recognition expressed by therapist FC. Research findings are fairly consistent in showing that high status members initiate communication more often, and have more influence over the decision-making process (Owens, Mannic & Neale, 1998). Shortell and Kaluzny (2000) defined status as “the measure of worth conferred on an individual by a group” (p. 166). The relative status of individual professional groups is achieved by salary and education especially for the medical profession. One reason for lack of status may be the high percentage of female occupational therapists in the profession (Mandy, 1996) that is more than ninety percent of registered occupational therapists practicing between 2000-2002 were females (Fraser, 2002).

One way of dealing with lack of status was to promote the profession by constantly educating team members about its role. Suggestions put forward were being assertive about the occupational therapy role by both doing the job well and by speaking up in the multidisciplinary teams on behalf of the profession. Improved knowledge about occupational therapy was perceived as having a positive influence on their professional status. It can be concluded that there were mixed feelings regarding teamwork. Working in teams can be positive because it allows pooling of skills together, provides a social environment for providers to interact with each other and sharing of patient caseloads. However, a closer analysis of the multidisciplinary team, as reported in this study indicates that there are many problems associated with the
multidisciplinary team. The problems were the lack of role clarity, inter-professional communication barriers, inter-professional rivalry and poor working relationships. Therefore teamwork, despite the positive gains for health care organizations, remains a key factor impacting on job dissatisfaction for occupational therapists working in physical acute care occupational therapy environments.

**Occupational therapy practice**

The second theme that arose from this study was the nature of occupational therapy practice. Participants identified that the scope of their practice in the physical acute care settings was limited by a number of factors. This section outlines and discusses these factors and how they impacted on their practice.

The first formal definition of occupational therapy was given by a medical doctor with the intention to reinforce the role of occupational therapy as a prescribed profession. Occupational therapy was defined as “any activity, mental or physical, definitely prescribed and guided for the distinct purposes of contributing and hastening recovery from disease or injury” (Pattison, 1922 p. 19). Available evidence indicates that occupational therapists welcomed the prescription system and it has become the normal practice in most health care system (Griffith, 1988; Serret, 1985). The above definition places occupational therapy as a profession dependent on the medical profession for its existence and based entirely on a biomedical orientation.

Previous literature indicates that prior to the biomedical influence, occupational therapy was grounded in the humanistic, traditional methods of intervention. Art and craft were commonly used approaches to treatment. The profession gave in to the medical pressure that questioned the efficacy and scientific basis of occupational therapy (Wilcock, 1998). The profession responded by adopting a more physiologically based approach in order to justify its presence in a medicalized health care setting. It is during this shift that the occupational therapy profession adopted the medically oriented approaches such as the biomechanical, neurological and the psychoanalytic models. When using the biomechanical approach, occupational therapists focus on the mechanical body and factors such as range of motion, strength
and endurance and how these factors influence occupational performance. These models are reductionist in nature in that they focus mainly on the physical limitations of the disability (Rogers, 1982).

Findings from the current study indicate that medical patronage is accepted as important to occupational therapists in acute care. One therapist illustrated this as quoted below:

// I like working with Post Traumatic Amnesia patients because my charge nurse has given me the right to decide when to discharge even against doctors’ decisions. Occupational therapy is the bottom line when it comes to PTA. So it depends on the charge nurse, mine is good, twice I have told the doctors not to discharge and was successful. I think PTA wise we have got a lot of influence on the medical side, which is very important but it depends on the people you work with. // (F1: FM:8).

Thus she gained respect and recognition by using a bio-medically based assessment tool. McCallin (1999) notes that professional recognition and respect are earned from peers when competence is established in performing a particular role. According to Kielhofner (1999), competence involves the ability to identify patients’ problems, understand the nature of the problems patients face and knowing how to address these. Occupational therapy practice in the area of brain injury was well accepted and understood by the medical profession because the therapist used a neurological model of practice whose foundation is based on the medical profession. The above illustration also highlights the issue of prescription that happens in the acute care setting and the continual reliance of occupational therapists on the use of the medical diagnosis when carrying out their assessments and intervention.

Findings from the current study and previous literature indicate that there is a strong influence of the biomedical framework on occupational therapy practice (Craig et al., 2004; Griffin & McConnell, 2001; Griffith, 1988; Mattingly, 1994). In this study, the bulk of the occupational therapists’ work was referred to them by doctors and relied on the patients’ medical diagnosis and subsequent dysfunction as a key that oriented
them in their clinical reasoning. They judged the appropriateness of referrals based on the medical diagnosis of the patients. This finding is consistent with the fact that medical diagnosis is the most critical factor influencing how therapists assess their patients and organize their treatment plans. The medical diagnosis has also provided an initial short cut to patient management especially in fields where time is limited (Mattingly & Fleming, 1994).

Furthermore, Kielhofner (1999) stated that the medical model puts emphasis on the human need for biological wellness and survival, with doctors focusing on solving problems that threaten survival and well-being. It views the human body as a complex machine made up of parts and processes and having the potential to see inside this human machine with the use of physical examinations, x-rays, laboratory tests and biopsies (Leder, 1990 and Toombs, 1993). It also acknowledges the presence of natural laws that define the operating of different body processes. Illness or trauma is caused by disruptions to these laws and this concept guides doctors in using the biochemical and physical interventions in their approach. Kielhofner (1999) observed that the medical profession looks for the causes of the conditions that threaten the body and apply treatments designed to result in a restoration of order. Hanschu & McFadden (1981) cited by Sutton (1998) found that “the primary orientation in hospitals is to relieve pathology, which may preclude the occupational therapy perspective of occupational performance” (p.1087). Therapists in the study held the doctors responsible for focusing on the disability and lacking an understanding of their role in relation to occupational performance. It can be argued that this blame on doctors is misplaced when taking into consideration that the primary orientation of doctors in patient management is to relieve the illness. In a team, the responsibility to address the impact of the illness experience on occupational performance lies with occupational therapists (Zwarenstein & Reeves, 2000). Previous literature identified occupational therapy practice as a key source of job dissatisfaction but failed to elaborate more on the practice (Bailey, 1990; Brown, 1995; Taylor et al., 1995).

For some time there has been a drive to develop specific occupational therapy models, which can assist patients to cope with the illness experience rather than basing treatment on a medical diagnosis (Mattingly, 1994). The increased discontent
with the use of medically based models gave rise to the formation of the Model of Human Occupation (Kielhofner, 1972) which was put forward as a strategy to address the limited role of occupational therapists in the management of patients. The model of human occupation was perceived as having the potential to address patients’ occupational performance as a prerequisite for successful rehabilitation and community participation. According to Kielhofner, occupational therapists’ viewpoint is that illness or trauma happens when there is a disruption in the interaction between a person and his or her environment. When occupational therapists intervene to address a patient’s problems they seek to restore order in the relationship between the human being and the environment.

In spite of having the potential to address the occupational performance needs of the patients the feasibility of the model’s use in the acute care area remains a challenge. Therapists in the study cited the fast patient turnover as dissatisfying. The changes in health care strategies and trends do not favour the long stay of patients in acute care settings that poses a challenge to occupational therapy practice (Craig et al., 2004; Griffin & McConnell, 2001). The changes in the health care system have modified occupational therapists’ practice to adapt to the role that is expected in acute care (Griffin, 1993).

In the study, some occupational therapists reported using the compensatory approach in line with the limited time frame. These compensatory approaches included the use of rehabilitative aids and equipment, retraining in activities of daily living as well as educating patients on safe occupational performance as summed up by the following therapist:

// Giving people different options is quite helpful, sometimes when they come to hospital they think that’s the end of it. But when you show them how to get into the shower, use the toilet and they appreciate it. // (F3: C: 4).

Wilcock (1998) commenting on the use of compensatory techniques suggested that there is an increase in the use of compensatory techniques by occupational therapists in health care settings committed to fast turnover of patients. Previous literature also
supports the use of compensatory techniques as an acceptable occupational therapy intervention in settings characterized by high patient turnover (Craig et al., 2004; Griffin, 2002; Griffin & McConnell, 2001).

The World Health Organization (WHO) (2001) is consistent with this move away from a medical orientation. They have developed an International Classification of Functioning, Disability and Health (ICF) as an integrating model for researchers and providers when classifying or mapping the impact of a disease or disorder on individual functioning. The defining construct in the ICF is the health condition (previously termed disability) and its resulting effect on individual function. When using the ICF, individual clinicians are provided with an assessment structure that moves the focus away from pathology (Levack, 2004). In other words, the ICF encourages clinicians to move way from treating medical problems and towards treating the people who have them. Patient assessment can be conducted using the ICF conceptual framework to better understand the genesis of the patients’ problems from a holistic perspective. Socio-cultural as well as biomedical factors and the relationship between them can be explored when evaluating causes of problems, and therefore these factors can be considered when developing intervention strategies. The ICF language such as functioning, participation, contextual factors as well as the socio-cultural dimensions is highly consistent with occupational therapy concepts.

Therapists in the study reported having communication problems with doctors on the process of patient management. Therapists attributed this communication barrier partly due to the medical focus on patient’s management by doctors. This focus, according to the study findings, was at odds with the conceptual frameworks occupational therapists were keen to employ. Focusing on the ICF conceptual framework has the potential for all health professionals working in the acute care area to shift from treating disabilities and towards addressing the disability experiences of people. In addition, the disability and functioning terminology parallels occupational therapy terminology (occupational performance areas, performance components and performance contexts) that can support therapists to provide occupation-based interventions. However, the use of the medical model in acute care settings favours the current health care trend whereby the focus is on early discharge of patients into
the community in order to reduce spending on hospitalization (Gauld, 2001; 2003) rather than taking socio-cultural factors into account.

In the face of the changing health care system, occupational therapists need to adapt their practice to suit the prevailing conditions or else they remain, unfashionably stuck with their time-demanding conceptual models (Sutton, 1998). The time-consuming occupational therapy models used to guide the professional practice require patients’ long stay in hospital in order to be fully implemented. Researchers aimed at addressing the changing occupational therapy role have put a number of recommendations forward. Griffin (1993) urged occupational therapists working in acute care settings to redefine their role in terms of assessment and discharge planning. In a health system characterized by the need for cost-effectiveness and efficiency, providing safe and effective discharge for patients helps reduce hospital re-entry. Evidence indicates that Australian occupational therapists working in acute care settings have successfully made adjustments to their practice to accommodate the reduced patient bed stays (Griffin, 1993; Griffin & McConnell, 2001). In addition, the occupational therapy practice in acute care settings is not based on occupational therapy specific models, as they are inadequate to guide their practice but involves procedural reasoning in its ‘quick-fix’ approach to patients’ problems (Craig et al., 2004; Fleming, 1991; Griffin, 2002). Occupational therapy educators are also urged to ensure that graduates are prepared for the realities of acute care practice and that they can work quickly and efficiently to prepare patients for safe discharge (Wittman, 1990). In New Zealand, acute care is an area of service delivery where the medical model drives the delivery of occupational therapy service (Craig et al., 2004). The biomechanical approach, in which compensatory methods such as prescription of equipment and patient/family education are embedded, fits in well with the medical model. Therapists in the study reported using the above compensatory techniques and needed reassurance that their service was appropriate in the prevailing health system.

There is evidence to indicate that the New Zealand health sector has changed significantly over the past few decades when new political governments came into power (Gauld, 2001). This has resulted in fundamental changes in workplace environments that impact on health professionals’ focus and expectations.
Occupational therapy practice in such a rapidly changing context therefore requires practitioners who are flexible and able to manage change and complex situations (Mackersy, Robertson & McKay, 2003). Study findings suggest that occupational therapists are dissatisfied with the fast pace at which patients are managed in acute care settings because they are not able to apply occupational therapy conceptual models. Occupational therapists need to evaluate their practice from the perspective of the service delivery model currently required for practice. In addition, Baum (2000) encouraged occupational therapists to seize the opportunity provided by imminent changes in health care delivery models and systems and to carefully evaluate their practice. A close examination of their practice will aid therapists in identifying practice patterns and conditions that impact on use of occupations as interventions. This assists acute care occupational therapy practitioners to formulate and implement strategies that support the integration of occupation-based intervention into daily practice.

One way of conceptualizing occupational therapy practice in acute care as being occupation-based is to use the intervention continuum model that classifies therapeutic interventions along a continuum based on the purpose of the activity and the level of perceived meaningfulness to the client. According to Chisholm, Dohli and Schreiber (2000), the four stages of intervention are the: the adjunctive methods, the enabling activities, purposeful activities and occupation-based interventions. The application of these interventions vary with every practice setting but do provide a starting point for self analysis in order to meet individual practice needs. In the acute care area, adjunctive and enabling activities may be implemented because they require less time and treatment space, which is characteristic of the environment and by doing so it leads to use of purposeful activity. However, the intervention sequence depends on the needs of the client and the clinical reasoning ability of the practitioner, as there is a possibility of bypassing any of the stages of intervention. While in the ideal world an occupation-based and client-centered approach is good the reality of acute care practice refutes client-centeredness because of challenges such as high caseloads and shortened bed stays.
Summary

This chapter has discussed two key issues that arose in regards to job satisfaction and dissatisfaction that is, teamwork and professional expectations in physical acute care occupational therapy practice. Teams provided both positive and problematic working environments. They worked well and were a source of support when team members were respected and their contributions acknowledged. However, inter-professional rivalry and lack of status for individual professions gives rise to discontent. In the acute care environment, the role is clearly that of a discharge therapist. This orientation is suited to what is known as ‘compensatory’ approaches, during which aids, equipment, education or alternate methods are provided for people to safely manage daily tasks and minimise the disability. While therapists’ expectations of their role are highly influenced by their professional education, the demands of the current health care system are sometimes in conflict with professional ideals regarding their practice. Professional expectations are influenced by the current health care system and need to be updated to meet the current needs. Occupational therapy cannot be divorced from the realities of the physical acute care workplace. The ideals of professional concerns need to be tempered with the demands of the health care service.
CHAPTER EIGHT

CONCLUSION

Limitations of the study

The interpretive approach endeavours to make the meanings that circulate in the world of lived experience accessible to the reader. In the process of interpreting the meanings attached to job satisfaction by participants, the researcher also became part of the research process. According to Kemmis and McTaggart (2000), the interpretive researcher takes the identities of an advocate and cultural critic who speaks from an informed moral and ethical position. This is achieved when the researcher forms interpretations of participants’ actions and contributions from the transcribed data. The aim of the research was to provide an avenue for therapists to communicate their perceptions on the subject of job satisfaction. These interpretations are subjective and depend on the ability of the researcher to make a correct reflection of the interpretations. The interpretations must be understandable and resonate with the understandings of the participants. The researcher bias was minimized when the researcher consulted with the project supervisor throughout the study. Furthermore, the use of an assistant researcher to collect and independently analyze data ensured rigor. Member checking was carried out when the researcher took back a summary of the results to the participants for verification.

In addition, the interpretive approach assumes that interpretations are always grounded and local to the particular population being studied (Geertz, 1973). In this study a selected population of occupational therapists who were viewed as information-rich informants were involved in the study. The contextual factors for inclusion to the study were being a registered occupational therapist in New Zealand and practicing in a public hospital in a physical acute care setting. The context also
set the limits to the application of the findings from the study. Although the results can be generalized to the entire population of occupational therapists who share similar qualities to those involved in the study, the findings cannot be directly applied to therapists practicing in different health care systems. The findings from an interpretive inquiry are contextual and cannot be generalized. However, in qualitative studies the aim is to gain an understanding of a phenomena of which little is known (Strauss & Corbin, 1990). There is no published study in New Zealand on the subject to date hence the need for the study.

It is also important to note that all interpretations made are unfinished, provisional and incomplete because they change when the researcher returns to the phenomena. The previous interpretations and understanding shape the new interpretations. According to Gadamer (1975) value free interpretive research is impossible because the researcher brings own preconceptions and interpretations to the problem being studied. This situation is referred to as the circle of interpretations. However, conclusions can still be drawn although interpretation is never finished. The current study made an attempt to interpret the perceptions of acute care occupational therapists on the job satisfaction phenomena but has nevertheless not exhausted all that can be known about the phenomena. The researcher addressed this shortcoming by recommending areas for further research.

There are weaknesses in using focus groups as the only method of data collection. For instance data produced is affected by personal characteristics, social factors and personal relationships outside the group when participants are known to each other. It is also acknowledged that the discussion only includes what participants are prepared to express in front of others therefore data generated consists of public rather than private views. Despite the two researchers, there could be some issues, which were never followed through. Furthermore, the researcher and assistant researcher being males and the participants being mainly females could have impacted on the data collected. The presence of the researchers had the potential to create a power relationship between the female respondents and the male researchers. One final point to make is that the researcher was from a different ethnic group and country, this could possibly have affected the discussions.
Recommendations

The following recommendations result from this study.

1. Occupational therapy educators need to ensure that graduates are prepared for the realities of the acute care practice and are able to work quickly and effectively to prepare patients for safe discharge.

During the past two decades the New Zealand health care system has undergone massive changes (Gauld, 2001). Whereas theory evolution is a slow and methodical process, occupational therapy practice occurs in a rapidly changing system. The ever-changing health care system presents the professional educational system with a constant challenge to teach effective roles and functions to new therapists who will be required to handle clinical responsibilities in adaptable, flexible and dynamic ways. This discrepancy between the educational preparation of occupational therapists and expectations of real practice was evident in the current study. Therapists in the study faced challenges in applying the learnt long-term rehabilitation models of occupational therapy practice in an environment identified by shortened bed stays. The core knowledge of occupational therapy in acute care needs to be described and defined to enable therapists to define their roles clearly thereby enabling them to be effective team members. In the study, participants expressed frustrations when they unsuccessfully attempted to implement the traditional, time-demanding occupational therapy models in their practice because of shortened bed stays.

2. Acute care occupational therapists are required to understand the political environment in which they are practicing.

Health sector restructuring and policy changes in the past two decades have occurred in New Zealand whenever there was a change in the political government. Also evidence indicates that politicians in New Zealand have used health sector policy as a campaigning strategy to win elections. (Gauld, 2001; 2003). The changes have been rapid and unpredictable. This created unplanned and unwanted consequences in the acute care settings’ health service delivery and management. The changes had
numerous implications on practice such as the demand for business thinking during the 1990s health reforms and the current demand for accountability placed on the clinician. The shift in health sector policies implies that the occupational therapy practitioner has to know the prevailing political environment in order to avoid frustrations in their practice.

3. It is important to use theoretical models that are consistent with the dominant health service model.

Current study findings and previous research have shown that the use of compensatory techniques such as education, home visits or issuing equipment as interventions is acceptable practice for acute care occupational therapists (Fish & Rudman, 1998; Griffin, 2002; Kaufman cited in Joe, 1996). Evidence also suggests that the long-term occupational therapy models that require an extended patient hospitalization period are not applicable in the acute care settings which are characterized by an increased short bed stay (Hanschu & McFadden, 1981). It is therefore necessary for acute care occupational therapists to adopt approaches that are consistent with the broader philosophy of the organization.

4. Occupational therapy in acute care should be defined as a specialty area

Participants expressed a demand for quick clinical decision making, high patient turnover, work prioritization and a good knowledge base about various clinical conditions as essential skills needed in order to execute physical acute care occupational therapy responsibilities. These skills clearly expose the practice demands, which may be challenging to professional newcomers. Also, they reported acute care settings as traditional training grounds for newly qualified therapists with senior therapists shunning the practice and cited working alongside senior practitioners as satisfying. It can be inferred that making the acute care setting attractive may be a potential recruitment and retention solution for senior occupational therapists.
5. Occupational therapists need to be trained to work or to communicate effectively in teams.

Findings from the current study and evidence from previous studies done involving occupational therapists in both New Zealand and Australia show that teamwork is a common source of both job satisfaction and dissatisfaction (Craig et al., 2004; Griffin, 2002; 1993; 1994). Therapists’ ability to offer effective health care services is influenced by their ability to work within such an environment. Therapists in the study reported encountering communication difficulties within the team and also felt undervalued when unable to convince team members of the value of their contribution. This is an ongoing issue requiring the development of team building skills in both undergraduate and induction programs.

6. Employers need to maintain occupational therapy teams.

Therapists reported that the support they got from the occupational therapy team was highly satisfying. It gave them a sense of identity as professionals and they received moral, administrative and clinical support. The occupational therapy department provided an emotional home to the participants. It is therefore vital for employers to maintain occupational therapy departments/teams with effective team leaders in order to address job satisfaction issues for occupational therapists working in acute care settings.

7. Self-management skills are essential for acute care occupational therapy practice.

Participants in the study suggested skills such as time and stress management as vital when practicing in acute care. The above skills can be incorporated into the educational curricula of occupational therapy schools and could be developed in areas of employment as part of continuing education.
It is vital to promote the occupational therapy profession

Participants identified the need to promote occupational therapy to ensure its continuous existence among other health care professions. All occupational therapists practicing in various fields were seen as potential advocates. Strategies recommended to aid in the promotion of the profession are targeted at an individual and national level. These involve educating other health professionals on a case-by-case basis, quality discharge of occupational therapy service by individual occupational therapists and adopting a national occupational therapy day.

Further Research

This study has explored acute care occupational therapists’ experiences of job satisfaction, job dissatisfaction and their recommendations for addressing job dissatisfaction. The following questions arise from the study for further exploration.

1. Would senior occupational therapists suggest the same factors influencing their job satisfaction as junior occupational therapists?

The study findings suggested that new graduate occupational therapists were satisfied with working in well structured supportive settings such as hospitals but were dissatisfied by lack of understanding of their role by both patients and other team members. However the above findings could not be compared with those by senior occupational therapists because the selection method did not account for differences in work experiences.

2. Would separating participants according to gender have any impact on the outcome of the study?

Previous literature indicates gender as a factor that influences job satisfaction in occupational therapy (Brown, 1991; Madill, 1987; Parish et al., 1990; Posthuma, 1983; Rider & Brashear, 1988; Taylor et al., 1990; Turgeon & Hay, 1994; 1995). Although eighteen of the twenty participants in the current study were females, it did
not explore the impact of gender difference on their contributions. The study focused on group interpretations as compared to individual responses.

3. What kind of learning opportunities are needed for professional development?

Therapists in the study recommended professional development as a strategy to equip them with the necessary skills to work in acute care settings. However it is unclear what knowledge and skills need to be developed.

4. What theories of practice do physical acute care occupational therapists use to guide their practice?

Another area of further study is the clinical reasoning process of occupational therapists working in acute care settings in order to establish how they make their clinical decisions. In addition, a further investigation is needed in order to gain an understanding of the theories guiding their practice that is from a grounded theory perspective. In the study, acute care occupational therapists expressed dissatisfaction with the medical approach used in the acute care area, which was seen as precluding the use of traditional occupational therapy models such as the model of human occupation to guide their practice.

5. Why do senior occupational therapists shun physical acute care practice?

Therapists in the study reported that their seniors were avoiding working in the acute care settings and cited opportunities of working alongside them as satisfying. Further research is needed to establish whether they actually shun the settings and if so the reasons why.

**Concluding Statement**

One of the key findings from this study suggested that teamwork was a pivotal issue that contributed to both job satisfaction and dissatisfaction. It was regarded that a
multidisciplinary team could be both a safe haven typifying a happy family as well as a battlefield characterized by interdisciplinary contests for professional status and power. Participants cited poor inter-professional communication between occupational therapists and doctors and the blurring of physiotherapy and occupational therapy practice boundaries as common sources of their job dissatisfaction.

A second key finding suggested that the occupational therapist’s role in acute care should be defined as a discharge therapist. The role was characterized by a ‘quick-fix’ approach to patient management and it involved the use of compensatory approaches to address the problems. It is also suggested in the study that participants struggled to accept the new identity and kept the desire to implement the traditional, rehabilitative occupational therapy models. This desire faced a challenge because the demand for extended patient hospitalization was inconsistent with the current health care system of reduced bed stays. This challenge became a source of job dissatisfaction.

However, a short time of contact with patients was both a source of satisfaction and dissatisfaction. The fast turnover provided opportunities to meet many people and learn about a range of conditions but this was also frustrating because it limited the range of occupational therapy rehabilitation skills that could be used. Nevertheless, the idea of working in a well-structured hospital setting and having regulated working times was equally important for their job satisfaction.

While this study has added to the existing body of knowledge in the area of physical acute care, it also highlights the need for further research to continue to explore the job satisfaction phenomena. Such studies are crucial considering the changing nature of the New Zealand health care system. They are also important to inform the education of occupational therapists and successfully orientate new graduates to the realities of physical acute care occupational therapy practice.
REFERENCES


   Edinburgh: Churchill Livingston.


   Wellington: Health Workforce Advisory Committee.


APPENDIX A

CONSENT FORM

I have read the information sheet concerning this project and understood what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request for further information at any stage.

What the study will involve

I understand that:

- The study will involve focus group interviews with New Zealand registered occupational therapists working in public hospitals in the area of acute wards, specifically surgical, medical, paediatrics and orthopaedics. Four major public referral hospitals in the north island region of New Zealand have been chosen for the study for location of the potential participants within close proximity to each other.

- The study will seek to explore the above occupational therapists’ perceptions on factors influencing their job satisfaction or dissatisfaction.

- My participation is entirely voluntary and a signed consent form will provide evidence of agreed participation.

- I have a right pull out of the study at any time with no explanation required and without any disadvantage.

- The group interviews will not take more than ninety minutes to finish and that the specific date and time of the interviews will be negotiated between the participants and the researcher.

- I am aware that the interviews will be audio-recorded, observations will be recorded and brief notes will be made during the interview.

- That the information will latter be used for data analysis.

- That an assistant will help the researcher by recording observations and writing brief notes on the group discussions during the process of the interview but will not participate in the discussions.
- That the assistant researcher will also be bound by the contents of this contract by signing and observing it.

I am also aware that in the event of the results of the project being published or used at an academic conference my anonymity/ confidentiality will be preserved.

Additional information given or conditions agreed to---------------------------------------
-------------------------------------------------------------------------------------------------------
-------------------------------------------------------------------------------------------------------
-------------------------------------------------------------------------------------------------------
-------------------------------------------------------------------------------------------------------
I agree to take part in this project under the conditions set out in the information sheet

Signature of Participant--------------------------- Date---------------------------
Signature of Researcher--------------------------- Date---------------------------
Signature of Assistant Researcher--------------------------- Date---------------------------

This project has been reviewed and approved by the Otago Polytechnic Ethics Committee
APPENDIX B

RESEARCH INFORMATION FOR THE PARTICIPANT

Researchers

Simon Shiri
Occupational Therapy Student
Master of Occupational Therapy
Occupational Therapy Dept
Box 742
Whangarei

Supervisors

Dr. L. Robertson & Dr. M. Yeats
School of Occupational Therapy
Private Bag 1910
Dunedin

Introduction

My name is Simon Shiri. I am a Master of Occupational Therapy student carrying out a thesis programme at the School of Occupational Therapy, Otago Polytechnic. I have chosen to look at job satisfaction and I am inviting occupational therapists working in the acute wards (medical, surgical, paediatrics, coronary, orthopaedics) in public hospitals to participate in this study. Please take time to read the attached material.

Project Title

Predictors of Job satisfaction for New Zealand registered occupational therapists working in acute ward settings in physical medicine: A Focus Group Approach
Purpose of the study

1) To explore factors influencing job satisfaction as well dissatisfaction for New Zealand registered occupational therapists working in acute physical ward settings in public hospitals

2) To make information available to occupational therapists and employers, relating to job satisfaction, which can impact on occupational therapists’ recruitment and retention.

Methodology

Occupational therapists working in the areas of medical, surgical, coronary, orthopaedics and paediatrics wards in four referral hospitals in the upper north island region will be invited to attend focus group interviews that will be held at convenient venues to the participants.

The researcher will seek approval for the involvement of acute ward occupational therapists in the interviews from the team leaders. Information sheet with details of the study, a supporting letter from the school of occupational therapy and a request letter with the researcher’s contact details will be send to the team leaders. The letter will seek to identify potential participants, approval for their involvement in-group interviews and ask for an allocation of a suitable room, free from any disturbances as venue for the group interviews. Participants will be contacted directly by letters and telephone.

Should you agree to take part in this study you will be asked to sign a copy of the consent form together with the researcher and assistant researcher before the interview. This ensures that your confidentiality will be preserved. Names will be used during the interview and pseudonyms will replace these to ensure that anonymity is maintained. Your consent will be sought for any publication or any use of the information outside this contract. A draft copy of the report will be send to you if you wish that to be done. Data will be recorded using an audiotape and some written notes with the assistance of an assistant moderator who will be taking down short notes on observations but will not be participating. Efforts will be made by both
the researcher and assistant researcher not to record information that will make
identification of participants possible. The final copy will be kept in the Otago
Polytechnic Occupational Therapy Department and the Otago Polytechnic Bill
Robertson library for general reading.
You may request a final copy of the project via the Bill Robertson library and a
summary report will be available on request from the researcher.

Data Storage

The data collected will be securely stored in such a way that only those mentioned
above will have access to it. At the end of the project any personal information will
be destroyed for any raw data on which the results are based. This will be retained in
secure storage for a period of five years, after which it will be destroyed (unless
agreed otherwise on the consent form).

It is important to note that you can decline to participate without any disadvantage to
yourself of any kind. If you choose to participate, you may withdraw from the project
at any time, without giving reasons for your withdrawal.
If you have any questions about the project, either now or in the future, please feel
free to contact me or my supervisors whose contact details have been provided above.

Yours faithfully

Simon Shiri

Any additional information given or conditions agreed to will be noted on the consent form
Dear………………………………………………………………

In order to prepare for the focus group discussions, I have listed below some questions, which will aid in our discussion and I would encourage you to read and give some thought to the questions prior to the discussion.

Research Questions

1. We will start by introducing ourselves and talking briefly about our experiences of working in the area of a physical acute ward setting.
2. What are the most satisfying aspects of your job? What are the factors that you can identify that can contribute to the satisfaction?
3. What have you done to make your job satisfying or what was in place to make your job satisfying?
4. What are the general concerns you have about your job as a physical acute care occupational therapist?
5. Please expand on these?
6. What are the things you are dissatisfied with? What are the factors that you can identify that contribute to the dissatisfaction?
7. Have you a sense of the relative importance of the things in your workplace which most contribute to your job satisfaction/job dissatisfaction?
8. In the case of the things that cause job dissatisfaction, how do you think these might best be overcome and by whom?
9. Any other issues pertaining to the discussion you may want to bring to the group’s attention?

Thank you and hoping to meet you on the day of the interview

Yours faithfully

Simon Shiri
APPENDIX E

CODING TRANSCRIBED DATA

Key to the coding process:

Job satisfaction: Categories

A: Red.
Support: Occupational therapy and Multidisciplinary team.
B: Bold
Well-structured working times/environment
C: Grey
Working with patients

Job Dissatisfaction: Categories

1. Brown
Nature of occupational therapy work
2. Plum
Lack of involvement in discharge planning
3. Blue
Lack of knowledge about occupational therapy by other multidisciplinary team members.
Lack of respect for occupational therapy contributions.
4. Pink
Medical model
5. Orange
Fast pace of work/Busy
6. Lavender
Not enough staff
7. Sky Blue
Organizational problems

Strategies to maintain job satisfaction or rectify job dissatisfaction
All in Green

The Interview

R: “Good morning everyone, the focus of today’s discussion is to explore the factors influencing our job satisfaction and dissatisfaction as acute care OTs (occupational therapists). We will kick start this discussion by introducing ourselves. I will start by introducing myself. My name is Simon. I am working at …… and have worked in the area of acute care in New Zealand for two and a half years. I have seven years experience working as an OT. Who would like to start? (All laugh and look at each other)

KP: “My name is KP and this is my first year working as an OT. I am working in the orthopaedics ward at the moment.

R: “Thank you”

S: “My name is S, it will be two years in January. I am in a rotational position. I have worked in rehab and surgery and now in medical (she laughs)

R: “Thank you”

E: “I am E and have been working here for 4 years. I started off at this hospital doing rehab for a year, then general medical, surgical and rheumatology in a rotational position and I am now in renal and it’s nearly 3 years

R: “Thank you E”
C: “I am C and been working for 6 years. I started off in community, mental health for a year and I moved here. I have been everywhere and I am the professional supervisor.

R: “Thank you”
Kt: “My name is Kt. this is my third year out, spent the first 6 months doing residential rehab elsewhere. Just over 15 months ago I have worked in medical and I am now in the neurology ward.

R: “Thank you, I can see that there is a wide range of experiences in this group which is great for our discussion today (all laugh). Lets start off positive and talk about those aspects of our job and OT profession we find satisfying. Who would like to start?

S: “I enjoy working in the acute care here because of support. Our team is very supportive I stick out with my buddies and if I need help I know it’s there, you can go directly to.

R: “So the issue of support?”

Al: “Yeah”

E: “Supportive team in form of supervision. The supervision is formal and structured, I like that. Educational opportunities, external and in-service ones”

R: “So the issue of support?”

E: “Yeah”

K: “Hospital is a good structured environment, good for Ots to work. That was the major reason for me to come and work in the hospital environment. There is formal supervision and few chances to go wrong.”
E: “It’s pretty much structured in acute as compared to community setting”

R: “What advantages do you find working in a structured hospital environment?”
K: “You get regular supervision, formal support, emotional support as well as social support, I think. (all laugh)

E: “It’s okay, we are having a debate.”

S: “The work load is prioritized, I mean referrals are allocated priorities and it becomes easy to work your day out.

E: “The reason I have for staying so long is the supportive nature of the team.

E: “Good social environment” (all laugh)

S: “We were very well trained in team building. OtS(occupational therapists) are well known for good team building.

K: “I think as a new graduate it’s good to work in such a supportive environment.

R: “We are talking about the team, who are the people comprising in the team?”

C: “I was talking about the OT(occupational therapy) team which includes the acute and the rest of the team.”

R: “So all OtS in general?”

C: “yeah”

R: “Any other factors?”

Kt: “What we miss most?”
R: “Yeah, about your work?”
Kt: “Our patients”

R: “What is it about your patients?”

Kt: “Working with patients, meeting new patients.”

R: “In other words, you enjoy working with people”
All: “Yeah”

C: “You have been working with a patient who is making good progress and being involved in discharge planning. That’s satisfying.

R: “Seeing your patients getting better and being involved in discharge planning gives you satisfaction?”

K: “Even seeing them getting down to rehab”

C: “Getting patients who appreciate what you do, no matter how simple or you tell them something they haven’t heard before. That’s really satisfying.”

R: “Being appreciated? (All laugh) Anything else?”

E: “Sometimes the other MDT members. Suppose you are away and when you get back you find them saying I missed you and I will be trying to update you even on social issues as well. Even working with different team members during the rotation is good. It may be unsettling initially but it’s really good.”

Kt: “Culture may change”

R: “Culture may change, what do mean by that?”
Kt: “You know different groups have different cultures. Different groups you will work with will be different and that’s what I mean.” (All laugh)

R: “Any other factors”

E: “It depends on the season and how busy the hospital is. How many staff are around in the MDT. If the staff complement is full then that’s great. But if there isn’t enough staff, then you find patient’s discharge being delayed. That’s not satisfying.” (Dissatisfaction)

R: “If I may ask, how do you keep yourselves happy at work? What strategies are you employing or you have put in place to keep yourselves happy with your work and profession?”

Strategies to Maintain Job satisfaction

All: “Angel week” (strategy)
C: “Having time together as a team, helping each other out when stressed, team building.” (Strategy)

E: “We have Angel week that sort of thing”

C: “Quite a lot of it surrounds a lot of humour, morning tea, breakfast tea plus lunch.

R: “What’s involved during the Angel week?”

E: “Just doing good things to each other. We rotate amongst ourselves. Making cakes, assisting with case load for that person. Just being nice to that person.

R: “Anything else?”
K: “If team realizes that someone is stressed, we will have a chat, talk about it and you may realize that it’s nothing serious. Talk to the team leader.” (Strategy)
R: “How do tell that someone is stressed?” (All laugh)

E: “They stay away from lunch, become grumpy, do not answer their locaters, do not take breaks.”

S: “Talking about it” (strategy)

C: “Every morning we have meetings where we try to catch up with every one and that’s where people can open up.”

E: “You find out that there may be someone really busy and 3-4 wards being quiet. We just turn up in large numbers and bless that ward by helping out, so that by the end of the day they feel relieved. That’s where also the issue of priority comes into place. You will only see high priority ones. We sort of know what happens with all wards due to the rotation so it’s easy to help out.” (strategy)

C: “One way for me is to sit down and talk to someone. Saying look I am overwhelmed, I can’t manage, can you please help me.” (strategy)

R: “In other words being honest with yourself?”

All: “Yeah”

R: “There is a lot about supportive team coming up, how do others keep yourselves satisfied with your work.”

Kt: “For me I guess is keeping in touch with the patient, helping them and treating them and listening to what patients say. That’s satisfying.” (strategy)

R: “So your source of satisfaction is patient contact?”

Kt: “Yeah”

R: “Any other strategies or satisfying factors?”
S: “Making sure you take your breaks” (all laugh)(strategy)

R: “Let’s move on to dissatisfaction factors” (all laugh)

**Dissatisfaction Factors**

Kt: “The safety staff”

R: “What is it about safety?”

Kt: “The responsibilities placed on Ots about the issue of safety when patients are discharged.”

R: “How do you find your role on this issue of safety?”

K: “We have to document all that we do with the patient in case an incident happens. That’s where the issue of supervision comes into play as well.”

S: “We are so busy in acute and what we can do has been cut down severely to just discharge.”

E: “Yeah, discharge therapists. Despite the education we do we still find a lot of referrals coming that have nothing to do with us and all we have to do is to screen them and have to explain why we can’t see the other patients. Doing that is time wasting and that time could possibly have been used on some other patients.”

R: “So in other words if I got you well we have discussed the issue of time frame which you described as failure to do what you want because patients are discharged too early and then the issue of inappropriate referrals.’

E: “Yeah”
K: “When I said safety, I meant patients being send home whilst still unwell and not ready for discharge and that’s dissatisfying because they often fail to cope at home.”

R: “Somebody mentioned that we are d/c therapists”

C: “I think it’s around the issue of time frame as well. OT play a functional role, bed, toilet transfers and feed back to the team on discharge planning. We end up like d/c therapists rather than safety therapists.”

R: “What else?”
C: “The lack of communication, among team members” (she laughs)

E: “We work from 7:30 to 4 and at 3:30pm you get a referral saying patient is being discharged at 4pm. sometimes we go up to 4:30pm and 5pm and yes you get time in lieu, but not paid for it. If you don’t use it you lose it. So in other words the organization does not recognize your efforts, other team members may though.”

R: “So in other words that does not give you that extra zeal to continue seeing the patient even after your working times?”

E: “Yeah, by the time you leave here, traffic jam will be a problem. You know some people live on the other side of the bridge and it may take an hour or half an hour to get home.”

Kt: “Its good that we are fully staffed at the moment but when not, the pressure to other acute care Ot’s to cover for the missing gaps. The other thing I like about OT is working from Monday to Friday and finishing at 4. No showers during weekend. (all agree) (Satisfaction-time frame)

R: “So the issue of working times?”
E: “The times can be a disadvantage as well. You get seniors interested in the job and who may want to take up some hours in the evenings but because of this restriction of 7 am to 5 pm, they cannot”

K: “It’s good to see seniors like C working alongside us. Traditionally acute care has been the training ground for junior occupational therapists so we need all the senior Ots to come and work in our area” (All laugh) (Satisfaction)

R: “So you have found it satisfying to have seniors working alongside you?

Kt: “Yeah, it’s a balance really”

R: “Before we move on you mentioned something about communication breakdown in the team and previously we talked about good team work. Whom are we referring to on the issue of communication breakdown?”

Kt: “Communication between Ots and other MDT members like medical team”

R: “Medical team referring to?”

S: “The doctors when discharging patients”

K: “Say you get a message that they are discharging a patient at 3:30 pm and they need your input.”

E: “The other thing is that you may recommend that the patient is not safe for discharge but doctors may decide that the patient is going home anyway. Then we end up running around trying to get them home safe but it’s not the ideal situation.”

R: “I can see the issue of power in terms of decision making coming into to play. How do you view your role in the team working in acute care?”

S: “It depends on the team, some doctors are good. Previously I worked with junior house surgeons when they were just starting, I always explained to them the value and role of Ots whenever an opportunity arose. I managed to mould them; some of
them, and now some are nearing consultancy level and have better knowledge and value for OT, some of them. This applies to junior and new nurses coming to the ward, through creating a good rapport with them and explaining the OT role and you end up getting appropriate referrals. (Strategy)

R: “How do you find it in your area?”

S: “It depends on individual doctors, some listen and some don’t”

R: “How do you find the medical team?”

Kt: “They dictate to us and I find it quite fun when you are working in an inter-disciplinary team. They totally employ the medical model and as OtS we find it difficult for us to fit in, you know. I hope it’s changing especially with new doctors who are implementing a more holistic approach.”

R: “You mentioned the issue of medical model, can you explain further please?”

Kt: “Yeah, I think with people using the functional model such as OtS when working with say neurological conditions, doctors focus on the disability and totally disregard function. The hospital clearly operates along the lines of disability rather than function.”

S: “I think it depends on the wards, I think the surgical wards are now utilizing the medical model than what is happening in the medical wards where we are focusing on function. My role now is functional, I am now doing more functional assessments whereas in the surgical you don’t.”

E: “In surgical it’s about equipment, it’s about safety, it’s more medical now.”

S: “We now look at patient’s quality of life, how they are functioning and also focus on their future functional status. So different areas in acute do different interventions hence have different satisfying factors.”
R: “Any other dissatisfying factors?”

C: “Staff turnover. People don’t stay for too long (all laugh). It’s different now but when people leave, they do that at once. You just feel like this kind of change is gonna happen any time”.

R: “In other words, there is high staff turn over of acute care ots?”

C: “Yeah”

R: “Any other factors?”

Kt: “The time we see patients is getting quite tight, it’s more like bang, bang, bang! Thus compromising on quality.”

R: “So are you saying that you don’t get enough time to see the patients?”

Kt: “We do but it’s difficult with some patients who need a lot of input like amputees. You are limited on what you can do due to resources.”

R: “Resources, what do you mean?”

K: “Resources is probably one thing, even the experience, with equipment and cultural background of the patients. Like I have a lady who uses a bucket to shower herself in her country but in the ward I am expected to assess self cares and issue out appropriate equipment.”

R: “That’s an interesting one! Uuum you wanted too add?”

E: “As acute care Ots, we are really busy and under pressure because we get referrals from elsewhere like outpatients and community especially rheumatology patients. We end up visiting patients in their homes, which might take up to 3 hours. Instead of
focusing on the wards we end up doing everything, something I feel community Ots should be doing.”

S: “You get a patient initially planned to go to rehab and all of a sudden there is change in discharge plan and patient is suddenly for discharge to home environment. That’s a worry too and it looks like it’s a trend.”

R: “Who decides on patients discharge?”

S: “Charge nurse”

K: “Doctors”

E: “In the past 2-3 weeks we have had lots of patients waiting to come up to the ward for admission and the pressure has been on us to quickly discharge patients so as to create more beds.

S: “The issue of safety comes in play as well, you can never guarantee that patients will be safe on discharge considering the short space of time these patients stay on the ward.”

R: “any other factors?”

S: “Getting sick all the time. I have never been so sick in my entire life”

R: “What’s causing that?” (All laugh)

S: “Everything, the nature of the work”

R: “So it has to do with the actual work in the work area?”

S: “It has to do with carrying equipment.”
E: “I quite like that, it’s exercising. You get an opportunity to actually move out of the building to another area in order to fetch equipment. You feel like getting away from the actual work area.” (All laugh)

K: “Parking is another issue”

R: “What is about parking?”

E: “It’s not a perk. You have to pay for parking or else you come early. My day starts at 6 am. That’s my choice but the car parking here is expensive. It was okay if we could get public transport.”

Kt: “Actually public transport is subsidized. I catch a train and it’s quite cheap.”

El: “Actually in Auckland there is no bus that will come straight to your work or house, so you have to walk. It makes the journey a lot longer so I would rather bring my car and park down the road and leave early.”

R: “You have mentioned quite a few factors you find dissatisfying, what strategies can we employ if we had the power to change the situation, so that we can rectify it?” (all laugh)

**Strategy**

C + K: “More staff”

E: “More money, more senior staff as well, extra senior staff from the highest level.”

S: “We have a lot of senior staff who have been overseas and it’s good for them come and work in the area, feed backing on their knowledge.”

R: “So more senior staff working alongside you?”
S: “With more staff you start getting more time to work with patients and do some rehab and not just discharging. Start to make use of the skills learnt in school.”

Kt: “We would like to use the Model of Human Occupation which is more holistic than the medical model, so with more staff we will be able to that. We can show what we actually do as Ots. Show the managers that this is what Ots do in addition to discharge planning. I think we have a lot of the equipment thing but OT is changing and the profession is changing.”

R: “What’s the entry point?”

S: “Taking full control of what we do, being clear of what we do as well as implementing the occupational performance model.”

K: “Educating that our role in the wards is not just discharge planning, but we do other things as well.”

Kt: “Even in oncology for patients going to hospice there is a tendency to focus on equipment because that’s what is expected of us by the rest of the team, but we can do a lot of functional assessment and treatment to improve their quality of life.”

R: “What is about equipment?”

El: “Sometimes it’s a lot of it”

R: “Is it your own view about “equipment People”

S: “People don’t value you they see you as being slack or something” (Dissatisfaction)

R: “Who are these people?”

E: “Patients”
K: “Patients and nurses”

C: “Tell them what we do and try to do that regularly”

S: “I think educating will improve it”

R: “How else can we address the issue of being viewed as equipment people? You have mentioned education, any other strategies?”

C: “One of the things we are doing together with E is trying to gather information on the role of OT and try to clarify what we do, the issues surrounding equipment and all the models of practice we use and all issues pertaining to doubling up by physios doing the same thing. So we are trying to find strategies to run away from that.”

E: “Furthering our education, doing research and some further post grad including masters. we need to encourage each other. Sometimes it comes back to the issue that we need more staff so that people can attend courses.”

R: “W hat can we do about those people making inappropriate referrals?”

K: “We are so busy in the wards and sometimes it’s because they don’t see us doing something else in the wards and so end up thinking that it is all we can do.”(dissatisfaction)

S: “Taking opportunities as they come and educating them.”

K: “The more staff we get then, the more time we will have to do functional stuff.”

R: “It’s the second time physios being mentioned as trespassers into the OT field of practice, how can we deal with this situation?”
E: “Educate as we work alongside them. Sharing knowledge like how we see them as taking our role but we are not doing anything. We need to be actively involved in the whole process. Again the issue of time. Then we end up upset because we are loosing out to the physios.”

R: “So in other words you are mentioning the issue of time as a limited resource in acute care?”

Kt: “Yeah”

R: “Why are patients being discharged too early and pressure being put on us?”

E: “To save money”

R: “Any other strategies?”

Kt: “Increase pay, to keep us happy. That’s the reason why we are working.”

C: “We are planning to have some combined interviews with other DHBs including physios so that they will know where they are coming from.”

El: “Incident reports and accident reports for patients who go out of the ward and we haven’t been involved even if there was need.”

R: “So effective documentation?”

El: “No, incident reports to try to push it a little bit more, so…”

C: “So that it gets to management and they become aware of what our problems are”

E: “The more we do this the more they become aware of our plight” (all laugh)
R: “The issue of money was mentioned so can we discuss it further?”

E: “The hospital runs at a loss, have seen freezing posts and the quality of service is getting down just to save money. The whole public system has no money.”

R: “What’s the way forward? Where are we going?” (all laugh)

E: “Even though the hospital does not recognize us and value us we are doing something worthwhile.”

R: “Any burning issues?”

All: “No” (Nods their heads to say no further questions)

R: “I would like to take this opportunity to thank you and to wish you all the best in your careers.”