Accountability and Competence: Occupational Therapy Practitioner Perceptions

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Objective. Occupational therapy practitioners must meet ever-increasing accountability demands in all service delivery environments. Accountability is made possible through the ongoing development of continued competence throughout a practitioner's career. Behaviors that demonstrate accountability and reflect competence include commitment, leadership, and professional knowledge. This article discusses issues related to accountability and competence, presents findings from focus group discussions with occupational therapy practitioners regarding professional competence, and identifies actions that will bring about greater understanding of this topic.

Method. Thirty-nine randomly selected occupational therapy practitioners attended one of two focus groups. Participants responded to a structured discussion guide, including questions addressing the definition, process for sustaining, and outcomes of continued competence.

Results. Several themes emerged from these discussions. Views about what constitutes and contributes to continued competence in occupational therapy were diverse, and perceptions of occupational therapy “practice” were broad. Participants believed that the “outcomes” of a practitioner’s continued competence were best defined as autonomy in executing the occupational therapy process.

Conclusions. Findings offer potential language to articulate competence in occupational therapy and facilitate a discipline-wide conversation. The findings likewise challenge practitioners to assume new professional behaviors that require both personal and interpersonal skills. Such behaviors are critical to demonstrating accountability and competence.

Since the early part of this century, the occupational therapy profession has experienced great growth and seized opportunities for the advancement of the discipline. Previously met challenges (e.g., role autonomy, establishment of educational programs, accreditation and certification standards, the recognition of occupational therapy as an essential service by payers and legislators) provide an important base for practitioners engaged in changing and innovating service delivery models. Today, we often are overextended and pulled in many directions as we balance payment, staffing, role boundaries, outcomes, and ethical issues. Assuring our own professional competence, as well as that of those for whom we may have supervisory or programmatic responsibility, is an issue that compels each of us to assume accountability for our actions. This article will present findings from focus group discussions with occupational therapy practitioners regarding their views about professional competence and stimulate further discussion of accountability and professional development issues.

In the ever-evolving service delivery environment, the
individual practitioner's accountability is challenged in the struggle to deliver cost-effective, efficient, and quality services (Grady, 1990). Foto (1996, 1997) described this accountability challenge in relation to outcomes research. She noted the need for "objective proof" (Foto, 1996, p. 620) of treatment efficacy and cost-effectiveness. As practitioners of the discipline, it is our responsibility to be simultaneously accountable to both the organizations for which we work and the profession at large.

Responsible and accountable practice depends, in part, on each practitioner's practice behavior. Connors, Smith, and Hickman (1994) defined accountability as an "attitude of continually asking what else can I do to rise above my circumstances and achieve the results I desire. It requires… making, keeping, and answering for personal commitments" (p. 65).

Many behaviors reflect responsible and accountable occupational therapy practice. Commitment to the welfare of the clients and families who receive occupational therapy services is a fundamental requirement for demonstrating accountable practice. This commitment is fostered in part by the active engagement in a lifelong learning process crucial to demonstrating practice competence. According to Ewert (1993), this process requires tending, nurturing, and vigilance. Skills of organizational planning, priority management, time management, and occupational therapy evaluation and intervention must be developed and mastered. These skills encourage the development of the flexibility and adaptability required to work in constantly changing situations.

Accountability is likewise achieved through the ongoing development of continued competence in the core areas of the occupational therapy process that addresses occupation across the life span in varied environments. Active engagement in skills enhancement in the areas of leadership, critical reasoning, communication, collaborative team participation, lifelong learning, and research is essential to accountability. Investigating how occupational therapy practitioners continue to develop these attributes throughout their careers is of interest to the National Board for Certification in Occupational Therapy (NBCOT). As the credentialing arm of the profession, NBCOT seeks to identify trends in the discipline that will inform the public about the ongoing competence of its providers. The NBCOT recently sponsored two focus groups to elicit opinions of randomly selected practitioners regarding basic premises of ongoing competence. The findings reported herein suggest perceptions of occupational therapy practitioners about their own accountability and evaluation of individual and collegial continued competence.

Method

Sample Selection

NBCOT contracted with Wirthlin Worldwide, Inc., an international survey research firm in McLean, Virginia, to identify participants, collaborate on the discussion guide, and facilitate the focus groups for data collection. Because San Antonio, Texas, and San Jose, California, have large practitioner populations and variation (licensure vs. trade—mark only) in state regulation of occupational therapy, the NBCOT database was queried for a potential sample from these cities through specified zip codes. From this population of 2,150 occupational therapy practitioners, a stratified random group was identified for each location. Stratification criteria for participant selection were (a) level of practice (occupational therapists, occupational therapy assistants) and (b) years in practice (1–10 years, 11–20 years, > 21 years). These criteria ensured inclusion of a mix of practitioner level and experience. A telephone contact identified persons meeting the selection criteria and then determined their willingness to attend a local area focus group. Those who agreed received a confirmation letter with directions to the focus group location.

Fifty practitioners agreed to participate in San Antonio, and 16 (32%) did so. Forty practitioners agreed to participate in San Jose, and 23 (58%) did so; thus, 39 practitioners attended the two groups. Reminder telephone calls were made 3 days before the San Jose focus group to improve the participation rate.

Instruments

Communication technology. PulseLine™, an interactive communication software program, is a computer-based research system that measures audience response to proposed ideas. All participants have a "response box" linked to a computer by which they make an individual response to a question. These individual responses are immediately processed by the computer and projected in summary form on an overhead screen. For example, by way of introduction, the facilitator asked participants to identify their practice level with the response box. Occupational therapy assistants pressed 1, and occupational therapists pressed 2. After the tally was completed, a bar graph depicting the number of occupational therapists and occupational therapy assistants in the group was displayed. Because all group members "vote," this research system records, and the bar graph reflects, the perceptions of both speaking and nonspeaking participants. This information allows the group’s facilitator to focus follow-up questions in relation to group-specific responses. Use of this technology makes participants aware of their responses in relation to those of the entire group, which in turn heightens participant curiosity and involvement.

Discussion guide. A structured discussion guide was used to explore practitioner beliefs regarding professional competence throughout one’s career. Participants were asked to
think broadly about competence and accountability from the perspective of the profession (e.g., to think about the attributes of colleagues they consider competent). They were cautioned against responding on the basis of an individual or personalized self-judgment.

The discussion guide included multiple-choice survey questions with specific response options. Participant reaction to the guide during the first focus group in San Antonio served as a basis for instrument modification before the second focus group in San Jose; however, the content categories were the same for both focus groups. The question categories included the following:

- The definition of competence
- What it means to be in occupational therapy practice and the relationship of practice to continuing competence
- Appropriate occupational therapy clients
- Outcomes of occupational therapy practitioner competence
- The contributions of informal learning and formal continued learning to ongoing competence

Data Analysis

Responses from both groups were combined and tallied. Descriptive statistical analysis included citing the number of participants selecting each response option and using this number as a proportion of total responses. This analysis allowed identification of themes and provided a basis for future discussions within the discipline about accountability, professional development, and continued competence.

Results

Definition of Competence

Participants considered three definitions of competence in occupational therapy:

- “Those performance, knowledge, and skill abilities requisite for fulfilling the responsibilities of the given practitioner’s generic practice” (Wilson, 1977, p. 574)
- “Reflected by job performance and is assessed by how skillfully an individual performs in a particular work environment” (Thomson et al., 1995, p. 3)
- “The application of knowledge and the interpersonal, decision-making, and psychomotor skills expected for the practice role, within the context of public health, welfare, and safety” (National Council State Boards of Nursing, 1996, p. 3)

Participants considered all three definitions relevant. As indicated by combining responses from both groups, a plurality of practitioner votes (39%) favored the definition addressing knowledge and interpersonal, decision-making, and psychomotor skills. Discussion of these definitions focused on the role of the employer versus the discipline in defining competence. Participants recognized that considering competence within the context of a specific professional role or work environment gave the employer an important voice in defining practitioner competence. They commented, however, that when describing the competent occupational therapy practitioner, one must consider the breadth of occupational therapy practice and the wide range of systems in which occupational therapy services are delivered.

What Constitutes Occupational Therapy Practice?

The continuing professional education literature, particularly that on obsolescence, suggests a strong relationship between the professional stimulation of the workplace and sustaining competence (Bennett & Fox, 1993; Dubin, 1990; Fossum & Arvey, 1990). But what does it mean to be in practice? The discussion guide for the first focus group presented 4 “indicators of practice”:

1. Only direct time with clients
2. Indirect time preparing to serve or serving clients
3. Volunteer service to the profession or one’s community
4. Various combinations of the first three indicators

Responses did not discriminate or heighten understanding about what constituted “practice” in occupational therapy.

For the second focus group, a series of practitioner case examples targeting nondirect service professional roles was introduced. Table 1 provides selected examples of these scenarios and participant responses. Greatest consensus was evident with examples describing practitioners who function as managers and educators or who had some minimal direct client contact (2 weeks per year plus observation) in addition to relevant continuing professional education. Eighty-seven percent or more respondents determined the occupational therapists and occupational therapy assistants in these cases to be “in practice.”

Table 2 presents participant opinions regarding the minimum amount of time during a year a professional should spend in practice to sustain competence. These data suggest that occupational therapy practitioners recognize a link between engagement in a wide variety of professional roles and competence.

Occupational Therapy Practice: Clients and Outcomes

Table 3 presents participant perceptions of who are appropriate clients to receive occupational therapy services. Three of six examples received consensus (i.e., 75% or higher). These were “a recipient of services in a clinical setting,” “a referral source,” and “a payer.” Between 50% and 74% of participants indicated that they considered “a grant funding agency,” “an individual who reports to you,” and “a student” to be valid recipients of an occupational therapy practitioner's services. These responses encompass most professional
roles of occupational therapy practitioners as discussed in the Occupational Therapy Roles document (American Occupational Therapy Association [AOTA], 1993).

Table 4 summarizes responses from both focus groups regarding the relationship between practice outcomes and practitioner competence. Questions posed in the first focus group \( (N = 16) \) framed outcomes of practitioner competence in relation to client outcomes resulting from an occupational therapy intervention. Participants expressed their disagreement with this framework verbally and by their response boxes. They judged client outcomes with a positive bent \( (e.g., \) client returns to occupation, client lives independently in assisted living) to have a relationship to practitioner competence. Conversely, they judged outcomes with a somewhat negative bent \( (e.g., \) client receives disability benefits and leaves paid work, one's practice is audited by Medicare) to have a weak, if any, relationship to practitioner competence. Conversely, they judged outcomes with a somewhat negative bent \( (e.g., \) client receives disability benefits and leaves paid work, one's practice is audited by Medicare) to have a weak, if any, relationship to practitioner competence. Participants reported that they did not believe that practitioners can adequately control a sufficient number of recipient-specific and delivery system variables to link practitioner competence and client performance outcomes.

The second focus group \( (N = 23) \) framed outcomes of practitioner competence around the occupational therapy process. Examples of such responses included the following:

- Identifying professional development needs of staff members
- Implementing a new treatment program in response to consumer demand
- Identifying remedial options for a student

Participants indicated a consistent and strong relationship between practitioner competence and service delivery outcomes with this framework.

**Importance of Formal and Informal Learning**

Participants in the first focus group did not report as strong a relationship between informal learning experiences associated with the work site \( (e.g., \) structured team meetings, reading and discussing professional journals and books, exchanging information and tips with a peer network) and continued competence as did participants in the second focus group. Overall, participants attached more value to informal learning response options that included interactions with occupational therapy colleagues or professional literature. They generally attached less value to those on the basis of interactions with related disciplines.

Formal learning opportunities, such as continuing education experiences, were seen as promoting continued competence. Ninety percent of participants reported attending a structured continuing education program sponsored by their employer or a content-based local or regional workshop in the past 3 years (see Table 5). Sixty-nine percent reported attending a local, state, or regional conference sponsored by a professional association during the same period. Participants uniformly viewed these experiences as important to their continued professional development and competence.

Eighty-two percent of participants agreed with requir-
ing demonstration of learning from continuing professional education. There were, however, diverse perceptions on "who" should conduct such evaluation of learning. Forty-one percent indicated the immediate supervisor, 26% cited a peer, 20% cited a panel of outside experts, and 3% cited "evaluation by client."

Discussion

The discussion elicited in these focus groups offers opportunities to understand the perceptions of occupational therapy practitioners about continued competence throughout a career. A frequent refrain was: "I know a competent practitioner when I observe one, but I cannot describe this for you." The insights obtained from these findings offer a potential language to articulate a common definition of competence and expectations of professional accountability. Such a language can facilitate a discipline-wide conversation about competence. This conversation is necessary to address the present and future accountability demands of the practice environment.

Diverse Views Regarding Definition of Competence

Participants had diverse views about what constitutes and contributes to continued competence in occupational therapy. They reacted with surprise and curiosity to the lack of homogeneity in perception that emerged in their discussions about the assumptions that were explored. Clarifying these basic assumptions will facilitate an understanding of the discipline's expectations of competence and consensus about what constitutes competence.

All three definitions of competence cited in the discussion guide incorporated the context of a professional role or work environment. This generated an interesting tension for participants. On the one hand, they wanted the freedom, flexibility, and autonomy to define competence within the context of a specific professional role. This allows professionals latitude to practice occupational therapy in a wide range of delivery sites and use diverse treatment approaches. Participants recognized, however, that this definition makes the employer a major stakeholder in operationalizing the definition of competence. Participant responses warrant further investigation into the optimal balance between the discipline and the practitioner-practice environment in defining competent and appropriate professional practice. Findings of such research would elevate the discipline's understanding of competence and ability to articulate consensus on its definition.

Multiple Practice Roles

Most participants accepted a wide range of professional involvement, responsibilities, and roles in what they considered to be occupational therapy practice. They viewed competent execution of these multiple roles as competence within the discipline. Variance around responses to discussion guide questions of professional role scenarios, appropriate occupational therapy clients, and competent practice out-

<table>
<thead>
<tr>
<th>Example</th>
<th>Agree (%)</th>
<th>Strong (%)</th>
<th>Weak/Not Sure (%)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>A recipient of services in a clinical setting</td>
<td>82 (N = 39)</td>
<td>56</td>
<td>44</td>
<td>16</td>
</tr>
<tr>
<td>A grant funding agency</td>
<td>64 (N = 39)</td>
<td>75</td>
<td>25</td>
<td>16</td>
</tr>
<tr>
<td>A person who reports to you</td>
<td>59 (N = 39)</td>
<td>62</td>
<td>38</td>
<td>16</td>
</tr>
<tr>
<td>A student</td>
<td>56 (N = 16)</td>
<td>33</td>
<td>67</td>
<td>16</td>
</tr>
<tr>
<td>A referral source</td>
<td>91 (N = 23)</td>
<td>56</td>
<td>44</td>
<td>16</td>
</tr>
<tr>
<td>A payer</td>
<td>91 (N = 23)</td>
<td>56</td>
<td>44</td>
<td>16</td>
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</tbody>
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Note. N = 39.
comes reflects the tension noted in the definitions of competence. The degree of variance in discussion about professional roles, however, was much smaller than that about the definition of competence.

The most striking observation was that participants questioned the relationship between scholarly research and sustaining practitioner competence. This is a concern for any profession that is both a practice and a science. Academicians would argue that scholarly research enhances one's teaching and contributes to the knowledge base of the profession. That participants cited “reading occupational therapy literature” as contributing to their ongoing competence suggests that the outcome or “product” of these research efforts is important to practitioners. These comments raise a curious inconsistency in the perceptions about research and its contributions to the researcher’s versus the clinical practitioner’s competence. Further investigation of the relationship of research to competence and the perception of competence in researcher and clinician roles will inform the discipline about the strength and importance of these relationships. Such investigation should broadly define research and include its application.

Practitioner Autonomy as an Indicator of Competence

The occupational therapy process offers a context for considering the outcomes of competence; such outcomes reflect practitioner autonomy in executing this process. Participants cited a myriad of client-specific and delivery-system-specific variables over which they had no control as justification for not relating client outcomes to practitioner competence. These perceptions raise the question about the appropriateness of limiting expectations of a competent practitioner to such autonomy. An analogy might be drawn between participants’ discomfort in relating practitioner competence to client outcomes and the struggle in the discipline to relate treatment effectiveness to functional client outcomes rather than to improvement of occupational performance components. Further research is needed to delineate the outcomes of practitioner competence.

This finding may suggest that practitioners assume that the process of service interaction is an important, if not the most important, variable in demonstrating competence. Additional investigation is needed to better understand the presence and strength of the relationship among implementation of the occupational therapy process, practitioner competence, and client performance outcomes resulting from occupational therapy service delivery.

Informal Learning Among Occupational Therapy Colleagues

Participants valued informal learning most when it was within the context of the discipline. They placed the highest value on interactions with occupational therapy colleagues (including structured team meetings) and reading and discussing occupational therapy literature. There was greatest consensus on the contribution of time spent “in practice” and the presence of an occupational therapy peer network to sustain professional competence. These findings suggest that expectations of reformed delivery systems for new colleague networks and expanded professional interactions (e.g., interdisciplinary and transdisciplinary health and social service system “teams” with mid-level practitioner autonomy) will challenge occupational therapy practitioners. Articulating the contributions of a broader range of informal learning from other disciplines to the practitioner’s professional development may facilitate the discipline’s effective participation in these new delivery systems.

Formal Continuing Education

Formal continuing education was the highest rated vehicle for continued professional development and sustaining competence. Participants assumed a positive relationship between these experiences and professional role performance. Accountability for demonstrating this relationship, however, caused discomfort. Expecting accountability in terms of sharing learning with others versus individual application of learning to one’s practice may diminish this discomfort. Such demonstration is necessary for future research investigating the influence of continuing education on practice patterns and outcomes.

Limitations

These data reflect the perspective of 39 practitioners. As such, replication of this study is encouraged. The purpose of the focus groups was to facilitate a lively discussion among practitioners about continued competence in occupational therapy. Replication of this study method would further elicit such discussion.

Summary

All delivery systems expect increased accountability from their service providers, including occupational therapy practitioners. Meeting the accountability challenge is critical if occupational therapy is to thrive in health, education, and human services delivery systems. This expectation is referred to now as continued competence. Comments from 39 practitioners participating in two focus groups suggest discomfort with such expectations while recognizing their necessity under new delivery system models. These expectations will challenge practitioners to assume new behaviors. Fidler's
(1996) description of personal and interpersonal skills that comprise professional behaviors in the context of student development provides a model to articulate these expectations. Her analysis appears equally appropriate to experienced practitioners functioning amid changing expectations. Addressing accountability expectations by demonstrating one’s practice competence will encourage and enhance development of these critically necessary behaviors.

The data from these focus groups stimulate many future research questions. Among the most crucial are identifying the relationship between research and competent role performance, articulating the underlying assumptions and definition of competence, and investigating the influence of continuing education experiences on practice patterns and outcomes.

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References


