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Effects of Professional Commitment and Organizational Context on the Professional Development of Canadian Occupational Therapists

by

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ABSTRACT

Over the past two decades, health care has undergone massive change, both in scientific and technological advancements, and in the manner in which services are structured and delivered (Angus, Auer, Cloutier, & Albert, 1995). Social, political, and financial pressures have resulted in organizational restructuring, which in turn influenced the delivery of health care at all levels. The knowledge base of the occupational therapy profession has continued to expand and there is increasing evidence of the effectiveness of its services. For these many reasons professional development has become especially critical as it enhances practitioners' abilities to respond appropriately to these ever-changing external forces (Nolan, Owens, & Nolan, 1995) and ensures evidence-based practice (Craik & Rappolt, 2006), thus benefitting both patients and organizations.

As professionals, occupational therapists are personally accountable for the quality and outcomes of the services they provide (Friedson, 1994). This study examined the factors that induce occupational therapists - important resources for the health care system - to maintain, adapt, and enhance their competencies. I explored the potential drivers of professional development using a combination of commitment theory and organizational support theory (Eisenberger, Huntington, Hutchison, & Sowa, 1986; Meyer & Herscovitch 2001). Hierarchical regression analysis showed that, though perceived organizational support and development-oriented human resource management practices play a role in professional development, occupational therapists' professional commitment is the most important influence on professional development. Moreover, in the population studied, performance appraisals did not appear to influence professional

development. Participants' open-ended comments suggested that occupational therapists do not perceive such appraisals as relevant to their practice or learning needs.

These findings have important implications. The education of occupational therapists and the role of professional bodies become important for instilling and supporting professional commitment. For employers, the hiring process for occupational therapists and the policies and human resource management practices related to encouraging professional commitment become especially critical.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

CHAPTER 1

Introduction

In today's rapidly evolving health care environments the life span of knowledge and skills gained in entry-level academic professional programs is rapidly shrinking (Haines, 1997). Population demographics, evidence regarding the determinants of health and well-being, and health care policy are constantly changing and emerging. Persons are living longer more productive lives and doing so while subject to chronic medical conditions. Simultaneously, society is increasingly interested in accommodating their environmental requirements within the mainstream community. Primary health care, specifically health promotion and illness prevention, are the new priorities of policy makers, reflecting consumers' expectations of their own and their loved ones' lifestyles. Simultaneously, increasing healthcare costs and generalized concern about the sustainability of a publicly funded healthcare system in Canada have resulted in a gradual policy shift from public service to market-driven values in the management of resources. Health care budgets are being tightened and funders are wisely demanding scientific evidence of the efficacy and efficiency of services and interventions.

Healthcare professionals must posses the appropriate skills to adapt and respond to these ever-changing internal and external forces in the health and social care sectors. Professional development, in its broadest sense, facilitates the provision of the competent, evidence-based services that society expects (Hobson, 1990). For these reasons, it is critical to have an understanding of the psychological processes through which occupational therapists engage in on-going professional development.

Problem Statement

Organizational effectiveness requires health care practitioners who possess appropriate skills, knowledge and adaptive intervention approaches in order to effectively deal with the health and social needs of changing client populations and evolving trends in service delivery (Stolee et al, 2005). Continuing professional development, also referred to in the literature as continuing professional education, is the means by which members of professionals maintain, improve, and broaden their knowledge and skills and develop the personal qualities required in their professional lives. It reflects a commitment to being professional, keeping up to date with new developments, and continuously seeking to improve. (Chartered Institute of Personnel and Development, 2000). The term professional development is used throughout this thesis and is meant to encompass activities referred to in the literature as continuing education and/or competency maintenance.

Though professional development is primarily a voluntary activity on the part of occupational therapists (Brockett & Bauer, 1998), research demonstrates that it is highly influenced by the context and the organizational setting in which health care practitioners find themselves (Grzyb, Graham, & Donaldson, 1998; Lysaght, Altschuld, Grant, & Henderson, 2001; Nolan, Owens, & Nolan, 1995; Rivard, Hollis, Darrah, Madill, & Warren, 2005). Occupational therapists have reported being concerned that their continuing professional development is jeopardized in current health care environments (Lysaght et al., 2001). A dilemma thus emerges for both the individual professional and his or her employing organization. From the perspective of individuals, maintaining competence and accountability for their services are defining features of the very

activities that make one a professional (Sullivan, 1999). From an organizational point of view however, though professional development is undoubtedly valued and known to benefit effectiveness, it is often not part of explicit employment contracts, not funded, nor contractually rewarded (Swick, 2000). In fact many organizations expressly adopt a personal responsibility approach in their management of employee development (Maurer & Shore, 1995).

A variety of studies have examined the reasons why, and the manner in which professional development is enacted by health professionals in current health care environments. Researchers have identified facilitators and barriers to professional development and proffered recommendations to individual practitioners, managers, educators, and professional organizations. However, there is little or no published research addressing the underlying psychological mechanisms through which organizations and health care professionals view, engage in, and manage professional development (Brockett & Bauer, 1998). The personal, psychological, and social forces at play in the relationships between the management practices of the employing organization, and professional development of employees require examination from a theory based perspective.

Theoretical Approach

The contemporary occupational therapy paradigm guided the development of my study. This paradigm is premised on the assumption that occupations are reciprocal transactions between people and their environment (Stone, 2005). The emergence of this paradigm over time is discussed in Chapter 2 of this thesis. In addition, in considering potential drivers of professional development I utilized a combination of general

commitment theory (Meyer & Herscovitch, 2001) and organizational support theory (Eisenberger, Huntington, Hutchison, & Sowa,1986) to guide the development of a basic conceptual model.

General commitment theory holds that employees develop a commitment to an entity, such as one's profession, that binds them to a course of action that is relevant to that entity, in the absence of extrinsic motivation (Meyer & Herscovitch, 2001). Commitment, as conceptualized in the organizational management literature, is distinguishable from exchange-based forms of motivation and can play a role in shaping behaviour even in the absence of extrinsic motivation or positive attitudes.

Antecedents of commitment have been widely studied through the lens of organizational support theory which stipulates that employees form general beliefs concerning how much their organization values their contributions and cares about their well-being. It has been demonstrated that employees who feel valued and supported by their organization reciprocate through their commitment to organizational goals and to the behaviours that contribute to the achievement of those goals (Eisenberger, Armeli, Rexwinkel, Lynch, & Rhoades, 2001).

Summary of Previous Research

Previous research consistently reports that health care professionals (a) value professional development and pursue it primarily to improve their own knowledge for the purpose of providing better patient care, (b) receive mixed messages from policy makers and employers about professional development, and (c) identify economic, administrative, and inter-professional barriers to professional development itself and to the integration of new knowledge into their practice (Dowswell, Hewison, & Hinds,

1998; Furze & Pearcey, 1999; Huggins, 2004; Rappolt & Tassone, 2002; Townsend, LeMay-Sheffield, Stadnyk, & Beagan, 2006). Outside the health care arena, a study of professional accountants noted that attitudes towards professional development correlated more with identification with, and commitment to, the profession than with tenure within the profession, job status, age, and qualification level (Rothwell & Herbert, 2007).

In her study of the variables affecting the competency maintenance behaviours of occupational therapists, Lysaght et al. (2001) concluded that "although environmental factors enhance competency maintenance activities, active participation in competency maintenance is also related to the personal commitment of the individual therapist" (p. 28). No studies were found that specifically examined the interaction between individuals' commitment to their profession, and organizational policies and procedures with respect to the professional development behaviours of Canadian occupational therapists. There are no existing models that capture the essence and relationships between the personal and the contextual factors that facilitate and inhibit continuing professional development. My study aims to begin the exploration of this gap.

Significance for Particular Audiences

The ultimate goal of professional development is the assurance of competent occupational therapy provision to the public (Courtney & Farnworth, 2003). Professional development enables therapists to find and critically evaluate evidence that may be applied to their practices (Rappolt & Tassone, 2002). An improved understanding of the associations between organizational context and support, professional commitment, and professional development behaviours will contribute to the theoretical base that informs (a) health and social policy-makers, (b) human resource management policy discussions

and practices, and (c) academic programs, professional associations and regulatory bodies about the internal mechanisms that underlie professional commitment and professional development.

Overview of Remainder of Dissertation

In the next chapter the theoretical foundation of the profession of occupational therapy, the development of its specialized knowledge base, and its professionalization are presented. An overview of the competencies required to practice occupational therapy in Canada is also presented. Chapter three describes the development of a hypothesized basic conceptual model of the associations between professional commitment, perceived organizational support, development-oriented human resource management practices, and professional development. Chapters four and five present the methods used to collect, measure, and analyze data, and the study results. Chapter six contains discussion of the study limitations, the theoretical and practical implications of my findings, and recommendations for future research.

CHAPTER 2

Background

This chapter sets the stage upon which the thesis of my study was developed and examined. My research was designed from the perspective of the contemporary occupational therapy paradigm (Kielhofner, 2004), thus reflecting the premises upon which the profession rests. One aspect of that paradigm is the belief that occupation (e.g. professional development) reflects the complex interactions between persons and their environments (Law et al., 1996).

I begin with an overview of the development of the profession of occupational therapy. First I describe the theoretical foundations of the profession, and the breadth and complexity of the occupational therapy knowledge base. This description provides the basis for understanding the growth trajectory of the profession, the evolution of its knowledge base, and the growing importance of professional development for occupational therapists. It also adds insights to how social and political context influenced this development. Second, I describe the professionalization of occupational therapy, and the societal expectations and individual practitioner responsibilities that are associated with being a professional, in particular those related to professional development. Lastly, I present a description of the environments in which occupational therapists currently practice and enact their professional development.

Occupational Therapy

Theoretical Underpinnings

The occupational therapy profession evolved out of the moral treatment approach to the care of persons with mental illness which was inspired by the *humanitarian* philosophy of the enlightenment period. In the early nineteenth century, philosopher Philippe Pinel proposed a *révolution morale* to replace the view that individuals with mental illness were dangerous, incurable, and should be locked away (Pinel, 1809). The main features of his moral treatment model included respect for human individuality, acceptance of the unity of mind and body, and the belief that a humanitarian approach using daily routine and occupation could restore mental health (Schwartz, 2006). At its core, moral treatment was an *environmental* therapy, in which physical, temporal, and social environments were engineered to correct the mentally ill person's *faulty habits of living* (A. Meyer, 1922). This was reflected in the thinking of the founders of occupational therapy, two of whom were architects, who conceptualized the importance of *proper healing environments* and the v*alue of creative, pleasurable experiences*. That is, they believed that a carefully-managed environment would provide patients with the opportunity to have their needs met, to develop healthy habits, and to strive to lead meaningful lives (A. Meyer, 1922).

Adolf Meyer, a psychiatrist, contributed further to the theoretical foundations of occupational therapy when he applied the views of nineteenth century *evolutionary* thinking, positing that psychiatric diseases were "largely problems of adaptation" to forces in the environment (A. Meyer, 1922). Occupational interventions for persons with mental illness were based on the premise that environment and how humans react,

respond, and adapt to it in all aspects of their lives are critical to well-being. The view that interaction between persons, the everyday activities in which they engage, and their environment, has guided both occupational therapy practice and its research knowledge. This view also inspired conceptual practice models that progressed occupational therapy to a holistic and comprehensive approach to patient evaluation, intervention, and determination of targeted outcomes. The ability to assess, plan interventions with patients, and agree outcomes based on in-depth knowledge of human functioning (biological, psychological, and spiritual), the environment (physical, social, cultural, institutional), and their effect on performance requires a specialized body of knowledge.

Emergence of a Specialized Body of Knowledge

The unique nature of the profession's knowledge base is the result of the diversity of the occupational therapy profession founders who originated from a variety of disciplines, including social work, architecture, medicine, arts and crafts education, and nursing. The founders integrated their knowledge and experiential backgrounds, influenced by humanitarian, environmental, and evolutionary paradigms, to develop a specific approach to intervention that focused on the healing potential of occupation and its inter-relationship with environments (Gordon, 2009). It must be noted that in 1917 the term occupation was defined as "what occupies one, means of filling up one's time" (Oxford University, 1911). As with many other terms, the meaning of the word occupation has evolved over the years to ultimately be used primarily in referring "a person's usual or principle … means of making a living" (Merriam-Webster, 2003). In my study, the word occupation is used in its broadest sense, e.g. "activities or tasks which engage a person' time and energy", "ordinary and familiar things that people do

everyday' (Townsend & Polatajko, 2007, p. 17), and "meaningful work, play, or daily living tasks in the stream of time and in the contexts of one's physical and social world" (Kielhofner, as cited in Townsend & Polatajko, p. 17). Research and increased knowledge have helped occupational therapists understand occupation at a deeper level, encompassing the notion that occupation, in it widest sense, is a biological imperative for individuals. For occupational therapists, occupation is a fundamental part of everyday living that is influenced by the environment in which it occurs, ultimately facilitates normal developments and self efficacy (Dickey, 2009) and is a requirement for health and well-being (Townsend & Polatajko, 2007).

A number of socio-political events occurred in the first half of the 20th century that influenced the evolution of occupational therapy. The most significant were: immigration to North America, industrialization, World War I, and the rise of the scientific model in health care. The surge of immigration to North America from Europe in the late 19th and early 20th centuries, led to a recognition of the need to assist immigrants in developing and maintaining useful skills for adapting to their new environment. Coinciding with this were the consequences of the later phases of the industrial revolution - specifically the migration of citizens from rural agrarian environments to urban factory-based employment both in Europe and in North America. Simultaneously, the 'arts and craft movement' arose in the United Kingdom as a potential solution for a growing number of workers who were dissatisfied with monotonous working conditions. It was felt that working at an art or craft was "spiritually uplifting and civilizing, and would serve as an antidote for the demoralizing repetitiveness of daily piece-work" (Friedland, 2003, p. 208). Settlement houses were established in Canada and

the United States with a mandate to decrease dependency in immigrant and poor populations, assist them in developing skills, build healthy communities, and improve quality of life. O*ccupational aides* were employed and under the leadership of the profession's founders utilized arts and crafts, and other cultural activities as intervention modalities (Friedland, 2003). Crafts were viewed as especially appropriate as they had the added benefit of providing attendees with potential future sources of income. The profession was formally named *occupational therapy* by its founders at an inauguration meeting in 1917 (Schwartz, 2006).

World War I also had a significant impact on the profession, resulting in the need for increased knowledge and skills in occupational therapy practitioners. Many returning soldiers were unable to return to their former jobs due to residual mental and physical impairments. The need to reintegrate veterans into society resulted in the broadening of occupational therapy practice to include assisting soldiers to develop return-to-work skills and thus prepare them for appropriate employment. Intervention programs consisted of: "bedside occupations for those still convalescing, workshop occupations for those well enough to leave the ward, and job training for those ready to pursue a new vocation" (Friedland & Davids-Brumer, 2007, p. 31). The programs "helped men move from the role of invalid to being productive, kept their thoughts from dwelling on their traumatic experiences, and began to give them hope for the future" (Friedland & Davids-Brumer, 2007, p.32). It was during this period that, in addition to the psychological benefits of occupation, the physical benefits of occupation were recognized and harnessed. By 1928, occupational therapy intervention was being described as follows:

> … a scheme of scientifically arranged activities which will give, to any set of muscles or related parts of the body in the cases of disease or injury, just the degree of movement and exercise that may be directed by a competent physician or surgeon. Stimulating heart action, respiration and blood circulation accurately prescribed, and at the same time yielding some joy and satisfaction that wisely selected wholesome occupation provides in normal life. It thus takes its place with nursing, medicine and surgery as one of the important departments of medical art (Dunton, 1917, p. 3).

As the century progressed, health and social care priorities, and intervention approaches evolved in response to emerging technology, cultural contexts and values, and perceived human needs. The reductionist scientific approach was increasingly embraced by the medical field to "understand health and illness phenomena through careful analysis of the building blocks of the human psyche and body" (Kielhofner, 2004, p.45). Scientific management theory became an underlying tenet of the science of medicine. Medical intervention in such a framework aimed at repairing broken parts through such means as surgery, chemotherapy, and psychotherapy.

Application of a reductionist approach to occupational therapy practice resulted in the selection of crafts and other activities for intervention purposes based on the analysis of components involved (e.g. joint position, muscle action, and muscle strengthening). As a result, the knowledge base and skills required to practice occupational therapy were once again considerably broadened. Occupational therapy education programs added knowledge of human systems and applied medical content to the humanities and social sciences in their curricula. Occupational therapy education programs retained the liberal arts, including the historical relationship of arts and crafts to health and well-being, but by the 1970's also included physiology, anatomy, neurosciences, pharmacology, kinesiology, pathology, general medicine, and psychiatry (Larson, Wood, & Clark,

2003). This shift towards a medical model had the effect of temporarily moving the profession away from community work into hospital-based practice. Hospital-based practice provided a secure and supervised environment for new graduates and set the scene for occupational therapy managers to initiate ongoing professional development for their staff based on expanding research and applied knowledge. Hospital based practice allowed for recognition of occupational therapy as an important contributor to the health care arena, but resulted in temporarily pulling the profession away from social sciences, art, and teaching, and moving occupational therapy practice towards work with physical illness and away from mental illness. When the profession found its way back to community based practice there was no organizational structure, nor historical precedent, for promoting the enactment of ongoing professional development.

During the late 1960's and early seventies a new social movement arose arguing that disability should be viewed from a cultural, political and social lens rather than a biomedical one. Disability was seen to be created by environmental factors that prevented individuals from being fully functioning members of society (Schwartz, 2006). This return to a more social view of the world initiated intense discussion within the profession and provided an opportunity for occupational therapy to distance itself from the reductionism of the medical model and to reclaim its original holistic, environmental, and patient-centred model of care. By the early 1980s, the profession was returning to its original philosophical tenets. Occupational therapists were once again articulating their distinctive view of the human need for occupation, and the belief that participation in occupation creates and affirms meaning in life, and is a determinant of health (Wilcock,1998; Yerxa, 1990). The inextricable link between occupation and

environment, as initially propounded by A. Meyer (1922), was re-emphasized and occupational therapists returned to community practice, starting with visits to hospitalized patients' homes and eventually moving their practices to the community via home care programs, community clinics, and school systems.

The renewed examination of occupation by academics sparked a return to the early theoretical frameworks to explain the art, science, and practice of occupational therapy (Mounter & Ilott, 2000). Occupation became a legitimate topic of research, and new and expanded ways of characterizing it continue to emerge. For example, Christiansen (1994) proposed that persons who are denied access to, or have restrictions in, meaningful occupations are at risk of experiencing a reduction in quality of life. A lack or disruption of participation in occupation is posited to restrict normal development resulting in reduction of functional capacity and maladaptive reactions (Whiteford, 1997). Occupation as diversion, as treatment, and as adaptation has been empirically demonstrated to be a successful means to the promotion of health and well-being as well as the prevention of disability and illness (Clark et al., 1997; Glass, de Leon, Marrottoli, & Berkman, 1999; Kleinman & Stalcup, 1991).

Occupational science, a multidisciplinary academic discipline, has emerged and is generating research and thinking about the construct of occupation that informs academic programs and occupational therapy practice. For example, Whiteford, (2000) has written about the occupational deprivation of individuals who are denied meaningful activity and the consequent reduction of self-efficacy and impact on identity construction. Other academic disciplines, including anthropology, psychology, and sociology, have joined the

ranks of occupational science scholars to examine occupation and its relationship with the environment and its effect on health and well-being.

The field's scope of practice grows exponentially as the research on the benefits of occupation are demonstrated in a variety of new and diverse ways and contexts. For example, occupational therapy practice has expanded beyond hospitals into private homes, schools, long term care centers, hospices, community centers, the workplace, insurance companies, the medical-legal arena and community clinics. Occupational therapists now intervene with the homeless and immigrants, and have added other populations such as prison inmates, war refugees, and retirees who seek assistance with transitioning to retirement, to their day-to-day practices. In 2006, the approximate distribution of employment areas of practicing occupational therapists was as follows: 45.6% were hospital-based, 30.8% were community-based (publically funded), 11.5% were in private practice, and 10.7% were employed by post-secondary institutions, governments, and commercial or manufacturing industry (Canadian Institute for Health Information, 2007).

Occupational therapy education programs are now at a Master's degree entry level and emphasize the profession's theoretical foundations, conceptual practice models, and lifelong scholarly practice. The professional and clinical competencies required for entry into practice and for on-going evidence-based practice have become increasingly arduous, particularly when considering the evolving environmental situations in which therapists work. Increasing knowledge and skills are required to critically appraise the evolving research that informs practice. Diverse historical contexts and academic disciplines have contributed to the profession's knowledge base, and more recently,

political and legislative forces have initiated and promoted the professionalization of occupational therapy.

Profession, Professionalization, and Professional Development

Professions are generally recognized as consisting of three essential characteristics: expert knowledge, self-regulation (which connotes autonomy and accountability), and a fiduciary responsibility to place patients ahead of self-interest (Larkin, Binder, Houry, & Adams, 2002). Professionalization is the process by which specific occupational groups develop and assume these characteristics (Haines, 1997). The development of a specialized body of knowledge was described earlier in this chapter. Following is a brief review of the journey travelled by the profession to acquire professional status and the embedded responsibility for ongoing development.

The professionalization of occupational therapy was set in motion in 1917 when education programs were established in Canada and the United States. By 1970 there were nine occupational therapy education programs across Canada. The Association of Canadian Occupational Therapy University Programs was founded in the late 1950s. This was a forum for developing programs to support each other and share information, and to foster consistency in educational curricula and consequently the standard of graduates. Employing organizations were encouraged to exclusively hire persons who were graduates of accredited university programs to guarantee the quality of the care provided by individuals who called themselves occupational therapists.

Meanwhile, given the political and legislative nature of Canada, practicing occupational therapists had been organizing themselves into provincial professional associations to promote their work and to mentor one another. In 1926, these provincial

associations gathered together to form the Canadian Association of Occupational Therapists (CAOT) whose role, among others was "the protection of the properly qualified [therapists] who [were] members of the Association" (Dunlop, 1933, p. 10). Within this role, the CAOT contributed to the establishment of standards for the education of student occupational therapists and in 1972 developed and implemented a national accreditation process for the systematic review and accreditation of program curricula based on these agreed standards..

Since the 1930s occupational therapists had been articulating the need for a better understanding and recognition of their work by other professionals and the public. For example, in 1935 Perigoe called for research that would provide a "scientific basis for more efficient treatment in the future" (cited in Friedland, Robinson, & Cardwell, 2001, p.18). Research in occupational therapy became a stronger theme in emerging professional journals such that, in 1968, leaders in the profession were predicting that the next era for the profession would be one of research activity (Cockburn, 2001). Today, there are more than 20 scientific occupational therapy journals, and researchers also publish in a number of related professional journals in medical, educational, and psychosocial sectors.

Through the 60s and 70s, occupational therapy leaders across Canada recognized that informal encouragement of employers to hire only graduates from accredited programs was not sufficient to ensure competent, safe, and ethical service provision. By the early 1980s provincial associations were lobbying their respective governments for legislated self-regulation. From a societal perspective, self -regulation is based on trust that members of specific professions are best qualified to set practice standards and to

monitor the practice of their members. Self regulation thus affirms society's acceptance of a profession's *autonomy* in the identification of knowledge, abilities, and skills required for its practice (Hall, 1968).

Professional *autonomy* demands that practitioners continually adapt to changing practice contexts, develop new intervention models as needed to serve patients, and make unique contributions to health care (Esdaile & Roth, 2000). Self-regulated professionals are personally *accountable* for their practice decisions, and for the outcomes of personal actions and services. Central to autonomy and accountability for practice effectiveness is a personal responsibility and professional obligation to maintain and enhance competence. Ongoing competence is achieved through commitment to continuing competence and to scholarship (Fawcett & Strickland, 1998; Swick, 2000).

All Canadian provinces now mandate professional regulatory bodies to monitor their members with respect to the specified competencies essential to the delivery of safe, ethical, and effective practice. Regulatory bodies are also required, through legislation, to implement mechanisms for monitoring the competence of their registrants. For example, the Health Professions Act of Alberta (2004) states that professional regulatory bodies "must establish, maintain and enforce standards for registration and of continuing competence and standards of practice of the regulated profession" (Government of Alberta, 2004, p. 15). All Canadian provinces have similar laws governing licensed health professionals.

In 1989 the registrars of all occupational therapy regulatory bodies formed the Association of Occupational Therapy Regulatory Organizations (ACOTRO), one of whose self-appointed tasks was the development of a comprehensive document listing

and describing the specific occupational therapy competencies that are essential for competent practice in Canada (ACOTRO, 2000). This continually up-dated list of competencies provides criteria against which regulatory organizations can assess occupational therapy graduates to ensure fitness to practice. Practicing occupational therapists are required to provide evidence that demonstrates these competencies to their regulatory bodies in order to annually renew their license. The competencies are organized into seven units, all equally essential, and each with specified performance indicators. The units are: Assumes Professional Responsibility, Demonstrates Practice Knowledge, Utilizes a Practice Process, Thinks Critically, Communicates Effectively, Engages in Professional Development, and Manages the Practice Environment. Table 2.1 displays the *competencies* and *performance indicators* that relate specifically to the domain of professional development.

The final commonly agreed characteristic of a profession is the fiduciary responsibility of its members to place patients ahead of self interest (Larkin, 2002). Provincial regulatory bodies each maintain a Code of Ethics that guides members' practice. These codes encompass the concepts of respect for client, integrity in practice, and the primacy of clients' welfare (e.g. Alberta College of Occupational Therapists, 2007). Failure to comply with these concepts has the potential to result in disciplinary measures. As practitioner-patient trust is inherent in fiduciary responsibility, professional development must occur to ensure ethical, safe, and effective practice.

The need for ongoing professional development is thus inherent in the identified professional attributes: i.e. specialized expert knowledge, self -regulation (autonomy and accountability), and fiduciary responsibility to patients.

Table 2.1

Units, competencies and performance indicators related to professional development

Unit Title	Competencies	Performance Indicators
Assumes professional responsibility	Practises within the scope of professional and personal limitations and abilities	Keeps abreast of changes in practice setting that affect scope of practice
		Engages in a process to identify personal and professional abilities and limitations that may impact on professional practice
		Takes action to ensure that personal and professional abilities and limitations do not cause practice to fall below a level considered acceptable in the jurisdiction
Engages in professional development	Demonstrates a process of self-evaluation related to one's practice and participates in on-going professional development	Identifies areas requiring new learning
		Identifies learning strategies for professional growth
		Actively participates in the acquisition of new knowledge and skills
		Demonstrates integration of new knowledge, skills, and behaviours into practice
		Identifies and utilizes appropriate resources to advance professional knowledge, skills, and behaviour
		Uses various sources of information for professional development
		Reviews and critically evaluates the information obtained for professional development

As the occupational therapy knowledge base is continually updated and expanded, professional development is essential for the integration of research and clinical-evidence into current and new practice contexts. Self regulating professionals, such as occupational therapists are expected to maintain and enhance their competencies to ensure they are capable of practicing with autonomy and accountability.

Professional Development

Professional development is defined for the purpose of this study as "the systematic maintenance, improvement and broadening of knowledge and skills, …for the execution of professional and technical duties throughout the individual's working life" (Haines, 1997). Placed in the context of lifelong learning professional development is more than attending an occasional course, but rather a process that involves a long-term investment or commitment throughout a professional career (Madill, 1984). For the purpose of this study, professional development is proposed to be the *behavioral manifestation* of on-going personal commitment to maintain and improve professional competence (Meyer, Allen & Smith, 1993).

Health professionals actively learn from a variety of sources. Workshops, conferences, seminars, on-site in-services, reading professional journals, consulting a mentor or peer, critical reflection of one's own practice, student supervision, conducting research, and academic course work have all been identified by therapists as methods used to maintain and enhance their professional and clinical competence (Courtney & Farnworth, 2003; Craik & Rappolt, 2006; Hobson, 1990; Long & Emery, 2000; Lysaght et al., 2001).

The ultimate goal of competency maintenance and enhancement is the delivery of better patient care (Brockett & Bauer, 1998; Umble & Cervero, 1996; Waddell, 2001). There is ample evidence that professional development contributes both directly and indirectly to organizational effectiveness. Waddell found that 75% of health care practitioners who participate in professional development deliver improved patient care upon their return to the work environment. Other empirically demonstrated beneficiaries of professional development include: the individual professional, employing organizations, professional associations, and society at large by way of well-informed social policy (Grzyb et al., 1998). More specifically, Nolan et al. (1995) demonstrated that improved patient care planning, enhanced informal exchange of ideas between practitioners, greater assertiveness and autonomy in practice, and enhanced competence and accountability were all outcomes of professional development. Overall, professional development enhanced practitioners' abilities to respond to rapid changes in the delivery of health care and to better meet the needs of society.

By virtue of their professional status, and the autonomy and accountability entrusted to them, occupational therapists are "responsible for meeting [practice standards], irrespective of the practice context and the specific demands of the work environment" (Rappolt et al., 2002, p.294). Individual occupational therapists are thus accountable for the maintenance and enhancement of their competencies, including adapting to social, economic, and policy changes they encounter throughout their career. As an occupational therapist, knowledge of the interrelationships between personal characteristics, environmental conditions, and occupational demands prompted me to examine professional development from a person-environment-occupation perspective.

Application of the occupation therapy paradigm, as described earlier in this thesis, demands consideration of the impact of environment on the actualization of professional responsibility for professional development on the part of occupational therapists. The next section provides a description of the environments in which occupational therapists currently practice.

Current Health Care Environments

In his description of professionalism, Hall (1968) referred to the need for professionals to continually adjudicate between the administrative and policy practices of their organization and the requirements of their own professional codes. Over the past few decades, health care professionals and organizations around the developed world have been buffeted by rising costs, perceived inefficient use of resources, and consumer and provider dissatisfaction with the delivery and outcomes of care (Rathwell & Persaud, 2002). In Canada, as in many other countries in which health care is publicly funded, a new health care management paradigm evolved that is largely based on the application of market-based approaches to policy frameworks and to the delivery of services. This resulted in a move to a service line management structure that in most cases included the replacement of profession-specific management structures with *program-based* administrative models that use specific patient populations as the organizational unit. Within this model, all members of the team who intervene with a given diagnostic group (e.g. stroke, spinal cord injury, psychiatric illness) report to one program director (Gage, 1995). In effect, this resulted in a shift of authority and responsibility for professional service delivery from professional managers to *program* (e.g. neurology, oncology, pediatrics, psychiatry) directors, managers or coordinators. As such members of all

professions within a program report directly to program managers who, regardless of their professional background, normally have full accountability for the fiscal and human resources within their respective programs.

Though the rationale for these changes may have been well-advised and even appropriate, there were unintended consequences as a result of the drastic reduction or elimination of positions directly related to monitoring the competencies and professional development needs of practitioners. Research on these restructured environments demonstrates that, while therapists are highly motivated to continue their education (Humphris, Littlejohns, Victor, O'Halloran, & Peacock, 2000), workplace barriers, including lack of availability of peer mentoring and quality monitoring systems, thwart ambitions to achieve high standards of professional development (Lysaght et al., 2001; Rappolt,).

Some organizations, recognizing the need for each health care discipline to maintain clinical and professional competence and accountability for their practice, created profession-specific *practice leader* positions. Incumbents were charged with overseeing the quality and standards of patient care (Salvatore, Simonavicius, Moore, Rimmer, & Patterson, 2008). These positions however are usually advisory in nature and incumbents normally do not have line authority over professional services, and are rarely provided with budgets for promoting professional development and quality assurance (Globerman, Davies, & Walsh, 1996; Rappolt et al., 2002). In addition, practice leaders are often too far removed geographically from the day-to-day practice of the professional staff to mentor and provide useful feedback on their performance, and have little time to devote to this activity as they often carry clinical caseloads of their own (Salvatore et al.,

2008).

As the program management model effectively eliminated middle management and profession-specific supervisory staff, individual professionals are increasingly placed in situations of greater personal autonomy and responsibility for their clinical decisions and actions (Globerman et al., 1996). In the absence of profession-specific management and monitoring of health care practitioners, the personal responsibility of each to maintain his/her clinical competence, via professional development, is all the more pronounced.

Summary

Occupational therapy is a recognized profession with an expert knowledge base that continues to broaden as new research evidence emerges to inform practice. Professional development enables therapists to remain current with respect to evolving intervention approaches, evidence of practice effectiveness, and new practice contexts. As previously discussed, occupational therapists are personally accountable for the application of their expert knowledge across evolving health care environments. However, an emerging observation in the literature is that the frequency and intensity of professional development may reflect the extent to which employing organizations support and encourage these activities (Lysaght et al., 2001).

Over the past two decades, health care has undergone massive change, both in knowledge and in technological advancements, as well as the manner in which services are structured and delivered (Angus, Auer, Cloutier, & Albert, 1995). Social, political, and financial pressures have resulted in massive organizational restructuring, which in turn influenced the delivery of occupational therapy, transforming both role descriptions

and client care processes (Lloyd & King, 2001). Occupational therapists and other healthcare professionals have reported ever-increasing difficulties in maintaining professional development activities (Canadian Physiotherapy Association, 2000; Globerman et al., 1996; Herkt & Hocking, 2007; Hollis, Madill, Darrah, Warren, & Rivard, 2002; Lysaght et al., 2001). Rappolt et. al. (2002) specifically examined the impact of restructured organizational environments on occupational therapists' capacity to practice effectively and reported that front-line clinicians within the various forms of program management models experienced a sense of increasing alienation from their professional ideals, particularly that of professional development.

Organizational effectiveness requires that practitioners possess appropriate skills, knowledge and adaptive intervention approaches in order to effectively deal with the health and social needs of changing client populations and evolving trends in service delivery (Stolee et al., 2005). Organizational structures and human resource policies that facilitate and inhibit occupational therapists' professional development behaviours have been identified (Lysaght et al., 2001; Rappolt et al., 2002). However the individual psychological mechanisms that impact on professional development behaviors remain largely unknown. The following chapter describes the development of a conceptual model that describes the inter-relationships between individual occupational therapists, their practice environments, and the enactment of professional development.

CHAPTER 3

Development of a Conceptual Professional Development Model

In Chapter 2 professional development was defined, essentially, as an on-going personal commitment to remain current in one's technical field of expertise and to stretch and grow in one's professional role. From a legal and moral standpoint responsibility for professional development resides with individual professionals, even though the beneficiaries include persons and entities other than the professionals themselves (e.g., patients, employing organizations) (Umble & Cevero, 1996).

Research demonstrates that very often organizations simply expect that their professional staff will participate in development activities *on their own time* (Grzyb et al., 1998; Maurer & Shore, 1995; Nolan et al., 1995). However, an emerging observation in the literature is that, while individual commitment to professional development is important, the frequency and intensity of professional development may also reflect the extent to which employing organizations support and encourage these activities (Lysaght, et al., 2001; Rappolt, et al., 2002). So, while professionals and their employers may ultimately agree that development is a personal responsibility, important questions regarding how the actions of employing organizations facilitate or frustrate on-going learning processes remain unaddressed. For example, the effects of organizational support and human resources management practices, and how they are perceived, on professional development are unclear. These observations are congruent with the contemporary occupational therapy paradigm that is premised on the assumption that occupations are reciprocal transactions between people and their environment (Stone,

2005).

This chapter describes the development of a model of the processes through which occupational therapists enact their professional development (see Figure 1). First, I introduce the concept of professional development as a form of discretionary behaviour. Second, I discuss the interplay between the therapist's commitment to her profession and the expression of this commitment through a variety of discretionary professional development activities. The theoretical framework underlying the model development includes Meyer and Herscovitch's (2001) general theory of workplace commitment, and organizational support theory (Eisenberger et al., 1986; Rhoades & Eisenberger, 2002).

I then consider how the level of organizational support and management practices within the facility enhances or erodes professional commitment and actual development activities.

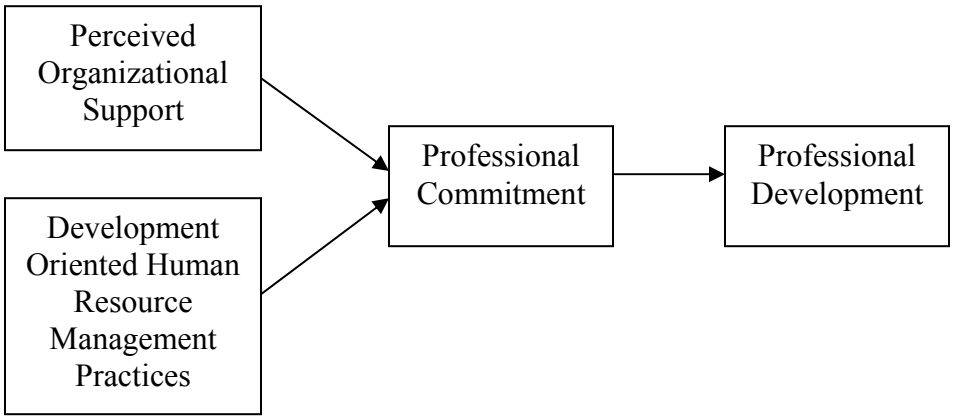

Figure 1 - Basic Professional Development Process Model

Clearly there are several other factors that might impact on the professional development behaviours of Canadian occupational therapists. For example, all occupational therapists are *required* by their regulatory bodies to provide evidence of their continuing competency activities. Other factors impacting on professional development might include, accessibility in a given geographic area, and applicability of education programming, therapists' personal commitment to evidence-based practice, peer pressure, and/or a naturally curious mind. However, as stated previously, I was specifically interested in exploring how the associations between person and environment impact on professional development behaviours of occupational therapists, and doing so from a specific psychosocial theoretical framework.

Professional Development as a Form of Citizenship Behaviour

A core characteristic of any profession is that its members are trusted to demonstrate technical and professional competence and to comply with ethical codes of conduct. In short, professionals are trusted to manage themselves. This requires ongoing professional development which is defined for this study as "… the systematic maintenance, improvement and broadening of knowledge and skills, and the development of personal qualities necessary for the execution of professional and technical duties throughout the individual's working life" (Lawton & Wimpenny, 2003, p. 41). As presented in Chapter 2, engaging in professional development reflects the ownership of professional accountability for practice effectiveness, and a responsibility to self, patients, co-workers, the profession, and the employer . On-going development is thus an important and fundamental activity.

Although employing organizations normally expect their professional staff to accept responsibility for staying current, they do not typically actively manage or reward development-oriented behaviours. A recent study by Townsend et al., (2006) found that there is a general lack of financial incentive for professional development and that formal expectations regarding these activities are often neither included in position descriptions nor in performance appraisals. Moreover, the remuneration and promotion of the majority of occupational therapists employed in publically funded organizations are affected more by the provisions in collective agreements (seniority, professional qualification) than the individual practitioners' attributes and competencies (e.g. Health Science Association of Alberta, 2008). Effectively then, the responsibility of maintaining competence typically rests with the individual. Viewed from the perspective of a professional being personally responsible for competency maintenance, professional development can thus be considered, in organizational terms, as *discretionary* in that professional development activities are controlled by the individual - those who choose to engage in professional development activities will likely vary with respect to the type and frequency of activities they engage in. This view of professional development activities as a discretionary activity has parallels with the citizenship behaviour construct.

Citizenship behaviour stems from the notion of being a good citizen, e.g. "helping a co-worker with a problem" (Bateman & Organ, 1983). In an organizational context, citizenship behaviour refers to voluntary employee activities that may or may not be managed or rewarded but that, in their aggregate, promote the efficient and effective functioning of the organization (Organ, 1997). Common examples of citizenship behaviours would be helping coworkers who have been absent, being punctual, working

with effort and enthusiasm, volunteering for tasks that are not part of one's job, and making innovative suggestions to improve the organization. Although there are many different types of behaviours that might seem to fit the definition of citizenship behaviour, research suggests two broad categories that differ according to who benefits from the activity: coworkers or the organization (Coleman & Borman, 2000). However, regardless of who benefits from these behaviours, citizenship behaviours generally: (a) go beyond formal role prescriptions (Miles, Borman, Spector, & Fox, 2002; Smith, Organ, & Near, 1983); (b) are not contractually rewarded or practically enforceable (Konovsky & Organ, 1996) and, (c) are necessary for the effective functioning of work units and organizations. Although not rewarded, discretionary behaviours are recognized as contributing to the effective functioning of organizations and play a part in enhancing productivity, building stronger organizational ability to attract and retain the best employees, and increasing organizational ability to adapt to environmental changes (Podsakoff & MacKenzie, 1997).

Of course professional development differs from citizenship behaviour in a number of ways. For instance, professional development is mandated by professional regulatory bodies, often requires time away from home, family, and other social commitments, and typically results in tangible personal outcomes such as receiving the kudos of colleagues for completing a course and/or receiving a certificate, diploma or degree. Nonetheless, there are sufficient similarities to suggest that professional development can be viewed as a form of discretionary citizenship behaviour.

Professional development behaviours are discretionary in the sense that it is often up to the therapist to decide *what, when,* and *how* activities occur, and that they

ultimately benefit clients, the employing organization, and the profession. This similarity provides a conceptual bridge to a literature that potentially affords new insight into the factors that influence professional development in an organizational context. Select theoretical lens used to view citizenship behaviour may also help us better understand professional development. In the next section, I look at one of the recognized antecedents of citizenship behaviours, employee commitment, and propose how it might also affect the frequency of professional development activities.

Professional Commitment and Professional Development

The notion of commitment to one's profession is not new. To help examine the link between professional commitment and professional development, I turn to the work of Meyer and Herscovitch, 2001. Meyer and Herscovitch reviewed the extensive literature related to commitment to various entities including the organization (Mathieu & Zajac, 1990), unions (Barling, Fullagar, & Thompson, 1992), occupations and professions (Blau, 1999; Meyer et al. 1993), teams and leaders (Hunt & Morgan, 1994), goals (Locke, Latham, & Erez, 1988), and personal careers, (Hall,1996). Aiming to provide consistency in future commitment research that is useful to employers who seek direction on questions such as: should we foster commitment in employees? and if so, commitment to what?, Meyer and Herscotvitch proposed a "general theory of workplace commitment". They argued that commitment has a "core essence" regardless of the context in which it is studied. Their proposed model is based on the propositions that "commitment is [a] force that binds an individual to a course of action of relevance to a target and (b) can be accompanied by different mind-sets that play a role in shaping behaviour" (p. 299). In the present study, this "generable theory of workplace

commitment" is applied to commitment to one's profession. Professional commitment is thus defined for examination in this study as: the psychological link between individuals and their profession that is based on an affective attachment, and that binds individuals to a course of action of relevance to their profession (Blau, 1999, Meyer et al.,1993). Please note that the terms occupation and profession are used interchangeably in the literature. In Chapter 2, I demonstrated the professionalization journey traveled by the occupational therapy profession as defined in the sociological literature (Hall, 1968; Friedson, 1994; Snizek, 1972). I chose to use the term *profession* throughout my study as targeted participants consider themselves and are viewed by the public as professionals. To understand how professional commitment develops I begin with a discussion of commitment in terms of its *behavioural consequences*, its *forms*, and its *correlates.*

Behavioural consequences.

Meyer and Herscovitch (2001) distinguish between two types of commitment-relevant behaviour: focal and discretionary. *Focal behaviours* are those to which an individual is bound by his or her commitment to a given target. When the target is an occupation or profession, the focal behaviour would be the specific intra-role (technical) activities that clearly demarcate it (e.g., doctors examine patients; construction engineers build structures) and that are explicitly identified in one's position description.

In addition to these focal behaviours, employees will often express their commitment through *discretionary behaviours* that are not explicitly specified within terms of employment. Discretionary behaviours of a committed individual are acts that might be viewed by others as beyond their "formal" role, but which the committed individuals view as included in their role or position. Within the context of professional

commitment, discretionary behaviour would include those activities that are self-initiated and not formally or contractually required by the employer, but that are nevertheless viewed by the incumbent as falling within the scope of her commitment to her profession.

Forms of commitment

Regardless of the particular foci Meyer and Herscovitch (2001) assert that viewing commitment as a "binding force" suggests that commitment is experienced as a mind-set (i.e., "a frame of mind … that compels an individual toward a course of action", p. 303). The authors extend Meyer and Allen's (1991) description of organizational commitment that "the *mind-set* accompanying commitment can take various forms including desire, perceived cost, and perceived obligation" to their proposed general commitment model. These mind-sets are conceptualized as follows. *Affective* commitment refers to the employees' emotional attachment to, personal identification with, and involvement in an entity. For example, employees with a strong affective professional commitment would remain within their profession because they *want* to do so. A further consequence of a *desire-based* (affective commitment) mind-set is that behavioural implications tend to be more broadly defined by the individual than if the commitment is non-affective in nature. In the case of being a competent professional, this may mean voluntarily engaging in (discretionary) professional development activities, regardless of whether these activities are formally required or rewarded by the employer. *Continuance* commitment refers to an awareness of the costs associated with leaving one's profession, such as expenses associated with retraining or difficulty finding work that pays the same as their current professional role. Employees whose primary link to a profession is based on continuance commitment remain in their profession because they

feel they *need* to. *Normative* commitment reflects a feeling of obligation to continue within a profession. For example, persons who have undergone a considerable amount of education and training to acquire a skill set might feel that they o*ught* to remain in their profession given the investment in time and money.

These different forms of commitment have different *correlates*, including empirically demonstrated antecedents and consequences (Mathieu & Zajac, 1990; Meyer et al., 1993; Meyer, Stanley, Herscovitch, & Topolnysky, 2002). In the present study, my focus was on affective professional commitment, which has the strongest demonstrated links to *discretionary* behaviors (Meyer et al., 2002; Organ & Ryan, 1995). The remainder of my discussion therefore applies only to the *affective* form of professional commitment, and is referred to simply as professional commitment.

Correlates of professional commitment.

Meyer et al. (1993) examined the professional commitment of registered nurses and found that professional commitment correlated positively and significantly with a range of profession and organization-relevant outcome measures, including sense of obligation to others, helping others, and effective use of time. On the other hand, professional commitment correlated negatively with tardiness, voluntary absence, and intent to leave the profession and the organization. Using hierarchical regression analysis, Meyer et al. also demonstrated that professional commitment predicted intention to leave the nursing profession, and involvement in professional activities. Their measurement of the latter included items related to number of courses taken since becoming a nurse, number of journals currently subscribed to or read on a regular basis, number of

professional books purchased within the past five years, their degree of involvement in professional associations, and amount of nursing-related volunteer work they had done.

It is important to note that, historically, researchers have suggested that commitment to professional and commitment to organization may be incompatible (Wallace, 1993). This view was not supported by Meyer et al.'s findings (1993) which demonstrated that while organizational commitment and professional commitment are distinct constructs, they correlate positively with each other and share a number of correlates. For example, commitment to both organization and profession correlated positively and significantly with: ratings of job satisfaction, sense of obligation to others, intention to leave both the organization and the profession, involvement in professional activities, and several organizational-relevant outcome measures such as helping others effective use of time. Meyer et al. further demonstrated, using hierarchical regression analysis, that both types of commitment made *unique* and significant contributions to the prediction of all of these variables, including of professional activity. In support of this, Vandenburg and Scarpello (1994) later demonstrated a causal relationship between professional commitment and organizational commitment; that is, their cross-lagged analysis supported suggestions in previous literature that viewed professional commitment as an antecedent of organizational commitment.

Returning to Meyer and Herscovitch's (2001) general theory of workplace commitment, a reasonable expectation is that people who experience high rather than low affective commitment to their profession will interpret their professional role more broadly to include both focal and discretionary acts. Moreover, people who experience a strong affective bond to their professional role will likely engage in a range of

discretionary behaviours seen to fulfill the terms of commitment defined by the individual. In the case of being a competent professional (as defined in professional documents and licensing requirements), this means voluntarily and routinely engaging in professional development activities, regardless of whether these activities are formally required/rewarded by the employer. It is thus hypothesized that:

> *Hypothesis 1: A positive relationship exists between the level of affective commitment to the profession and the frequency of professional development activities.*

Organizational Support, Commitment, and Professional Development

In keeping with the contemporary occupational therapy paradigm as a guide to my research design, I included consideration of the environmental characteristics in which occupational therapists practice in my proposed conceptual model. In this section, I look at some of the more salient aspects of organizational context that might impact on professional commitment and professional development. To accomplish this objective I draw on ideas expressed in organizational support theory (Eisenberger et al., 1986; Rhoades, Eisenberger, & Armeli, 2001).

At the heart of organizational support theory is the notion that individuals and organizations (or their agents) are situated in a give-and-take relationship, a relationship where both social and economic exchanges occur (Blau, 1964). Organizational support theory is focused on such social exchanges that occur between individuals and their organizations. Organizational support theory is distinct from commitment theory, as described in the previous section, in that it relates to a state of mind that exists when an individual experiences a positive exchange relationship with their organization (Meyer &

Herscovitch, 2001). Supportive management practices, for instance, are exchanged or reciprocated in kind by employees through their loyalty and dedication. Through their day-to-day experiences with agents of the organization, such as managers, individuals develop general beliefs concerning the extent to which the organization values their contributions and cares about their well-being. Beliefs about the genuineness and sincerity of this caring depend on employees' interpretation of the underlying motives of the organization. Agents' actions are thus perceived as indications of the organization's intent rather than attributed solely to the agents' personal motive (Rhoades & Eisenberger, 2002). Based on this "personification" of their organization, employees interpret favorable or unfavorable treatment as an indication that the organization favors or disfavors them and their contributions.

Organizational support theory also addresses the psychological processes underlying the consequences of these perceptions. First, on the basis of the reciprocity norm, employees' perceptions of a supportive organization produce a felt obligation to care about the organization's welfare and to help the organization reach its objectives. Second, to the extent that the caring, approval, and respect connoted by perceived organizational support satisfies important social and emotional needs, individuals incorporate organizational membership and role status into their social identity. Third, perceptions of support strengthen employees' beliefs that the organization genuinely recognizes and rewards increased performance. These processes have favorable outcomes for employees such as enhanced identification with, and interest in, the specific work they do (e.g. their professional role), and for the organization, such as increased

involvement in the organizational activities and willingness to pursue organizational goals (Meyer & Allen, 1991; Rhoades & Eisenberger, 2002).

Hundreds of studies have examined the correlations between affective organizational commitment and a variety of hypothesized *antecedents*. By far the vast majority of these antecedent studies focused on variables that fall into the category of work experiences. The variables most consistently and strongly associated with affective commitment are work experiences that communicate the organization's support for its employees and that "enhance[s] their sense of personal importance and competence by appearing to value their contributions to the organization" (Meyer & Allen, p.46). Demonstrated *consequences* of perceived organizational support include (a) actions that go beyond assigned responsibilities such as gaining knowledge and skills that are beneficial to the organization (George & Brief, 1992) and (b) job involvement, defined as "identification with and interest in the specific work one performs" (Rhoades & Eisenberger, 2002, p. 701).

Meyer and Allen (1997) suggested that correlates of organizational commitment are likely to apply to other domains (profession, union) to which employees become committed. On the basis of this suggestion I proposed that, to the extent that individual professionals perceive their organization to actively support them, organizational support theory would predict that individuals will reciprocate in kind, and demonstrate affective commitment to their profession:

> *Hypothesis 2. A positive relationship exists between perceived organizational support and affective commitment to the profession.*

Further, individuals who perceive their organizations to be supportive of them will not only experience high rather than low affective commitment to their profession but will exhibit a greater frequency of discretionary professional development activities.

> *Hypothesis 3. The relationship between perceived organizational support and professional development activities is mediated by affective commitment to the profession.*

Management Practices, Commitment, and Professional Development

In Chapter 2, I defined professional development as an on-going personal commitment to remain current in one's technical field of expertise, and to stretch and grow in one's professional role. I also suggested that the responsibility for these activities falls to individual professionals themselves even though the organization is a primary beneficiary of such activities. In the previous sections of this chapter the effect of organizational support, and how it is perceived by employees, on commitment and discretionary development-oriented activities was explored. In this section I discuss how professional commitment, and in turn professional development, can be shaped by an organization's human resource management practices.

The notion that an organization can use its human resource management policies and procedures to create the conditions necessary for employee commitment is not new. Walton (1985) observed that instead of forcing employees to comply with organizational goals, restricting their discretion through narrowly-defined jobs, and extensive rules and procedures, an alternate approach would be to use the power of human resource management practices to facilitate voluntary employee involvement and identification with organizational goals. This approach was coined a *high-commitment* or *high-*

involvement approach to human resource management. Over the years, numerous examples of "commitment maximizing" practices and taxonomies of these practices have been documented in the literature (Arthur, 1994; Delaney & Huselid, 1996; Huselid, 1995; Pfeffer, 1995; Wood & de Menzies, 1998; Youndt, Snell, Dean, & Lepak, 1996).

Gellatly, Hunter, Currie, and Irving (2009) found, in a sample of university alumni, that perceptions of development-oriented human resource management practices aimed at building employee capabilities were more likely to be associated with a strong affective bond with the organization than a weak one. Their finding confirmed the findings of an earlier study by Meyer and Smith (2000) that perceptions of development-oriented human resource management practices (e.g., performance appraisal, training and development) correlated positively with affective organizational commitment. As alluded to earlier, organizational commitment and professional commitment correlate significantly and positively with each other (Lachman & Aranya, 1986; Lee, Carswell, & Allen, 2000; Mathieu & Zajac, 1990) in addition to sharing common antecedents and common consequences (Meyer et al., 1993). It is therefore reasonable to propose that human resource management practices that enhance organizational commitment might also enhance professional commitment.

With a focus on professional development, certain human resource management policies and practices seem particularly relevant. These include tangible support for training activities such as release time for professional development, and a performance management system that emphasizes goal-setting and feedback with respect to professional-development goals (Lysaght et al., 2001). Not only do these development-oriented management practices exemplify a "commitment maximizing" approach (e.g.,

Arthur, 1992; Walton, 1985), they also create conditions that facilitate rather than frustrate individual professionals' attempts to develop themselves. It follows that as the salience of these practices increases so to should commitment to the profession as well as expression of that commitment in terms of their discretionary professional development behaviour.

> *Hypothesis 4. A positive relationship exists between perceptions of development-oriented HRM practices and affective commitment to the profession.*
>
> *Hypothesis 5. The relationship between perceptions of development-oriented HRM practices and professional development activities is mediated by affective commitment to the profession.*

Summary

I set out to examine the associations between the professional commitment of occupational therapists and their enactment of professional development behaviours in current health care environments. Specifically, the direct effect of professional commitment on professional development behaviours, and its mediating effect on the relationships between perceived organizational support and select human resource management practices, and professional development were measured. This chapter described the development of a basic conceptual model of the psychological processes that effect actual professional development behaviours based on both commitment theory and organizational support theory. My study hypotheses are:

1. A positive relationship exists between affective commitment to the profession and the frequency of professional development activities.
2. A positive relationship exists between perceived organizational support and affective commitment to the profession.

3. The relationship between perceived organizational support and professional development activities is mediated by affective commitment to the profession.

4. A positive relationship exists between perceptions of development-oriented human resource management practices and affective commitment to the profession.

5. The relationship between perceptions of development-oriented human resources management practices and professional development activities is mediated by affective commitment to the profession.

Chapter 4 presents the methodology used to design and conduct this study. Specifically, the methods used to: validate the measurement model, select the sample, collect and analyze the data, and test the hypotheses, are presented.

CHAPTER 4

Research Methods

My study examined the inter-relationships between professional commitment, perceived organizational context, and the enactment of professional development by practicing occupational therapists across Canada. In Chapter 3, I proposed a basic conceptual model of the hypothesized relationships between those variables. This chapter presents a description of the: target population, sampling technique and resulting sample, procedure for data collection, instruments used to measure the variables in the conceptual model, and the data analysis strategy used to examine the hypotheses.

Target Population

As organizational contexts and human resource management practices vary considerably from setting to setting, and from province to province, I chose to sample a broad representation of the environments and conditions in which occupational therapists work. The target population for this study was all Canadian practicing occupational therapists of which there are approximately 11,300 (Canadian Institute for Health Information, 2007). Table 4.1 depicts general demographic information about the target population as well as the settings in which occupational therapists practiced at the time the data for this study were collected (Canadian Association of Occupational Therapists, 2001). These data, except for those related to credentials information, represent occupational therapists who were members of the CAOT at the time the association's survey was administered.

Table 4.1

Population Demographics and Practice Settings

Age *		Gender*		Credentials: ‡		Practice Setting *	
24 or less	2%	Female	91%	Diploma/BSc	87%	Hospital	45%
25 - 34	33%			Masters	11%	Education System	8%
35 - 44	31%					Residential Care Facility	4%
45 - 54	24%					Community Health Center	10%
55 - 64	8%					Home Care	6%
65 +	1%					Industry	1%

Note. * CAOT data; Percentages are based on number of members who responded to the survey.
‡ CIHI data, 2007 (excludes Québec).

Credentials information was accessed from the CIHI (Canadian Institute for Health Information, 2007) and reflects summary information for all practicing Canadian occupational therapists. The CIHI obtains its data via collaboration with all provincial regulatory organizations (except Québec), and the CAOT. As a stringent quality-assurance process is in place to ensure accuracy, this data is considered to be of high quality (CIHI, 2007). Membership with the CAOT is voluntary, with approximately 68% of occupational therapists outside Québec, and 15% of occupational therapists within Québec choosing to be members. The lower proportion of CAOT membership in Québec is likely due to the fact that occupational therapists practising in Québec are not required to sit the CAOT national certification examination in order to become licensed to practise in that province. In addition the CAOT offers minimal services in the French language.

Occupational therapists practise in a variety of settings including publicly funded, non-profit, and for-profit organizations. Examples of practice areas in which they are most likely to provide services include general physical health, neurology, mental health, vocational rehabilitation, health promotion and wellness throughout the lifespan, and palliative care. Therapists practicing in all these areas were considered for inclusion in the study. Self-employed therapists (14%) and academicians (4.3%) however were excluded from the sampling process. As self-employed therapists are *their own employer*, many of the items in the questionnaire regarding organizational commitment, perceived support for professional development, and so forth, were either inappropriately worded or not applicable to them. Academicians were not included because the nature of their work is atypical to that of therapists in clinical practice settings. In addition, one cannot assume

that organizational changes and workplace support in health care have affected employees of academic institutions and private practices in the same way.

Sampling

A stratified systematic sampling approach was selected to ensure proportional representation from each of the Canadian provinces and territories. At the time of the study, a license to practice was required by practicing therapists in all constituencies except the Territories and New Brunswick. As such the lists maintained by provincial regulatory bodies are, in principle, a reliable and complete source of names and addresses of practicing occupational therapists across Canada. Once the sample proportion required from each constituency was determined (see Table 4.2) every N^{th} name, starting from a random name, was systematically selected from the respective provincial regulatory body's membership list. The selected "N#" was calculated based on the number of occupational therapists practicing in each given constituency divided by the number of participants needed as determined by the identified proportion practicing therapists in that constituency. This method was chosen to enhance the likelihood that the overall sample represented the population of interest, thus improving the potential for the generalization of findings from the sample to the target population (Creswell, 2009). Therapists from British Columbia, Alberta, Saskatchewan, Manitoba, Québec, Nova Scotia, and Prince Edward Island were selected in this manner. Despite several written and verbal communications, the occupational therapy regulatory body in Newfoundland and Labrador (NL) did not respond to requests for membership lists. As a result, therapists from that province (N = 137) were not included in my sample.

Table 4.2

Sampling Proportions

Province/ Territory	Total in 2001	Estimated in 2005 *	Percentage of total in Canada	Surveys sent per constituency (%)
NL	137	+ 9 = 146	.01	-
P.E.I	34	-5 = 29	.002	22 (1)
N.S.	3	+ 71 = 314	2.7	55 (2.5)
N.B.	206	+ 53 = 259	2.3	50 (2.2)
Quebec	2618	+ 400 = 3018	26.8	616 (28)
Ontario	3382	+ 601 = 3983	35.4	790 (36)
Manitoba	422	+ 93 = 515	4.6	110 (5)
Saskatchewan	222	+ 76 = 298	2.7	50 (2)
Alberta	974	+ 267 = 1241	11	220 (10)
B.C.	1234	+ 205 = 1439	13	286 (13)
Y.T.	12	- 4 = 8	trace	12 (.005)
N.W.T.	7	-1 = 6	trace	7 (.003)
Nunavut	No data	4	trace	4 (.002)
Total	9495	11238	99.5	2222

Note. * Numbers have been adjusted to account for increases in practicing Canadian occupational therapists during the four years since the survey results were published by the CAOT in 2001. Numbers for 2005 were estimated by examining the growth pattern in numbers of occupational therapists per constituency over the past 4 years and adding the mean growth (e.g. approx 71 additional therapists in NS between 2001 and 2005) within each constituency to its 2001 total.

In cases where provincial/territorial regulatory bodies did not exist at the time of this study, (New Brunswick, Yukon, Northwest Territories, and Nunavut) practising occupational therapists are required to be members of the CAOT. A list of names for these constituencies was obtained from the CAOT which has the capacity to randomize according to select criteria within its membership software package. The CAOT provided randomly selected names in numbers that reflect the appropriate percentage of Canadian therapists practicing in New Brunswick, Yukon, Northwest Territories, and Nunavut. Unfortunately, as NL has its own regulatory body, CAOT does not hold a complete registry of its practising occupational therapists, and as such, a list of names from that association would not have been complete. The 2001 CAOT survey utilized membership lists obtained from each of the provincial regulatory bodies, in addition to its own data for provinces/territories that do not have regulatory bodies' to scope the numbers and characteristics of Canadian occupational therapists. Because the CAOT numbers were from 4 years previous, they were adjusted for this study to account for increases in practicing Canadian occupational therapists during the 4 years since the population results published by the CAOT in 2001. Numbers were adjusted by examining the growth pattern of occupational therapists per constituency over the past 4 years and adding the mean annual increases to each constituency's 2001 total. The growth pattern was calculated using data from annual CAOT membership statistics reports. This method of estimating growth projections was commonly used to calculate future staffing needs in my previous management positions.

Given an anticipated response rate of 20% and a set target of 400 respondents, 2,200 surveys were mailed out. Please see Appendix A for sample size calculations for

variance estimation for both continuous and categorical variables, and for regression analysis. Numbers of surveys sent per province and territory reflect as closely as possible the actual proportions of therapists employed in each constituency as determined by the 2001 CAOT survey. For example, therapists from Alberta represent roughly 11% of total practicing therapists in Canada; therefore 10% of the 2,200 questionnaires were sent to therapists practicing in Alberta.

Description of Sample

Of the 2,200 mailed questionnaires, 638 questionnaires were returned for a response rate of 29%. This rate does not account for inaccurate membership registries and/or situations in which questionnaire recipients had moved or were no longer with the same employer at the time of the survey (and as such would not have received the questionnaire). As Canadian occupational therapists are required to provide evidence of their professional development activities to respective regulatory bodies, reporting of information about professional development has the potential to be sensitive. It was thus deemed important to maintain respondents' anonymity to promote honest responses. For this reason, the questionnaire did not contain identifying information. It is thus not possible to determine response rates per province and territory, nor to definitively determine why non-respondents chose to not participate. However a comparison of sample and population characteristics using the Chi-sq statistic demonstrates a non-significant difference between sample and population demographics (see Table 4.3).

Among respondents, 94.6% were female; the age range was 22 to 72 years with the mean age being 36.4 *(SD* = 10.5). Years of experience as an occupational therapist ranged from less than one year to 48 years with the mean being 12.3 years (*SD* = 9.6). On

average respondents had been in their current position for 5.6 years (range = < 1 to 34; *SD* = 5.9). Seventy-one percent of respondents were in full-time positions, and 87% worked on the front line. Other reported positions were practice leader (3%), coordinator (1.6%), administrator (2.8%), case manager (4%), and other (3.1%).

Table 4.3

Comparison between Study Respondents and Population Characteristics

Demographic	Sample (%)	Population (%)	sig.
Gender			
Female	94.6	91	**ns**
Male	4.9	7	
Age			
≤ 24	3.7	2	**ns**
25 - 34	44.9	33	
35 - 44	28	31	
45 - 54	17.6	24	
55 - 64	5.1	8	
65 +	0.6	1	
Credential			
Dip/Bach	86.9	87.2	**ns**
Masters'	13.1	11	

Note: Percentages do not include missing values.

Data Collection

A cross-sectional design was used in which a self-administered paper and pencil questionnaire assembled by the researcher was mailed to a sample of practicing Canadian occupational therapists. A postal questionnaire was selected over an electronic data collection method based on a review of the literature that tended to report greater response rates for the former. For example, Jones and Pitt (1999) reported a response rate of 72% for a postal survey sent to 500 systematically selected university staff as compared to a 34% response rate for email questionnaires and 19% for World Wide Web surveys. Jones and Pitt speculated that both a growing perception that email is "junk mail" and/or "out-dated" mailing lists might be negatively impacting on response rates to email questionnaires. Jones and Pitt also suggested that increasing commonality of email usage might result in respondents interpreting the researcher's "investment in sending a letter with a prepaid envelope as an indication of the survey's importance" (p. 557).

Jones and Pitt (1999) also reviewed seven studies comparing email with paper surveys between 1986 and 1997, and found that response rates for the latter were consistently higher (24% to 73% for email compared to 41% to 82% for postal surveys). One of the studies they reviewed compared physician response rate to postal service versus email and found a higher return (77%) for postal questionnaires than those sent via e-mail (56%). All participants were subscribers to a medical education list serve and thus were almost certainly regular email users. In a similar randomized controlled trial conducted by Van Den Kerhof, Parlow, Goldstein, and (Milne, 2004), assessing the likelihood that Canadian anaesthesiologists would respond to an electronic compared to a

postal questionnaire, determined that physicians in the email group were half as likely as those in the postal group to respond to a closed-ended questionnaire ($p < .01$).

The questionnaire for this study was sent to two occupational therapists, one of whom is a front line practitioner, and the other an academic with extensive experience in questionnaire-based research, with instructions to complete the questionnaire and provide a critique and suggestions for improvement. The purpose of this was to test the readability and clarity of the questionnaire. I modified my questionnaire based on their feedback as well as on recommendations from members of my supervisory committee. Finally, the questionnaire was professionally translated into French in order to obtain responses from French-speaking therapists.

The survey package was mailed to all potential participants and included an introductory letter (Appendix B) informing subjects of the purpose of the study, the estimated time required to complete the questionnaire, contact information in the event of questions or concerns, and a self-addressed meter-stamped return envelope. Approval of the Health Research Ethics Board of the University of Alberta was obtained for all aspects of the study prior to distribution of the questionnaire (Appendix C). The data was collected during the first quarter of 2006. Return of the questionnaire was taken as consent to participate.

Study Measures

The measures used to collect data are described below and presented in their entirety in Appendix D. Unless otherwise noted, all variables were measured by participants' responses based on a 7-point Likert-type scales (1 = *strongly disagree*; 7 = *strongly agree*).

Professional development. As discussed in Chapter 2, health professionals enact their professional development in a variety of different ways. Findings in previous studies (Grapczynski, 2000; Lysaght et al., 2001; Rappolt & Tassone, 2002) guided the selection of specific professional development activities to include in my questionnaire. Following are the eight questionnaire items that were developed to inquire about therapists' professional development activities: How frequently do you (a) volunteer for training and development opportunities offered within your organization, (b) try to learn new knowledge and skills on the job from others or through new job assignments, (c) develop knowledge and skills by taking courses on your own time, (d) consult literature that is relevant to your clinical area, (e) reflect on and identify areas requiring new knowledge and skills, and (f) consult your professional peers to access new knowledge about practice? Questions (a) to (c) were answered on a 7-point *strongly disagree-strongly agree* scale; questions (d) to (f) were measured on a five-point *never-frequently* scale.

Two close-ended questions based on the Hall Professionalism Scale, as revised by Snizek (1972), were used to probe respondents' self-reported actual participation in professional development activities. The questions read as follows: (g) on average *how many* courses related to your practice do you attend per year, (h) *how many* different profession/clinically related journals do you read on a regular basis? As different metrics were used to measure these items (three 7-point and three 5-point Likert scales, and two items via and absolute number), scores for all eight items were converted to a standardized z - value and weighted based on their respective loadings in my measurement model testing. The latter will be described in detail in the Results section of

this paper. The mean for each of the eight items were combined to produce a professional development score for each respondent.

The reliability alpha coefficient for the eight standardized items scores was .63, which is slightly below the recommended ≥.7 (Pallant, 2005). However when there are a small number of items in a scale (fewer than ten), it is common to find lower Cronbach values (e.g. .5) (Pallant, 2005). In situations such as these, Briggs & Cheek (1986) recommend calculating the mean inter-item correlation for the items and suggest an optimal value as ranging from .2 to .4. The mean inter-item value for these eight items was .37.

Professional commitment. Respondents' commitment to the profession was measured using the six-item affective commitment scale developed by Meyer et al. (1993). This scale is an adaptation of the Allen and Meyer (1990) organizational commitment scale. The reliability coefficient resulting from the Meyer et al. (1993) study confirmed the professional commitment scale's psychometric soundness (coefficient alpha = .82). Meyer et al. (1993) demonstrated conclusively that the original organizational commitment scale is generalizable to the domain of professional commitment. Meyer et al. further stipulated that researchers wanting to use the scales to measure persons' commitment to other professions could do so simply by substituting the appropriate descriptor. The validity and reliability of the professional commitment scale has since been confirmed in studies of professions other than nursing (Irving et al., 1997). Descriptors in the scale used in this study were changed to target occupational therapists.

Perceived organizational support. Respondents' perceptions of organizational support were measured using the Survey of Perceived Organizational Support (SPOS)

developed by Eisenberger and colleagues (1986, 1990, 1997). This survey was created to measure the global beliefs of employees concerning the extent to which an organization values their contributions and cares about their well-being. Studies surveying employees from many different organizations and occupations have provided evidence of high internal reliability and uni-dimensionality of the SPOS, both in its original 36-item form and subsequent shorter versions, (Eisenberger, Fasalo, & Davis-LaMastro, 1990; Eisenberger, Cummings, Armeli, & Lynch, 1997; Wayne, Shore, & Liden, 1997). Rhoades and Eisenberger (2002) reviewed more than 70 independent studies that used the SPOS (containing an average of 13 items) and reported a mean reliability alpha of .90. Nine items were drawn from the original 36-item SPOS for this study based on their face relevance to the population and practice contexts. A principal component analysis, using SPSS, was conducted to confirm the uni-dimensionality of these nine items with my data from my sample. This factor analysis technique can also be used to determine the smallest number of items required to confidently measure the variable (Pallant, 2005). The six highest loading items in my study were retained for subsequent data analysis

Perceived human resources management practices. Measurement of specific human resource management practices was achieved using four questions (items) developed for this study based on previous literature. Two items were selected based on human resource management practices previously reported to directly or indirectly correlate with professional development (Lysaght et al., 2001). These two items measured perceptions of tangible supports for professional development: (a) My organization provides release time for professional development activities and (b) My organization provides financial assistance for professional development. The other two

items were designed to measure perceptions of performance management practices that emphasize performance feedback and goal-setting based on the 'development-oriented' human resource management literature (Whitener, 2001). These items were: (a) My performance review includes professional goal setting and (b) My performance review includes the identification of continuing development needs. Participants responded to these questions in a yes/no format.

Additional Closed and Open-ended Questions.

Respondents were also asked whether they receive regular performance reviews, to which they answered either yes or no, and to indicate the approximate month/year of their last review (see Appendix D). The data collected from these questions were not used in the statistical analysis. Rather they were used to assist in my interpretation and understanding of the statistical findings.

The following open-ended question was included at the end of the questionnaire: *In your experience what is the impact of your current management context on your professional development activities*. Open-ended questions are effective and enriching research tools through which respondents can express their thoughts and perceptions (Arnon & Reichel, 2009). They thus permit the collection of secondary information that sheds light on, and can assist in understanding and explaining, findings from correlational model work (Creswell & Plano Clark, 2007) .

Demographic Variables

Select demographic variables were measured in order to statistically control for characteristics that might have a moderating effect on the proposed predictor (independent), mediating, and criterion (outcome) variables. Age, tenure within the

profession, and level of education were measured based on their being mentioned in the literature as correlates of perceived organizational support (Mathieu & Zajac, 1990; Rhoades et al., 2001) and professional development behaviors (Barriball & While, 1996).

Age and Tenure Within the Profession.

Barriball and While (1996) examined the level of participation by nurses in continuing professional education and reported that older participants were consistently more likely to attend fewer study days. Specifically, 64% of participants age 56 or over, 44% of participants aged between 46 and 55 years, and 32% of participants aged between 36 and 45 years were poor professional development attendees (i.e. less than 5 development activities per year). In contrast 85% of participants between the ages of 26 and 35, and 91% of participants under 25 years of age had attended at least 5 professional development study days ($p < .01$). With respect to the correlation of professional tenure with professional commitment, Meyer et al., (1993) reported that, within their sample of nurses, professional commitment was significantly and positively correlated with number of years in the profession. Respondents in this study identified their age and tenure within the profession in absolute years. As in Meyer and Smith (2000), age was not included as a control variable in this study as it correlated highly with professional tenure (.91).

Education Level.

Though no empirical studies were found that measured the impact of education level on professional development, there are suggestions in the literature that graduates from masters' level entry occupational therapy programs will be more likely to be scholarly practitioners, i.e. better prepared to search for and apply relevant evidence to their day-to-day practice (Allen, Strong, & Polatajko, 2001; Hammel, Finlayson,

Kielhofner, Helfrich, & Peterson, 2001; Lall, Klein, & Brown, 2003). Respondents in this study reported their educational level by ticking a box to indicate their highest held credential: diploma, bachelors, masters or doctorate. For analysis of this sample data, the diploma and bachelor credentials were collapsed into one category due to the low number of practicing therapists holding diplomas (3.5% with diploma versus 83.4% with bachelors).

Analytic Strategy

Data were analyzed using LISREL 8.8 (Jöreskog & Sörbom, 2007), and the Statistical Package for the Social Sciences (SPSS) 15 computer software. Item non-response was treated as missing data using the list-wise deletion procedure for all calculations. Response frequencies of single items and scales were conducted to examine the distribution of scores, and means and standard deviations were calculated to assess central tendencies. LISREL was used to confirm the validity of the measurement model while SPSS 15 was used to compute descriptive statistics, including correlations, and to examine the hypotheses.

Testing the Hypotheses

Hierarchical regression analysis, which is based on correlations, permits an exploration of the inter-relationships among a set of predictor, mediator, and criterion variables (Pallant, 2005). In other words regression can tell a researcher how well a set of variables is able to predict a particular outcome, which variable in a set is the best predictor of an outcome, and whether a particular variable is still able to predict an outcome when the effects of other variables are controlled. Hierarchical regression

analysis allows predictor variables to be entered into an equation in the order specified by the researcher based on theoretical grounds.

Where significant associations between predictor variables and criterion variables were established (H1, H2 and H4), additional hierarchical regression analysis was conducted to determine whether the effects of perceived organizational support and human resource management practices were mediated by professional commitment (H3 and H5). Within the sociological and psychological literature, the mediator function is described as the "generative" mechanism through which the focal independent or predictor variable (in this case perceived organizational support and select human resource management practices) is able to influence the criterion variable of interest (in this case professional development). This is in comparison to the moderator function, described as the partitioning of a given independent variable into "subgroups that establish domains of maximal effectiveness in regard to a given dependent variable (Baron & Kenny, 1986, p. 1173). For example an experimental group might be partitioned into gender groups or ethnicity groups (moderator variables) prior to analyzing the effect of the predictor and criterion variables. A mediator variable is identified based on prior conceptual and theoretical evidence as a variable that might intervene between study variables and thus might augment or decrease the amplitude of the relationship between those variables. The central idea behind a mediating model is that the effects of the independent variables are impacted on (mediated) by a transformation process internal to the individual.

The recommended method for examining mediating relationships involves the calculation of two regression equations for each proposed predictor variable (Baron &

Kenny, 1986). The first equation calculates the effect of the predictor variable on the criterion variable while the second equation calculates the effect of the predictor after partitioning out the effect of the proposed mediator. If the predictor variable's effect in less in the second equation than the first, mediation is present. Perfect (full) mediation holds if the predictor variable has no effect when the mediator is controlled.

Closed and Open Ended Questions

Responses to the questions about receiving regular performance reviews and date of most recent review were simply totalled and expressed in percentages. Responses to the open-ended question were analyzed using a pre-assigned coding scheme based on the variables and hypotheses being examined. This analytic strategy is based on Creswell's recommendation that a researcher may use "predetermined codes and then fit the data to them … based on the theory being examined" to add depth and breadth to the understanding of the quantitative data (Creswell, 2009, p. 187). Once participant responses were assigned to each pre-determined code (e.g., perceived support, human resource management practices) I reviewed them several times (within their assigned codes) to obtain a sense of the information, and developed an essence description for each.

Though this was not an ethnographic study, 'ethnography - based' procedures as described by Creswell, (2007) were utilized to further analyze participant responses to the open-ended question. An ethnographic approach involves the examination, description, and interpretation of a *cultural group* (e.g. occupational therapy professionals) and their shared patterns of beliefs and behaviours. The ethnographer uses 'standard categories and [describes] participant views through closely edited quotations and has the final word on

how the culture is interpreted and presented" (Creswell, 2007, p. 70). The culture of the targeted group, as described in Chapter 2, provided the context for the inductive analysis approach used to identify sub-categories within codes. This contributed depth to my understanding of psychological mechanisms underlying the quantitative findings. These findings also provided explanatory information and assisted in validating and understanding of the quantitative results. This approach, based on guidelines provided by Creswell (2009) is appropriate for identifying the essence of the experiences of participants, in this case of the impact of professional commitment, perceived organizational support, and human resource management practices, on professional development behaviours.

The resulting analysis of the open-ended question responses was cross-checked by my thesis advisor to test reliability (inter-coder agreement) and validity (accuracy). Inter-coder agreement refers not to having a second person independently code the same passages of text, but rather to check her agreement with the codes and statements that I assigned to the same text (Creswell, 2009). Validity in qualitative analysis involves determining whether findings are accurate from the stand-point of both the researcher and a second coder.

A discussion of the research methods and description of the sampling procedure, participant sample, data collection instruments and analytic strategy were provided in this chapter. The next chapter presents the results of the quantitative and qualitative analysis.

CHAPTER 5

Results

This chapter presents the results of my examination of the professional development behaviors of Canadian occupational therapists in current health care environments. I measured respondents' professional commitment, its direct effect on professional development, and its mediating effect on the relationships between occupational therapists' perceptions of (a) support from their organization, and (b) specific human resource management practices, and their actual professional development behaviours.

The sample size required for this study was 400 as calculated according to Bartlett et al.'s (2001) recommendations for the number and type of variables, measures, and analysis strategy used (Appendix A). The sample size calculation was based on the specification of an alpha of .05 and a medium effect size. According to Cohen (1988), for the correlation *r*, a medium effect size is .30; for the coefficient R^2, a medium effect size is 0.15. Two thousand two hundred surveys were sent and 638 were returned for a response rate of approximately 29%. Of the 638 returned questionnaire, 542 were useable for statistical analysis.

In the following sections, results of the measurement model testing are presented, followed by the descriptive and correlation statistics, and the regression analysis results. Responses to the open-ended question are then presented.

Measurement Model Testing

Prior to analysing the data, the validity of the measurement model was tested using confirmatory factor analysis (LISREL 8.8). A measurement model represents the

linkages between latent constructs or factors (e.g. professional commitment, perceived organizational support), and their observed measures. Confirmatory factor analysis allows a researcher to confirm that the observed measures are linked to the underlying (latent) factor. In other words confirmatory factor analysis is used to determine whether the scales, and the items that they contain, are measuring what they are intended to measure. Scale items that display loadings of .4 or greater on a given factor are considered strong (Pallant, 2005).

In addition to a null (independent) measurement model, a four-factor and a five-factor model were tested. The null model is one of complete independence of all observed variables and serves as a baseline (expected frequencies) against which to compare alternative models for evaluating the goodness of fit. My proposed four factor model constrains all four human resource management items (tangible support and performance management) into one group whereas the five-factor model divides them into two groups, one consisting of support in funding and release time (HRM 1) and the other consisting of development-oriented performance evaluation items (HRM 2). Chi-sq, Residual Mean Square Error of Approximation (RMSEA), and Comparative Fit Index (CFI) are three different indices for measuring whether the proposed measurement model fits the sample data. The fit indices for each model are summarized in Table 5.1. In the case of the Chi-sq statistic, the more similarity between the observed factor loadings and the expected factor loadings, the smaller the Chi-sq value (and thus non-significance), the better the measurement model fits the sample data.

Table 5.1

Summary of Measurement Model Fit Indices

Model	*Chi-Sq*	df	*p*	RMSEA	CFI
Null Model	4267.15	252	0.00	0.17	0.49
Four Factor Model	1002.17	246	0.00	0.08	0.90
Five Factor Model	614.17	242	0.00	0.05	0.95

Note. Four-factor model specifies: Perceived organizational support, Human resource management practices (both dimensions combined), Professional commitment, and Professional development.
Five-factor model specifies: Perceived organizational support, Human resource management practices (divided into 2 dimensions), Professional commitment, and Professional development.

As the Chi-sq is influenced by sample size in that it loses sensitivity if the sample size is large (as in this study), it is important to consider other fit indices. The RMSEA estimates the model fit by taking into account the residual between the null model and the constrained (specified) model. A commonly accepted cut-off RMSEA value for a good fit is .05 (Green & Thompson, 2003). In a well fitting measurement model this value would be centered around zero. The Comparative Fit Index considers sample size in estimating the extent to which a hypothesized model fits or adequately describes the sample data in comparison to the null model (Byrne, 1994). A value greater then .90 indicates a good fit with the data.

My confirmatory factor analysis demonstrates that the five-factor solution, which

separates human resource management practices into two discrete variables (funding/time and performance feedback), provides the best fit for the measurement model: $X^2 = 614.17$, $df = 242$, $p \leq .00$, $RMSEA = .05$, $CFI = .95$. Factor loadings for the five-factor model are presented in Table 5.2. As the confirmatory factor analysis indicated that the scores for items measuring human resource management practices loaded on to distinct factors, (a) perceived support in funding and time (HRH 1) and (b) perceived performance management practices (HRM 2), these are discussed and analyzed separately from this point onward.

Descriptive Statistics

Prior to analysis, scores for the professional development scale items were converted to standard (z) values and weighted based on the results of the confirmatory factor analysis calculation. Descriptive statistics, including correlations are displayed in Table 5.3. Means and standard deviations for each variable are presented in turn followed by a discussion of the correlations between variables.

Means and Standard Deviations

The criterion variable, professional development behaviours, was measured using an eight-item scale assembled by the researcher based on results of previous research (Lysaght et al., 2001; Rappolt & Tassone, 2002). Three of the items were measured on a seven-point scale; three were measured on a five-point scale, and the final two items were measured on a continuous scale (e.g. number of courses attended per year). All item scores were standardized and weighted prior to calculating mean, standard deviation and correlation. The mean score for professional development is 3.31.

Table 5.2

Confirmatory Factor Analysis of Measurement Model

Items	Factors				
My organization is:	POS	HRM 1	HRM 2	PC	PD
1. willing to extend itself to help me perform my job	0.85				
2. strongly considers my goals and values	0.86				
3. wishes to give me the best possible job for which I am qualified	0.78				
4. would grant reasonable request for a change in my working condition	0.65				
5. cares about my general satisfaction at work	0.75				
6. takes pride in my accomplishments at work	0.70				
7. provides support in time for professional activities		0.87			
8. provides financial support for professional development		0.81			
9. performance review includes professional goal setting			0.89		
10. performance review includes identification of continuing education needs			0.92		

Note. $N = 542$; POS = perceived organizational support; HRM = human resource management; PC = professional commitment; PD = professional development. Chi-sq = 614.17; df = 242; p = .00; RMSEA = .05

Table 5.2 (continued)	POS	HRM 1	HRM 2	PC	PD
11. being an occupational therapist is important to my self-image				0.60	
12. do NOT regret having entered the occupational therapy profession				0.70	
13. proud to be in the profession of occupational therapy				0.85	
14. LIKE being an occupational therapist				0.81	
15. identify with the occupational therapy profession				0.66	
16. enthusiastic about OT				0.78	
17. volunteer for training & developemnt oportunities					0.47
18. learn new knowledge & skills on the job					0.51
19. develop knowledge and skills by taking courses on your own time					0.44
20. consult literature that is relevant to your clinical area					0.43
21. reflect on and identify areas requiring new knowledge and skills					0.5
22. consult peers to access new knowledge about practice					0.32
23. courses related to practice attended per year					0.33
24. profession/clinically related journals read on regular basis					0.37

Note. N = 542; POS = perceived organizational support; HRM = human resource management; PC = professional commitment; PD = professional development. Chi-sq = 614.17; df = 242; p = .00; RMSEA = .05

Table 5.3

Mea*ns, Standard Deviations, and Correlations*

Variables	*M*	*SD*	1	2	3	4	5	6
1. Education	1.13	0.34						
2. Tenure	12.26	9.65	0.03					
3. Perceived Organizational Support	4.42	1.20	0.03	0.03				
4. HRM 1	4.55	1.62	0.05	0.03	**0.51**			
5. HRM 2	0.57	0.47	**0.10**	0.00	0.04	**0.16**		
6. Professional Commitment	6.06	0.95	0.01	0.05	**0.12**	**0.13**	0.06	
7. Professional Development	3.31	3.33	**0.12**	**0.09**	**0.10**	**0.14**	0.07	**0.22**

Note. N = 542*;* Bolded correlations are significant at $p < .05$ (one-tailed test). HRM 1 = assistance in funding and release time. HRM 2 = performance management and feedback. Education : 1= diploma or Bachelors, 2= Masters; Tenure: expressed in number of years; All variables measured on a 7-point Likert scale except Professional Development.
All Prpfessional Development item scores standardized and weighted.

Professional commitment, was measured using Meyer et al.'s (1993) six-item affective commitment scale. The mean score for my sample data is 6.06 with a standard deviation of .95 and a variance of .91. *Perceived organizational support* was measured using an adaptation of the Survey of Perceived Organizational Support developed by Eisenberger et. al. (1986). The sample mean score was 4.42 with and SD of 1.20. *Support in funding and time* (HRM 1) and *performance management practices* (HRM 2) were measured using scales I developed based on literature describing commitment-maximizing management practices and on previous empirical findings (Lysaght et al., 2001). Perceived support in funding and release time (HRM 1) was measured using a two-item scale. The mean for this sample was 4.55 and the alpha reliability co-efficient for this two-item measure is .83. Perceived performance management practices (HRM 2) was also measured using a two-item scale in which responses were provided in a dichotomous yes/no format. The alpha reliability coefficient for these items is .90, and the mean response this sample is .57.

In response to the question "do you receive regular performance reviews?", 38% answered *yes*. Respondents were also asked the approximate month/year of their last review to which 5% answered *non-applicable* and 18% answered *never* (despite this option not being provided to them). An additional 28% reported not receiving a performance review in the two years prior to the time of the survey (2006). The non-response proportion was less than 1%. Overall, less than half (48%) of respondents reported receiving a performance evaluation during 2004 and 2005.

Bivariate Correlations

The correlation patterns between the study measures (Table 5.3), with the exception of performance feedback and management (HRM 2), are generally consistent with the proposed relationships in my conceptual model. Unless stated otherwise, all correlations discussed here are significant at $p < .05$.

Reported level of education and professional tenure did not correlate with each other. Level of education correlated significantly with the criterion variable, professional development ($r = .12$) and with only one of the other study variables - assistance in funding and release time ($r = .10$). The significant relationship between education level and professional development supports previous suggestions in the literature that practitioners with a masters degree preparation will be more inclined to imbed professional development within their day-to-day practice (Allen, Strong & Polatajko, 2001;Hammel, et al., 2001; Lall, et al.; 2003; Meyer, et al., 1993). Reasons for the non-significant correlation with HRM 2 (performance management and feedback) are difficult to interpret at this point; responses to the open-ended question may be informative in this regard.

Professional tenure correlated with the criterion variable (professional development) only, $r = .09$. This finding contradicts Bariball and While's (1996) finding that registered nurses attended fewer professional development days as they became older and thus had longer tenure within the profession. This discrepancy in findings may be due to the fact that nurses and occupational therapists differ vis-à-vis educational preparation, position descriptions and contractual agreements, and work structures.

In addition to education level and tenure, the criterion variable, professional development, also correlated with professional commitment, $r = .22$, with perceived organizational support, $r = .10$, and with one element of development-oriented human resource management practices - support in funding and release time, $r = .14$. Of note is the fact that the strongest correlation was that between the proposed mediator variable - professional commitment, and the criterion variable - professional development, $r = .22$.

Among the proposed predictor and mediator variables alone, support in funding and release time (HRM 1) correlated with professional commitment, r = .13 , and with perceived organizational support, $r = .51$. The latter correlation is considered large based on Cohen's (1988) correlation interpretation guidelines, indicating a lot of shared variance between perceived organizational support and assistance in funding and time release (HRM 1). This shared variance will be partitioned using hierarchical regression analysis in the following section. Correlations alone do not indicate the unique contribution to explained variance by the proposed control and predictor variables, nor to the hypothesized mediating effect of professional commitment on professional development behaviours. For these reasons hierarchical regression analysis was performed.

Regression Analysis

As previously indicated, hierarchical regression analysis provides information about a model as a whole, and the relative contribution of each of the proposed variables to the criterion variable within that model (Pallant, 2005). Hierarchical regression is also used to statistically control for potential confounding variables, such as educational level and professional tenure, when exploring predictive ability of independent variables.

Hypotheses 1, 2, and 4 were tested using hierarchical regression in the following manner. Level of education and tenure within the profession were entered in Step 1 of each regression formula thus controlling for their predictive effect. The proposed predictor variables (perceived support and assistance in funding and release time) were entered in Step 2 of each respective calculation. The solutions for each regression equation are presented in Tables 5.4, 5.5, 5.6.

Hypothesis 1, which proposed that a positive relationship would exist between affective commitment to the profession and professional development, was supported. Results of the regression analysis, displayed in Table 5.4, indicate that professional commitment explained 5% ($\beta = 2.21$, $\Delta R^2 = .05$, $F = 27.29$, $p = .00$) of the variance in professional development behaviours, over and above the 2% ($R^2 = .02$, $F\Delta = 7.07$, $p = .02$) contributed by education level and professional tenure together. In other words, controlling for educational level and tenure, as the level of professional commitment increases, so does the reported professional development of occupational therapists - an increase of 1 SD in professional commitment results in an additional increase of 5% in professional development. These results support the suggestions of previous researchers that persons who are committed to their profession will be more likely to keep up with new developments within it (Hall, 1968; Meyer et al., 1993; Morrow & Goetz, 1988). This result also substantiates Lysaght et al. (2001)'s earlier findings that participation in professional development is related to the personal commitment of individual therapists. Findings also comport with those of Meyer et al. (1993) that professional commitment "added significantly to the prediction of professional activities" (p. 546) in their sample of registered nurses.

Hypothesis 2, which proposed that a positive relationship would exist between perceived organizational support and professional commitment, was supported (Table 5.5). Perceived organizational support alone explained 2% ($\beta = .13$, $R^2 = 02$, $F\,\Delta = 10.09$, $p = .00$) of the variance in professional commitment. This confirms that, to the extent that an organization is perceived to value and actively support professional contributions, and that this support is viewed as sincere and genuine, individuals will reciprocate and demonstrate professional commitment.

Hypothesis 3 proposed that affective commitment to the profession would mediate the relationship between perceived organizational support and professional development activities. Given a statistically significant relationship between professional commitment and professional development, further regression calculation was conducted to determine if perceived organizational support makes a significant contribution to explained variance in professional development when the effect of professional commitment is partitioned out. Variables were entered into the equation in the following manner: Step 1 - education and tenure, Step 2 - professional commitment, and Step 3 - perceived organizational support. The effect of perceived organizational support was decreased to zero (fully mediated) when professional commitment was partitioned out ($\Delta R^2 = .00$, $F\Delta = 2.31$, *ns*) thus supporting Hypothesis 3.

Hypothesis 4 proposed that a positive relationship exists between perceptions of development-oriented human resource management practices - HRM 1 and HRM 2 - and respondents' commitment to their profession. As previously indicated, there was no correlation between perceived performance management and feedback (HRM 2). This variable was thus eliminated from this regression analysis. As displayed in Table 5.7,

support in time and funding (HRM 1) explained 2% of the variance in professional commitment ($R^2 = .02$, $F\Delta = 11.31$, $p = .00$). This result supports previous findings by (Lysaght et al., 2001) that financial support from employers is associated with professional development and competency maintenance. Hypothesis 4 is thus partially supported.

Hypothesis 5 proposed that professional commitment would mediate the relationship between respondents' perceptions of development-oriented human resource practices and professional development. As depicted in Table 5.8, professional commitment partially mediates the association between professional development and support in time and funding (HRM 1) with the latter's contribution decreasing from 2% to 1% ($R^2 = .01$, $F\Delta = 6.58$, $p = .00$) of the explained variance, when the 5% ($R^2 = .05$, $F\Delta = 26.81$, $p < .01$), contribution of professional commitment was parcelled out. It would appear that though support in time and funding plays a role in occupational therapists' professional development, that role is significantly mediated by the degree of professional commitment of the occupational therapist. That is, the effect of support in funding and time on professional development is greater when recipients are committed to their profession. Table 5.9 presents a summary of the hypothesis testing findings.

Table 5.4

Hypothesis 1 - Professional Development on Professional Commitment

		R^2	ΔR^2	$F\Delta$	p of Δ	β	t	p
Step 1	Education					0.13	3.30	0.00
	Tenure	0.02		7.07	0.00	0.01	2.30	0.02
Step 2	Professional Commitment	0.07	0.05	27.29	0.00	2.21	5.22	0.00

Table 5.5

Hypothesis 2: Professional Commitment on Perceived Organizational Support

		R^2	ΔR^2	$F\Delta$	p of Δ	β	t	p
Step 1	Education					0.02	0.46	ns
	Tenure	0.00		0.8	ns	0.05	1.13	ns
Step 2	Perceived Organizational Support	0.02	0.02	10.09	0.00	0.13	3.18	0.00

Table 5.6

Hypothesis 3: Mediating Effect of Professional Commitment on the Relationship between POS and PD

		R^2	ΔR^2	$F\Delta$	*p of* Δ	β	*t*	*p*
Step 1	Education					0.13	2.95	0.003
	Tenure	0.02				0.08	1.79	n/s
Step 2	Perceived Orgaizational Support	0.03	0.01	4.39	0.04	0.09	2.1	0.04

		R^2	ΔR^2	$F\Delta$	*p of* Δ	β	*t*	*p*
Step 1	Education					0.12	2.91	0.00
	Tenure	0.02		5.34	0.01	0.07	1.75	0.02
Step 2	Professional Commitment	0.07	0.05	30.42	0.00	0.22	5.32	0.00
Step 3	Perceived Organizational Support	0.08	0.00	2.31	ns	0.06	1.52	ns

Note : POS = perceived organizational support; PD = professional development.

Table 5.7

Hypothesis 4: Professional Commitment on HRM 1

		R^2	ΔR^2	$F\,\Delta$	p of Δ	β	t	p
Step 1	Education					0.02	0.41	ns
	Tenure	0.00		0.75	ns	0.05	1.32	ns
Step 2	Support in time and dollars	0.02	0.02	11.31	0.00	0.14	3.36	0.00

Note. HRM 1 = Support in funding and time for professional development

Table 5.8

Hypothesis 5: Mediating Effect of Professional Commitment on the Relationship between HRM 1 and PD

		R²	*? R²*	*F ?*	*p of ?*	*β*	*t*	*p*
Step 1	Education							
	Tenure	0.02		0.75				ns
Step 2	Support in Funding and Time	0.02	0.02	11.31				0

		R²	? R²	F ?	p of ?	β	t	p
Step 1	Education					0.11	2.59	ns
	Tenure	0.02		5.09	0.01	0.08	2.04	0.04
Step 2	Professional Commitment	0.06	0.05	26.81	0.00	0.20	4.8	0.00
Step 3	Support in Time and Dollars	0.08	0.01	6.58	0.01	0.11	2.57	0.01

Note . HRM 1 = support in funding and time; PD = professional development.

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Table 5.9

Primary Findings of Hypothesis Testing

1	A positive relationship exists between professional commitment and professional development.
2	A positive relationship exists between perceived organizational support and professional commitment.
3	The relationship between perceived organizational support and professional development is fully mediated by affective commitment to the profession.
4	A positive relationship exists between perceptions of support in funding and time (HRM 1) and professional commitment. A positive relationship does not exist between perceptions of performance management and feedback (HRM 2) and professional commitment.
5	The relationship between perceptions of support in time and funding (HRM 1) and professional development is partially mediated by affective commitment to the profession.

Open-Ended Responses

Responses to the open-ended question - *In your experience what is the impact of your current management context on your professional development activities?*, were analyzed using a pre-assigned coding scheme based on the conceptual model being examined. This produced over fifty pages of text data (pages formatted into two equally distributed columns with participant comments occupying the left-hand column, the right-hand column left blank for manual coding), that address participants' experience of the impact of current management contexts on their professional development activities.

For analysis purposes, a preliminary three-column codebook containing the relevant variables (e.g. professional commitment, perceived organizational support, and human resource management practices) was developed in a Word document with labels, and definitions where appropriate, placed in the left hand column (see Table 5.10). The human resource management code was divided into two sub-codes based on the results of the factor analysis (i.e. HRM 1 - Support in time and funding, HRM 2 - Performance management and feedback). Specific instances (participant statements) in which the code and sub-code were identified in the transcripts were then cut and pasted in the middle column next to the appropriate code. Once all the data were assigned to a code or sub-code, I developed an 'essence description' for the contents of each section, which was placed in the right-hand column. The data within the sub-codes were further analyzed in an inductive fashion and, as appropriate, grouped into qualifiers of the respective sub-code. Results of this analysis, including representative respondent statements and essence descriptions, are displayed in Table 5.10. French language responses were also managed using this format (see Appendix E). French language data reflected the same issues as the

English language data, and will be reported in a French language report.

Hypothesis 1 – a positive association will exist between affective commitment to the profession and professional development behaviours. Responses related to the relationship between professional commitment and professional development confirmed the quantitative findings and provided additional depth of understanding. Many respondents explained that their commitment to their profession and to lifelong learning is the primary motivator for their professional activities. Representative comments included: "I'm pretty self-directed regarding professional development activities so management practices have little impact on that aspect of my career", and

> At a department level, we have been able to maintain our [professional] practice leaders and [function] as a professional body. This enables me to continue to learn and grow with my colleagues. We have our own educational/clinical/research committees and run conferences/courses to support our educational and [professional] growth.

Some respondents cited their *commitment to patients* as driving their professional development behaviours, e.g., "I feel a personal responsibility to my clients and therefore ensure good practice because of my personal ethics". In a small number of cases, professional and regulatory requirements were also specifically mentioned as additional drivers of professional development: "The college of occupational therapists has a <u>much</u> more significant input than my employer on my professional development."

Hypothesis 2, which proposed that a positive relationship would exist between perceived organizational support and affective commitment to the professional, was supported by the quantitative data. The narrative comments relative to therapists' perceptions of their organizational support assisted in further understanding this result.

Though there was the occasional 'positive' statement regarding perceived organizational support, such as: "I feel valued as an employee and the skills that I can bring to the company", the perception of the majority of respondents appeared to be that organizational support was generally not forthcoming:

> My 'organization' is not aware of me as an individual, does not appear to support my profession, and makes rash, non-productive decisions repeatedly which hinder the progress of my colleagues and me as [an occupational therapist] and individuals. Upper management within my organization is not supportive … and does not seem to appreciate the role of [occupational therapy] within the organization.

The following comment express the frustration that therapists felt regarding this perceived lack of support and its effect on professional commitment specifically: "There is an increasingly poor climate in this organization for professional development … It impacts on one's skill development and even more, on one's interest in the profession". Therapists also reported receiving expressions of support and being valued from sources *other than* management:

> "We do not get recognition at a personal level. It is through our team that I get the most recognition and satisfaction, and from the clients we serve, knowing that I can make a difference in their child's life to some degree…".

More in-depth analysis of the response data addressing this issue yielded two qualifiers: *i) feeling NOT supported* and *ii) feeling supported*. With respect to *feeling Not supported,* twelve of 16 statements related to perceived organizational support reflected feelings that neither their profession nor their professional development is recognized, valued, and supported by their organization as evidenced by statements such as: "I feel as though I'm at the bottom of the funding food chain with very little opportunity for

participation in [professional] development activities. This obviously leads to a sense of feeling under-valued as a team member", and "It is very frustrating when your organization does not value professional development and keeping current". The overall effect this has on professional commitment was summarized by one respondent: "The work culture can be stimulating or suffocating. Right now although I still love my profession, my work environment actually prevents me from maximizing my professional development".

With respect to the *feeling supported* qualifier, a small number of respondents (4/16) reported feeling well supported: "Overall my present organization is very supportive of professional development activities. I have no concern regarding being able to meet goals both professionally and financially", and "The organization I work for values professional development and prides themselves on being current & up-to-date with clinical therapies/interventions."

Hypotheses 3 proposed that a positive relationship would exist between perceptions of development-oriented human resource management practices and affective commitment to the profession. With respect to HRM 1 – again respondent comments were helpful in shedding light on the quantitative findings related to the impact of tangible support for professional commitment and professional development. Of the more than 60 responses addressing this issue, more than 50% attached qualifiers to the support received. The following statements summarize the interplay between perceived funding support and reported professional commitment:

> Management is supportive if I take the initiative. They will fund 2/3 the cost of tuition, travel etc. They will fund courses but not conferences, which I find disappointing as often a great amount of learning is accomplished by networking with others at conference.

A more in-depth, inductive analysis of the responses regarding receipt of support in time and funding for professional development resulted in three qualifiers: *positive* (15), *negative* (11) and somewhat *mitigated* (38). Representative comments related to each of these are presented in turn.

Positive responses ranged from full support: "… provided with ample time & finances to attend both internal & external educational opportunities" and "Overall my present organization is very supportive of professional development", to partial support: "the facility will provide paid time for attending relevant courses. Registration fees have to be negotiated. I pay some, the facility pays some".

Negative responses ranged from no support at all: "the organization I work for does not provide paid time off OR course funding ... it is very disappointing", to a perceived insufficient amount of funding: "We get minimum financial support and very little 'incentive' to put our time/$ for professional development. We do sometimes get to go to 'free' events for a few hours", and "I look for personal and professional development on my own. I've stopped expecting it to come from my workplace".

The *mitigated* sub-category, by far the most prominent, was further distributed among three characterizations, (*i*) support not available for occupational therapy-specific professional development, (*ii*) organizational structure and policy, and (*iii*) heavy workloads. Following is a range of comments that reflect each of these in turn.

i) non-occupational therapy - specific support - The first of these characterizations refers to the fact that many organizations support generic training and development only, e.g. CPR, safety training, or non-occupational therapy specific development such as case-management: e.g. "management is supportive but … do not fund professional development activities unless they are required such as CPR, fire etc." Other comments reflecting this barrier include: "Education time often involves attending sessions that are necessary in order to function adequately (e.g. Computer courses like excel, online charting and access to [local area network] programs)", and "… seems to be reluctant to approve 'our' attendance at in-services/workshops not directly applicable to area of practice. It is very hard to get approval to attend 'general' [occupational therapy] courses that are area specific". Some respondents further indicated that only education and training that meets the specified clinical goals of their institution or their manager are supported, e.g. "Education that meets the goals of the organization rather than the individual is given higher priority. Education is often on more general topics i.e. communication, case management, etc. rather than specific [occupational therapy] skills", While support for this type of training may be appropriate, particularly in the minds of managers and human resource departments, it does not meet the spirit of the intent of professional development as a professional responsibility and legally mandated requirement.

Related to this are respondents' comments about the lack of career ladder available to them within the program-based management system, resulting in a perceived lack of recognition of the profession: "My supervisor does not advocate for change in the

hospital which affects the work of [occupational therapists] in the system. There are no opportunities for advancement to middle management", and

> The current management is not supportive of professional development - it can be very difficult to get approval to attend any course which is not directly related to my current position - therefore keeping pigeon-holed in the same place with no hope of advancement.

One respondent alluded directly to commitment, the key factor being examined in this study:

> Huge health Authority leveled out positions so all staff are at "level 2" and no other opportunity to move up by taking more courses etc.— you have to be self-motivated to take courses and continue to upgrade knowledge. It is not rewarded by allowing to move … to a more "expert" position or knowledge any other way e.g. could then be recognized as mentor etc.

ii) hampered by organizational structure and policies – The second qualifier emerged from comments related to respondents' concerns about the impact of the *organizational structure* on their practice. More specifically, the impact of program-based management structures was often mentioned in reference to perceived support. As described in Chapter 3, this management approach usually results in occupational therapists reporting to persons who do not fully understand their scope of practice, nor their professional development needs. Therapists in this study confirmed the difficulties this presents to their professional development enactment: e.g. "It is challenging under 'program management' to have our professional needs & perspective fully understood & supported in terms of management practices and professional development", "Now that we no longer are funded through the [occupational therapy department] department there is even less support, but ++ education for nursing staff", and

> Currently managed by Program Manager who oversees 6 professional disciplines. Present manager has nursing background and poor understanding of other disciplines. … Because the budget is program-based, individual disciplines are easily lost or non prioritized for more glitzy needs.

> It is challenging under "program management" to have our professional needs & perspective fully understood & supported in terms of management practices and professional development …I believe the most significant problem in a program-based management style is the loss of the identity of each discipline.

The fact that professional practice leaders (i.e. occupational therapists) were put in place in some organizations did not necessarily result in therapists perceiving that their professional identity was recognized, as expressed in the following responses:

> We have one part-time [occupational therapy] practice support person for ~30 clinical [occupational therapists] and no [occupational therapy]supervisors or practice leaders. Our larger organization has program specific (clinical practice leaders) and directors with whom we rarely have contact.

> We are program based with nursing managers both on a practice and administrative level with few or no rehab staff represented on these levels. Although a therapist has been hired to look into education and professional development, we do not report to them as frontline workers nor do they have power to change much within the management context. It would help to have a senior/mentoring therapist to direct and evaluate skills from a rehab perspective.

The following comments reflect the perception of 'across the board' *organizational policies* on professional development behaviours: "Region policies often stop all travel therefore no approval to attend continuing [education] opportunities if out of town", and "Current policy: funding now is to include reimbursement for hours normally worked, so although we have a [professional] development allowance, by the time hours are included, there is little left over to pay courses and travel fees."

iii) hampered by workload – The final characterization in the sub-category of "mitigated support" relates to situations in which workload pressures preclude therapists' ability to pursue professional development. For example: "We have support for 5 days/yr for [professional development]. Although we have this time and $ it is difficult to fit in the time as there is pressure to see 24 kids/week in school" and "workload and expected outcomes far exceed available time. No opportunity for professional development activities during work hours". These comments suggest that even though financial support is present, therapists may hesitate to take advantage of it due to workload per se, as well as its perceived impact on clients: "as we still put clients as # 1 - time for reading, etc. is almost non-existent", "It is hard to commit to reading articles when you have patient care to do", and its impact on colleagues: "you don't want to go on courses because of the burden on colleagues". Several respondents spoke of the lack of coverage for their position while away on professional development: "No coverage is provided when staff take time off. This creates extra stress on those working", "lack of coverage in my absence leading to too much guilt and stress from leaving my team with all my work", and

> The organization I work with is supportive of my professional development activities regarding assistance with costs and allowing me to organize time off I need. I am however expected to complete every aspect of my job (in addition to organizational committee [meetings] e.g., chart audit and quality assurance) during a week with a heavy workload when I may have registered for a professional development course.

HRM 2 – *performance management and feedback*; the proposed positive relationship between this aspect of human resource management practices with commitment to the profession is not supported. Again, respondents themselves provided

explanations for this finding. A large proportion of respondents reported either receiving performance reviews very infrequently, or receiving them from non-credible sources. Responses include: “After 6 years I have yet to have a performance review. It has never been done for me by any of the 4 managers I’ve had in this organization”. This comment is supported by other data from this study. In responding to the question, “Do you receive regular performance reviews?”, 62% (N = 629) of participants responded *no*. Additionally, of the participants who answered the question “What is the approximate date of your last performance review?”, 37% (N = 564) had not had their performance evaluated since 2002, that is, four years prior to the time of completing this study’s survey. Meyer et al. (1993) had also reported a lack of relationship between performance appraisals and commitment to the nursing profession.

A good number of respondents reported feeling that their managers did not understand their work and thus were unable to provide *meaningful* feedback as demonstrated by this quote: “Present manager has nursing background and poor understanding of other disciplines. As a result there is a poor understanding and limited support in day-to-day activities and in professional development”. Program-based management was perceived as hampering the effectiveness and pertinence of performance appraisals: “Admin/mgmt are ALL nurses so although I can seek out [professional development] activities I have no help with direction of practice, focus of practice (very much driven by individual [occupational therapy] skills/preferences/interests), feedback [regarding] efficacy of practice”, and

> Program management is current context. Nurse Manager gives performance review, although supportive, her framework is nursing. I prefer the discipline management style I used to have e.g. OT’s supervision when it comes to

> management for clinical feedback, [educational] opportunities, opportunity for advancement job/position wise.

Participants also frequently reported that self-reflection and feedback received from clients is more helpful than feedback from managers. For example: “I get little feedback. Feedback is mostly ‘internal’ as I know I am making a difference in peoples’ quality of life”, and “Feedback comes via others [I] work with, and satisfaction of clients”.

Further, occupational therapists who practice in organizations in which professional practice leaders are in place frequently reported that these individuals are too busy to do performance appraisals, or too geographically removed to provide informed and relevant feedback. This is exemplified by the following responses: “Regionalization causes the OT manager to be away from the department 3 of 5 days per week. Ongoing staff reviews have been falling behind”, “The OT Manager that I work with is too busy with ‘committee’ work to organize our department with regards to professional development”; and, “What I do know is the changes to program management have resulted in a leader who has time only to put out management related fires”.

For a small number of therapists the conditions described above appeared to impact negatively on the behavioural manifestations of professional commitment. On the other hand, many occupational therapists’ embraced their commitment to their profession all the more firmly as summarized in the following statements: “The lack of regular performance reviews does not deter my striving for ongoing education and keeping up with best practice”, “I perform my own annual performance reviews and base my professional goals/education/development needs on this self-evaluation”, and “The current management context does [impact on professional development] and [human

resource] management practices are driving me out of this job. But I feel a heightened need to stay professionally current while I consider other career opportunities".

With respect to *Hypotheses 3 and 5 which proposed a mediating effect by professional commitment on relationships between professional development, and perceived organizational support and human resource management, s*everal responses contributed to the understanding of the quantitative findings. In some cases professional commitment was clearly at play in the professional development behaviours of respondents: "Given the large # of [occupational therapists] in the organization we as clinicians are excellent at expertise sharing through formal/informal education sessions etc", and "As a group of 4 therapists, all working part time, we try to pass on knowledge gained at courses one of us attends".

Taken altogether, responses to the open-ended question suggest that with respect to the enactment of the professional development of occupational therapists in this study, professional commitment tends to over-ride both perceived organizational support and human resource management practices as operationalized in this study. Many therapists report having accepted current organizational environments, adjusted their expectations, and adopted new and adaptive perspectives toward maintaining their evolving professional identity and professional development. The comments further suggest that, in many cases, there is little connection in the minds and behaviours of occupational therapists in these environments, between their perceived organizational support and human resource management practices, and their professional development behaviours.

Chapter Summary

Overall, findings in this study indicate that professional commitment plays an important role in all measurements of direct and indirect effect on professional development. In addition to explaining the greatest amount of variance in professional development behaviours, professional commitment also mediates the effects of perceived organizational support and tangible support (funding and time release) on professional development. The hypothesized positive relationship between performance management and feedback, and professional commitment is not supported.

Responses to the open-ended question confirm the relationship between professional commitment and professional development behaviours. Respondents spoke of the great importance of organizational support but indicated that it tends to not be forthcoming, and that they have learned to not expect it. Respondents also confirmed that though support in the way of release time and funding impacts significantly on their professional development behaviours, this too is mediated by their professional commitment. There is also a strong indication that organizational policies and managerial decisions about type, location, and priority of professional development activity does not consider the specific professional needs of occupational therapists.

Finally, the ways in which health care environments are structured, and the busy fast-paced nature of the work, were reported to have considerable impact on professional development. There is general agreement within the open-ended responses that the lack of credible performance feedback impacts on any association there might be between current performance management practices on the part of organizations and professional development behaviours, and that therapists have turned to their own professional

accountability with respect to their professional development journey.

The following chapter presents the theoretical and practical implications of my findings for the various stakeholders whose roles contribute to the professional commitment and professional development of Canadian occupational therapists.

Table 5.10 *English Language Responses to Open-ended Question*

Code (*definition*)	Sub-categories	Representative Statements	Essence Description
Professional Commitment *(a stabilizing or obliging force that gives direction to behaviour in the absence of extrinsic motivation such as salary and benefits (Meyer & Herscovitch, 2001) "a person's belief in and acceptance of the values of his or her chosen occupation or line of work" (Irving, Coleman & Cooper, 1997)*	Affective Commitment to Profession	I have been an occupational therapist for many years. I feel I made an excellent choice in professions and my interest lies in front line, hands on therapy. Staying in the profession is a choice for me because I love it, not a loyalty or responsibility that implies feeling a pressure to stay in the profession. I believe that the skills learned as an [occupational therapist] will be applicable in most if not all [types of work] that a person chooses. Therefore I don't think I can ever leave the profession but can leave a position that is labeled an occupational therapist. At a department level, we have been able to maintain our [professional] practice leaders and [function] as a professional body. This enables me to continue to learn and grow with my colleagues. We have our own educational/clinical/research committees and run conferences/courses to support our educational and [professional] growth. I love being an [occupational therapist]. They should not stay if they do not believe in the values of the profession. To be a good [occupational therapist] you must believe in the important role of enabling participation in everyday life. I believe in the power of [occupational therapy] and strongly feel participation in daily life is integral to quality of life. [occupational therapy] makes sense to me - I love the diversity of the practice. I am an [occupational therapist] I believe it and love it, not because of guilt or duty. Given the large # of [occupational therapists] in the organization we as clinicians are excellent at expertise sha through formal/informal education sessions etc. The lack of regular performance reviews does not deter my striving for ongoing education and keeping up with best practice. I feel a heightened need to stay professionally current while I consider other career opportunities.	Most respondents reported that their commitment to their profession, to lifelong learning and to quality patient care were the primary reasons for their professional development. In some cases regulatory requirements were specifically mentioned.

As a group of 4 therapists, all working part time, we try to pass on knowledge gained at courses one of us Attends.

Professional Regulations
The college of [occupational therapists] […] has a much more significant input than my employer on my professional development.

I would say it is more [regulatory body] and personal expectations and goals that are the drive for my professional development activities

The profession of [occupational therapy] desperately needs strong leadership across all its contexts (regulatory educational, clinical).
If it is to keep pace with the changes in health care systems and services across the country and world over. Leadership skills should continually to be heavily fostered in universities and the workplace.

Commitment to clients
I feel a personal responsibility to my clients and therefore ensure good practice because of my personal ethics.

Perceived Organizational Support (*the global beliefs of employees concerning the extent to which an organization values their contributions and cares about their well-being)*	<u>Feeling NOT supported</u> I feel management does not recognize professional development. I feel as a new grad I am not supported in [professional development] as a better practitioner. This need was discussed during my interview and after, but [I] find it is not met. We do not get recognition at a personal level. It is through our team that I get the most recognition and satisfaction, and from the clients we serve, knowing that I can make a difference in their child's life to some degree. Presently we have an authoritarian micro-managing clinical leader who stifles the whole department. I feel little enthusiasm for [occupational therapy] professional activities We are the major tertiary pediatric center for a ++ large area spanning 3 provinces. As such it is quite embarrassing the lack of focus placed on developing/assisting expert/specialized skills in various areas. I don't feel my organization understands the importance of professional [development]. I feel as though I'm at the bottom of the funding food chain with very little opportunity for participation in [professional] development activities. This obviously leads to a sense of feeling under-valued as a team member My 'organization' is not aware of me as an individual, does not appear to support my profession, and makes rash, non-productive decisions repeatedly which hinder the progress of my colleagues, and me, as [occupational therapists] and individuals I look for personal and professional development on my own. I've stopped expecting it to come from my workplace. The impact of our current management practices are very negative on [professional development] activities. They want [professional development] to happen but not on their dime or their clock. It is an extremely frustrating experience. Management becoming more restrictive about education hours, flex time, sick time etc. overall using email more to communicate, which can sometimes leave us feeling that we are not fully trusted or valued to be	A considerable proportion (approx 70%) of comments relating to perceived support were expressions of disenchantment and not feeling valued and supported. Therapists who did express feeling valued frequently cited support for professional development as the reason for their positive feelings about their organization.

doing our best, and have less give and take about hours, practice etc.

I feel very strongly supported by my immediate supervisor [with respect to] my continuing competency. I feel much less supported and less trust for the overall organization's management. I do not feel there is much interest at the upper organizational levels for personal/professional development.

There is an increasingly poor climate in this organization for professional development. The same story is hea over and over …."no money". it impacts on one's skill development and even more, on one's interest in the profession. I like to challenge myself, learn new things and continue to grow as an [occupational therapist].

Feeling Supported

I consider myself fortunate to have continued my professional development and the variety of opportunities that continuing professional development enabled me to pursue.

My employer makes me feel supported in professional development via financial and time off work grant for various [occupational therapy] practice related courses.

The organization I work for values professional development and prides themselves on being current & up-to-date with clinical therapies/interventions.

Overall my present organization is very supportive of professional development activities. I have no concern regarding being able to meet goals both professionally and financially

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HRM 1: Support in time and funding *(these are one example of 'high commitment' HRM practices that aim to facilitate professional development for*

Support Received

… provided with ample time & finances to attend both internal & external educational opportunities.

My facility has allotted 1000$ for me to spend on continuing education. Without this I likely wouldn't be able to attend many courses.

My organization gives me time paid and money to get educated. Very happy… and lucky to work here.

Therapists' reports regarding receipt of support in funding and time for [were distributed between *positive* (15), *negative* (11) and *mitigated* (39). The 'in-between' responses identify issues related to

employees)	Financial and time support given by employer encourages us to participate in continuing [education]. … paid time to attend courses during work hours, responsible for own tuition/transportation/meal expenses. Allowed one to two work days to attend education. The facility will provide paid time for attending relevant courses. Registration fees have to be negotiated. I pay some, the facility pays some. Fortunately the current management is very supportive of professional development activities and funds for courses, travel and education time are available. I have a very supportive manager who allows me to take paid time off work for professional development. Company does not provide adequate financial support for me to pursue courses. They will pay up to $500/yr, which is good. We have a continuing [education] budget of $2000 for 20-30 professionals per year. We are paid our salary on the working days that the continuing [education] is held. If we attend courses on the week-end we are also allotted 50% of the hours to be put into our 'overtime bank'. Management is supportive of professional level activities in terms of time, less so in terms of money. Our existing management team and corporation support professional development for the staff. We have 2 paid days to take courses, there are some monies to assist with funding and when needed we are supported to use vacation time for learning opportunities as long as the necessary clinical coverage is in place. They are very supportive and will provide some funding and flexibility of work hours to meet my professional development goals." 13	support not available for occupational therapy-specific professional development, heavy workloads, and various issues due to organizational structure and policies as factors that mitigated on professional development enactment. It is notable that the tone of the responses indicates that what is deemed adequate for some is deemed inadequate by others.
	Support NOT Received The organization I work for does not provide paid time off OR course funding ... it is very disappointing.	

We get minimum financial support and very little 'incentive' to put our time/$ for professional development. We do sometimes get to go to 'free' events for a few hours.

… all my professional development activities are funded by me, not my employer

Resources are always an issue. Time and money have been whittled away over the years. More and more [professional development] are being left to ourselves to fund.

… needing to take unpaid or vacation days and paying course tuition/travel/accommodation expenses most of the time.

… little funding (for time and education costs) for professional dev activities. Paid for one peer support meeting (11/2 hrs/month).

There is minimal financial support available. Few other resources are made available to staff (i.e. relevant journals).

Sadly there is limited funding for education i.e., seminars, in-services out-of-house. The majority of funding for education available comes from our own fund-raising initiatives.

Basically there are no education days - you have to take it on your own vacation time of unpaid time and you have to pay your own course. … I've applied to have my 700.00 NDT course paid for that I took in early Oct. but still haven't heard anything - not very timely when talking about money - quite a financial blow - 5 days unpaid and cost me 700.00.

Attending out of province conferences is impossible due to cost.

Currently, if it is not funded financially then I can't go. I can give free time but can not always afford course fees. 11

Mitigated – restricted to non-occupational therapy specific professional development
Education time often involves attending sessions that are necessary in order to function adequately (e.g. Computer courses like excel, online charting and access to LAN programs). Education time is granted at ½ paid and ½ LOA up to 4 days per year.

… seems reluctant to approve ‘our’ attendance at in-services/workshops not directly applicable to area of practice. It is very hard to get approval to attend ‘general’ [occupational therapy] courses that aren’t area specific.

Management is supportive but … do not fund [professional] development activities unless they are required such as CPR, fire etc.

My current management context will support only directly related development if it will support current organizational goals and focus for my position. … Specific skills - i.e. leadership - has been recognized but not addressed with specific resource allocation or opportunities. Currently, advancement is limited unless I leave the profession or obtain additional qualifications outside i.e. MBA, MEd etc.

Education that meets the goals of the organization rather than the individual is given higher priority. Education is often on more general topics i.e. communication, case management, etc rather than specific [occupational therapy] skills. 6

Mitigated – hampered by workload
We have support for 5 days/yr for [professional development]. Although we have this time and $ it is difficult to fit in the time as there is pressure to see 24 kids/week in school.

The organization I work with is supportive of my professional development activities regarding assistance with costs and allowing me to organize time off I need. I am however expected to complete every aspect of my job (in addition to organization committee [meetings] e.g. chart audit and quality assurance) during a week with a heavy workload when I may have registered for a professional development course. Bottom line, the day to day needs/business of the organization comes before the professional development needs of individual clinicians.

Very little time available for professional development, and even trying to find time to read an article takes time away from clients; increasing wait lists, etc, etc.

… workload and expected outcomes far exceed available time. No opportunity for professional development activities during work hours. All such activities are after hours on my own time.

Continued competence is severely affected by there being no time during work to read the literature.

… lack of time (large caseloads make it hard to get away).

Our therapy organization is EXTREMELY BUSY where we are constantly trying to come up with strategies to address the unrelenting high number of referrals.

… professional development activities occurring at home due to increased caseload demands therefore less time to do searches at work.

Our caseloads are so large, it is hard (personally) to take time away from client treatment and still fulfill your job requirements.

Do not give any time during work to ↑ professional development e.g. no time for reading journals as workload and expectations of how many clients they want seen in one day are too great.

We have support for 5 days/yr for professional development. Although we have this time and $ it is difficult to fit in the time as there is pressure to see 24 kids/week in school.

… my current in-patient caseload is constantly demanding and I don't have physical time to be very serious about professional development.

The current management context and the organizations human resource management practices lead to the staff having a large caseload, making it difficult for me to take part in professional development activities.

… my current in-patient caseload is constantly demanding and I don't have physical time to be very serious about professional development. 14

<u>Mitigated – hampered by organizational structure and policy</u>
Each manager seems to code this differently and use the info differently. Some managers take the $ for the time out of our [professional development] allotment (therefore may deplete resources for tuition) others do not. Some managers commend and support [professional development activities; some gather the data and set a 'maximum' allowable. There seems to be a lack of consistency/variance in interpretation.

Compete for educational funding. 'Red tape' to confirm funding takes a lot of time and delays registration - results in courses being full.

Professional development is important to my organization … but they do not have resources (money and time) to support [professional development] fully. We get $300 towards fees/yr plus the time paid. But when we have to travel and stay over, we pay for this out of our own pocket.

Management selects specific areas that will be the focus for up-coming years, money is streamlined into these 1-2 areas – if you do not practice with that specific client population it becomes difficult to get courses funded.

… the organization will pay for a limited amount of education or I pay out of my pocket over and above that while the nurse is funded through the nursing assoc/union. We both do the same job.

There is not a set limit (min or max) on courses attended/funded per calendar year - several factors play roles - seniority (union position), # of people wanting to attend, # of courses already attended etc. Sometimes the 'calculation' seems unjustified/unfair, with management seeming pre-occupied with threats of grievances being filed.

Management is supportive if I take the initiative. They will fund 2/3 the cost of tuition, travel etc. They will fund courses but not conferences, which I find disappointing as often a great amount of learning is accomplished by networking with others at conference.

… limited resources only allow for 3 education days/year so to take longer courses need to use vacation time. Tend to avoid longer courses although they are most beneficial.

The company will fund $1000/yr but will not pay time for [professional development] activities. I have taken significant unpaid time for this reason [professional development] which I am finding is becoming too costly, restricting the [professional development] options I have.

It is not a problem to get time off to complete [professional development] - but financially it is next to impossible as the organization does not support me financially to a great extent (max $100/yr) and my wage is much lower than average.

The current management is not supportive of professional development - it can be very difficult to get approval to attend any course which is not directly related to my current position - therefore keeping pigeon-holed in the same place with no hope of advancement.

… management is supportive but because I continue to apply for term positions do not fund[professional] development activities unless they are required such as CPR, fire etc.

… ↑ red tape to go through course approval. Our library does not receive any rehab specific Journals,

Lack of awareness of professional development needs of [occupational therapists] in mental health. No encouragement (verbal or financial) to pursue professional development activities beyond the basics - limits growth and ↑ complacency amongst staff. Most of our 'in-house' [professional development activities]. As are nursing-focused. There are very few 'in-house' opportunities for [occupational therapy] specific [professional development activities]

The agency encourages teams/departments to host workshops as a revenue source.

No clear regional policy exists with respect to professional development therefore done on an ad hoc basis for approval or denial. If the manager agrees that it will improve service delivery then it will be approved if there is money in the budget. This means some staff takes part in multiple [professional development] activities whereas others do nothing. This leads to some inconsistencies [with respect to] skill levels and best practice delivery among staff.

… priorities seem to be given to nursing who do not need to work hard to organize educational opportunities - it seems to come to them as they have individuals whose primary job is to provide educational opportunities - 2 nurse educators.

Region policies often stop all travel therefore no approval to attend continuing [education] opportunities if out of town.

Current [education] policy: [education] funding now is to include reimbursement for hours normally worked, so although we have a [professional] development allowance, by the time hours are included, there is little left over to pay courses and travel fees.

	… is quite supportive to professional development requests to go to workshops as long as it is held in the city where I work. This hospital has absolutely no money set aside for continuing education (course fees) for allied health professionals but my supervisor is very creative at helping me with expenses by - for example accessing the nursing [continuing education] budget, allowing me to put hotel expenses on my purchasing card or using my monthly travel expense form for driving costs to courses. Because supervision is not an OT or has any rehab background, is difficult at times to be able to bring forth new professional development activities or courses that may be relevant. 14	
HRM 2: Performance Management and Feedback *(also an example of development- oriented HRM)*	Performance management and feedback received. Goal-setting and professional development are outlined in the annual report that I prepare. Professional development activities are well supported within the management/human resources practices at the organization I work within. My current management context is open, supportive and structured to promote my professional development. Every year I am required to [development] a personal learning plan (PLP) that outlines how I would spend approximately 1000$ (including travel) on my continued learning. I now write my past achievements, concerns and how I see I have done throughout the past 2 years. I set my goals. So far, my nurse manager has been supportive in this process. My manager respects input and decisions of each discipline. She supports continuing professional development. The management structure permits collaboration but this could change depending on the person in that position. … provides administration support, - feedback and assistance available by colleagues/professional leader. I know that I have been due for a performance appraisal for some time and a multi-disciplinary one is planned -- I have submitted names of co-workers from [occupational therapy], [physical therapy] and nursing to respond to my performance and have completed a self-evaluation.	Almost without exception, therapists report either not receiving performance reviews at all or not frequently enough, or receiving them from non-credible sources. Professional goal setting and monitoring is hampered by the fact that therapists are managed within a structure and by persons who do not possess knowledge of the transformation process involved in their day-to-day work and the accomplishment of outcomes. Workload on the part of both managers and therapists was frequently

Performance management and feedback NOT received.
I have requested another performance review because I have been in a new role for 1 year but was told that I was being too keen and my manager is too busy.

After 6 years I have yet to have a performance review. It has never been done for me by any of the 4 managers I've had in this organization.

I re-entered the field of [occupational therapy] after being away from it for 18 years. I re-credentialed; at this time I was evaluated. But since I've worked with the organization from April 2004, I have not been evaluated and I'm not aware of the formal evaluation process.

No interaction with [occupational therapy] colleagues on a regular basis, no direct supervisor, nor co-workers. Any performance review is self-reflection with occasional feedback from customers.

Although my manager is an [occupational therapist] I receive v. little direction/feedback/supervision on how I am performing or areas to improve on, and I have never had a performance review - very scary considering I am a fairly recent graduate.

Frequency of Feedback
… at this facility [occupational therapists] receive very little feedback (positive or negative) re: job performance.

… have very little to no supervision … Some contact with other [occupational therapists and physiotherapists] if happen to run into them when in the office. Rarely see [occupational therapy] manager but she is available for consultation if needed.

Organizational structure needs limit the resources available to allow performance reviews and professional development. … due to workload /patient needs and current staffing.

I get little feedback. Feedback is mostly 'internal' as I know I am making a difference in peoples' quality of life. *M*y supervisor is located at the main site and rarely visits or calls.

My [occupational therapy] practice leader seems to be always providing coverage due to staff shortage such that ↓ time to do [performance] review as such.

cited as a barrier to effective performance management and feedback.

[Organizational] growth set manager behind - just completing my [performance review] now (approx 5 years since last one). I asked my manager to do it as a way to get started for our team and got some current feedback.

Relevance and Applicability of Feedback

… lack of senior (or management) staff with clinical background [occupational therapy, physiotherapy, speech language pathology] to promote [professional] development activities.

My supervisor set goals for me that she felt would be beneficial but no input from me on this. This was not an interactive process.

Admin/mgmt are ALL nurses so although I can seek out [professional development] activities. I have no help with direction of practice, focus of practice (very much driven by individual [occupational therapy]skills/preferences/interests), feedback re: efficacy of practice.

Maybe when I've been an [occupational therapist] longer I will be better at priorizing and more effective at self-directed learning and a more reflective practitioner and be able to consider outcome measures. But my boss is not an [occupational therapist] and can't seem to help.

I have a manager who has a nursing background and does not complete routine, formal performance reviews.

… my [professional practice leader] works off site. I receive [regular performance reviews] but my supervisor relies on my colleagues to know if I am doing my work properly. Conflict of interest at times. No regular contact with me.

Although we do have goal setting during our [performance evaluation] not every[occupational therapist] has been reviewed ...

This facility has limited emphasis on performance reviews of staff by management but is in the process of setting up a structured performance review process.

As far as performance review, because the professional practice leader completes these reviews, at times we are evaluated by an off-site manager which makes feedback difficult.

Major flux currently also occurring within management which is also SIGNIFICANTLY impacting the continuity of goals in performance appraisal process.

We are currently trying to put in place a peer and a self evaluation procedure. The greatest problem is not getting feedback about what we are doing - how our 'work' contribution is seen or valued.

… program management is current context. [Nurse] manager gives performance review, although supportive, her framework is nursing.

… all management/supervisory positions are non-[occupational therapists]. It appears their understanding of [occupational therapy] is very limited and their expectation is that an [occupational therapist] is an [occupational therapist] is an[occupational therapist], therefore the service should be able to be provided on any type of unit to any type of clientele. The nature of specialization in [occupational therapy] is not understood/appreciated therefore limited allowance is made for learning and professional development opportunities.

CHAPTER 6

Discussion

The primary goal of my research was to investigate the underlying psychological processes involved in the enactment of professional development behaviours by Canadian occupational therapists practicing in current organizational contexts. My approach to this research was founded on the contemporary paradigm of the profession of occupational therapy: i.e. human occupation occurs in context as result of the dynamic interaction of person, occupation and environment. In Chapter 2, I described the theoretical underpinnings of the profession of occupational therapy and its professionalization, including the development of a specialized body of knowledge and the fiduciary responsibility to the public. The *occupation* of interest in this study was professional development. Commitment theory and organizational support theory were used as a framework to develop a basic conceptual model of the professional development process.

Summary of Research Problem, Hypothesis Development, and Methodology

Changes in health care interventions, structures, and management are creating work environments in which on-going professional development is increasingly critical. Population demographics, evidence regarding the determinants of health and well-being, technological advances, and health care policy and funding are constantly changing and emerging. Increasing healthcare costs and generalized concern about the sustainability of a publicly funded health care system in Canada have resulted in a gradual policy shift from public service to market-driven values in the management of resources. Health care budget restraints are requiring occupational therapists to do more with less, and funders

are wisely demanding scientific evidence of the efficacy and efficiency of our services. Occupational therapists must be able to adapt and respond to these ever-changing internal and external forces. Professional development enables occupational therapists to keep pace with changes and continue to provide the competent, evidence-based service that society expects (Hobson, 1990). Professional development is thus critical in assuring effective and efficient occupational therapy services in current health and social care environments.

Professional development represents a self-directed, internally driven accountability to the standards and values of the profession, including responsibility for life-long learning (Courtney & Farnworth, 2003). As professional development generally is not included in formal occupational therapy position descriptions nor contractually rewarded, it can be said to be discretionary, as defined in the citizenship performance literature (Podsakoff & MacKenzie, 1997). The antecedents of discretionary behaviour have been widely examined, particularly from the combined perspectives of commitment theory and perceived organizational support theory.

Commitment theory asserts that individuals develop different kinds of attachment to a variety of entities (e.g., organization, occupation) or courses of action such as staying with the organization or the profession (Meyer & Herscovitch 2001). According to Meyer and Herscovitch's general model of workplace commitment, employees will express their commitment through discretionary behaviours, particular if the commitment is of an affective nature. As described in Chapter 3, in the context of affective *professional* commitment, professional development would be a discretionary behaviour. Organizational support theory is based on the social exchanges that occur between

individuals and their organizations, and assists in understanding how commitment develops in employees (Rhoades & Eisenberger 2002). Based on the norm of reciprocity, the perception of organizational support strengthens commitment to the organization and increases employee efforts to help the organization reach its objectives (Eisenberger et al., 2001).

Applying these well-researched theories, I hypothesized that professional development behaviours would be positively associated with affective professional commitment, and that the latter would mediate the relationships between perceived organizational support and select development-oriented human resource management practices. In other words, perceived support and human resource practices would act on professional development indirectly, through their interaction with professional commitment.

Using survey data from 542 Canadian occupational therapists, my hypotheses were tested using hierarchical regression analysis with results largely supporting my proposed conceptual model. This chapter provides an interpretation of the major results of my study and a discussion of the theoretical and research implications of these findings, before going on to discuss the practical implications of the research for policy makers, employers, stakeholder organizations, and individual therapists. Prior to these discussions however, the limitations that must be taken into account in the consideration of my findings are identified.

Limitations

First, because data were collected at the same point in time, causal relationships between variables cannot be inferred. Second, use of a single questionnaire methodology

to collect data on all variables simultaneously and from the same sample introduces a common-method bias that has the potential to inflate relationships between variables. This bias is somewhat mitigated through the inclusion in my questionnaire of an open-ended question. Data collected from open-ended questions have the potential to offset this limitation (Creswell & Plano Clark, 2007). In the case of my study, participants' open-ended responses contributed to the understanding of the quantitative results, specifically as they related to the psychological mechanisms underlying actual professional development enactment.

Two of the scales used to measure variables, professional commitment and perceived organizational support, had previously empirically demonstrated validity and reliability. With respect to the professional development scale, existing professional development measurement measures in the literature lacked face validity for my study population and context. Both the professional development measure and the development-oriented human resource practices measure were developed for this study based on extensive previous literature. Reliability analysis (alpha) of these developed scales demonstrated good internal reliability, and examination of the measurement model through confirmatory factor analysis demonstrated acceptable construct validity. It would have been useful to pre-test these measures with a small subsample of the population representing a range of ages and lengths of tenure in the profession. In hindsight, this might also have improved the response rate. Limitations in time and finances precluded this. A post hoc examination of these correlates might confirm the validity of the measure. Nonetheless, their lack of other demonstrated psychometrics may compromise the related findings and their interpretation. For example there are other ways in which

occupational therapists pursue professional development that are not included in my measurement tool.

The measurement of employees' *perceptions* of management practices as opposed to actual practices may also have limits. A self-administered questionnaire was nonetheless considered appropriate to collect individual perception data of organizational support, professional commitment, and frequency of select professional development behaviours. This decision is supported by a study that demonstrated significant correlations between employee reports of the practices and procedures under which they work when compared to judgments made by external observers (Schneider, Ashworth, Higgs, & Carr, 1996). It may have been helpful to collect objective data on the employers' performance management activities and on the actual professional development behaviours. It should be noted however that questions about the implementation of human resource practices can result in different responses from different individuals. What employees believe the organization does for them is likely no less important than what the organization actually does, as it is the employees' beliefs that determine how they would react to organizational actions.

Another limitation is the possibility that individual participants responded in a socially desirable way, particularly given the fact that professional development is mandated by all provincial occupational therapy regulatory bodies. The guaranteed anonymity of responses should have made this less likely. Finally, professional development and professional commitment are complex constructs. This study design was limited in its ability to take into account all the variables which may impact on commitment and professional development and the variables I selected are among many

others that could potentially impact on the criterion variable. For these reasons I consider my study as exploratory with the acknowledgement that both more focussed and more complex investigations will be necessary.

The generalizability of the results to other populations is limited to the degree that they resemble the population of occupational therapists in current health care environments. As the study sample included therapists from a broad array of practice contexts across Canada however, it is reasonable to expect that findings will be generalizable to the entire population of occupational therapists (excluding self-employed and academic) within diverse practice environments.

Major Findings

The new and most important finding in this study is the apparent contribution of occupational therapists' profession commitment to their professional development behaviours. My first hypothesis, which proposed that the professional commitment of occupational therapists would be directly and positively associated with the frequency of professional development behaviours, was supported by both the quantitative results and participants' responses to an open-ended question. Professional commitment explained 5% of the variance in professional development (four times greater than the contribution of perceived organizational support), over and above the 2% explained by professional tenure and education. In fact, the unique effect of professional commitment on professional development was greater than that of all other proposed antecedent variables, indicating that individual professional commitment is critical to the enactment of professional development. Indeed, the most striking finding of this research is the dominant effect of professional commitment on professional development behaviour, and

its mediation effect on the relationships between perceived organizational support and development-oriented human resource management practices, and the reported professional development of occupational therapists. A second important finding is the suggestion in this study that antecedents known to enhance organizational commitment, (e.g. various work experiences, including perceived organizational support, job satisfaction, and support for training opportunities) contribute to professional commitment as well. This provides direction to employers with respect to enhancing professional commitment in their employees. In the following sections of this chapter, I explain the theoretical significance of these findings, their implications for practice, and then make recommendations for future research.

Theoretical Implications

Professional commitment and professional development. Meyer and Herscovitch described commitment as having a core essence, a "force that binds an individual to a course of action of relevance to a target" (p. 299) regardless of the context in which it is studied. They proposed that the underlying essence of commitment and its behavioural implications remain constant across workplace targets, be they a recognizable entity (profession), an abstract concept (standards of care) or the intended outcome of a course of action (competency). My findings support their general workplace commitment model.

Recalling that professional development is the behavioural manifestation of on-going personal commitment to maintain and improve professional competence (Haines, 1997), and viewing the "course of action" in this study as professional development and

the target as one's profession, the proposed general model of commitment in a context other than one's organization is supported.

Commitment theory is supported in at least two other ways. First, accepting that professional development is a form of discretionary behaviour, my study's finding that affective professional commitment is an important predictor of professional development complements findings in many previous studies that affective organizational commitment is strongly correlated with citizenship behaviours (Meyer et al., 2002). As indicated by the open-ended comments, occupational therapists in my study tended to perceive professional development as an integral part of their professional roles, enacting professional development regardless of the fact that it may not have been included in their position description. Second, there is some evidence that individuals' perceptions of their own competence might play an important role in the development of commitment (Meyer & Allen, 1997). Therefore, occupational therapists who feel competent in their professional skills and in the role they play within their organization would be more likely to be affectively committed to both their profession and their organization. This raises the question of whether professional development results in either, or both, professional and organizational commitment, or vice versa. Either way the potential circular nature of such a relationship might benefit both the individual therapists and the organization. It is recognized that there may be other explanations for this relationship, such as the possibility that competent people might select to join higher quality organizations which in turn inspire affective commitment (Meyer et al., p. 44).

Organizational support, commitment, and professional development. My second and third hypotheses proposed that a positive relationship would exist between perceived

organizational support and professional commitment, and that professional commitment would mediate that relationship. These hypotheses were fully supported, confirming organizational support theory's premise that employees who perceive their organization to genuinely value them and their professional roles, will reciprocate with behaviours that are likely to benefit the organization. The enactment of professional development clearly requires a synergy between individuals' professional commitment and their employing organizations.

According to organizational support theory, employees' perceptions of organizational support are abetted by organizational policies, norms, and culture that convey respect and consideration, and result in favorable outcomes for both the organization and the employee (Rhoades & Eisenberger, 2002). Finding a positive relationship between *organizational* support and *professional* commitment extends the previously demonstrated link between organizational support and *organizational* commitment (Rhoades et al., 2001). Meyer and Allen's (1997) conclusions that the antecedents and consequences of organizational commitment likely "apply to other domains … to which employees become committed" (p. 41), such as one's profession, are also supported.

Development-oriented human resource practices, commitment, and professional development. The fourth and fifth hypotheses proposed that a positive relationship would exist between select development-oriented human resource (HR) management practices and professional commitment and that the latter would mediate the relationship between those HR management practices and professional development. These hypothesis were partially supported. Performance management and feedback processes are believed to be

particularly important contributors to professional commitment and development because they generally involve the assessment of individuals' performance in terms of clinical effectiveness and the identification of opportunities for continued professional growth (Timmreck, 1998). Performance management and feedback thus have the potential to signify an organization's recognition and support for professional contributions to the workplace, resulting in enhanced professional commitment. On the other hand, the lack of feedback that is specific to practice is reported to result in alienation from professional ideals, perceptions of reduced capacity to meet professional standards of accountability, and a decline in competency maintenance and development (Rappolt et al., 2002).

Contradictory findings in my study do not necessarily signify that performance management is futile. First, the fact that 62%, (N = 629) of participants responded 'no' to the question: Do you receive regular performance appraisals? and 20% (N = 568) answered 'never', precludes the potential for a strong correlation with professional commitment and development. More importantly, occupational therapists in this study clearly indicated, through their responses to the open-ended question, that performance appraisal and feedback that is received from managers who do not understand their practice scope and processes is simply not relevant nor useful. Again this reality precludes the possibility of a correlation with professional commitment and professional development. These findings also support Lysaght et. al.'s (2001) findings that performance ratings from supervisors were generally not viewed by therapists as being useful to their competency maintenance.

The second form of development-oriented human resource practices examined in this study, support in funding and time for professional development, was positively

associated with professional commitment and professional development. In addition professional commitment mediated the relationship between this HR practice and professional development. That is, support in funding and time was most effective in enhancing professional development when provided to individuals who were more committed to their profession. An extension of this finding may be that the impact of professional commitment on professional development will be observed only in situations where employees are relatively unconstrained by other factors such as cost and time. For professional commitment to influence particular organizational outcomes it may be that employees must have adequate control over the outcomes in question. This is an important finding and stands to inform organizations in identifying employees who are most likely to benefit from financial support for professional development. Current development-oriented human management theory is thus not necessarily challenged by these findings, but rather further informed. These are important questions for future research.

Practical Implications

The findings in my study have practical implications for both individuals and collectives. Policy makers, employers, professional bodies, academic institutions, and individual occupational therapists each have a role to play in this important arena. The public expects qualified professionals to be competent in the discharge of their tasks and duties (Alsop, 2000). In addition to enhancing patient/client outcomes (Nolan et al., 1995; Umble & Cervero, 1996; Waddell, 2001), professional development has the potential to render health and social care more cost-effective by promoting evidence-based interventions (Angus et al., 1995; Courtney & Wilcock, 2005; Fawcett & Strickland,

1998). For these reasons, there is a need for an enhanced understanding of the motivation of occupational therapists, and other heath care professionals to engage in professional development such that individual professionals, educators, professional bodies, employing organizations and policy makers may work together to promote a culture of continuing competency.

Policy Makers.

The widespread establishment of program-based management in health care organizations and the elimination of professional-specific department managers has increased the autonomy and accountability of occupational therapists who are now fully responsible for their own competency maintenance and for monitoring their practice. Knowing that profession commitment is significantly important in predicting professional development behaviours, my findings suggest that policies that consider and promote commitment will likely result in enhanced professional development and ultimately, benefit the organization. For example policies that recognize the benefits of professional commitment, and that explicitly place individual professionals in charge of their own professional development might be considered. Tassone and Heck (1997) reported that allied health professionals' primary motivation regarding professional development is a desire to improve or expand professional knowledge. Policies that capitalize on this might include recognition of the value of informal professional development activities such as mentoring and communities of practice, implementing the required infrastructure.

Human resource management policies that include provision of tangible support for professional development were shown in this study to be most effective when

provided to an individual is committed to his/her profession. Participative and competency-based human resource management policies that incorporate a strong element of self-reflection might enhance both professional commitment and professional development. In addition to human resource policies related to the *process* of performance appraisals, policies about *content*, i.e. which competencies are appraised, is also relevant. It seems self evident that professionals should be evaluated against the knowledge, skills, and competencies that one was hired to execute. In the case of occupational therapists these competencies are listed in the Essential Competencies for the practice of Occupational Therapy in Canada (Association of Canadian Occupational Therapy Regulatory Organizations, 2000). Respondents in my study indicated that this is generally not happening as managers are not familiar with the scope of occupational therapy practice. Organizational structures and policies that ensure occupational therapists are able to assume their full practice scope and expertise, and that support profession-specific performance feedback and development might be considered.

Employers.

There is growing evidence of the need to link on-going professional development with organizational goals (Lawton & Wimpenny, 2003). The primary interest of health and social care service employers is to ensure the best possible outcomes for their patients/clients. The research literature is unequivocal in demonstrating that professional development plays a key role in ensuring up-to-date competencies that result in evidence-based and efficacious outcomes, (Davis, O'Brien, Freemantle, Mazmanian, & Taylor-Vaisey, 1999; Rappolt, Pearce, McEwen, & Polatajko, 2005; Umble & Cervero, 1996). However, as suggest by Irving et al. (1997), restructuring appears to have produced a

shift in organizations' relations with employees such that individuals increasingly focus their attachment to their professions rather than to the organization for which they work and that professional commitment may escalate in importance in current health care management structures. This may not be as problematic as it seems. My findings, in combination with Mathieu and Zajac's (1990) findings that professional commitment is highly correlated with organizational commitment, and with Meyer et al.'s (1993) conclusion that professional commitment is predictive of professional activities, provides employers with a starting point in planning their human resource management practices. Irving et al.'s findings that professional commitment may actually be an antecedent to organizational commitment lend still more

Employers who identify candidates with high levels of professional commitment for hiring and for promotions will likely enhance the effectiveness of the services they provide. One characteristic of professional commitment for example is involvement in professional associations (Breeden et al., 2000; Morrow & Goetz, 1988). Requiring membership in provincial and national occupational therapy associations in recruitment postings might be an effective way to screen applicants for professional commitment. Employment interviews that include questions about actual involvement in professional organizations could assist in selecting for professional commitment. Employers might also consider whether the professional commitment of current employees can be developed and if so, how that can be done.

A health care professional's work setting and his or her role as a member of a health care team can provide an environment that supports new learning and its application to the work situation. Active learning in work situations, professional

conversations and visits with colleagues, observations of skilled clinicians, effective supervision, and mentoring are all forms of professional development that maintain and enhance competencies (Anderson, 2000). Providing opportunities within the workplace for these informal professional development activities promotes accountability for professional development and can only be beneficial for the employer and for patient care.

As previously discussed, demonstrated antecedents of professional commitment include perceived career development practices on the part of the employing organization (Meyer & Smith, 2000), perceived access to training and social support (Bartlett, 2000), and perceived organizational adherence to career-oriented employment practices, including internal promotion, training and development (Gaertner & Nollen, 1989). Operationalization of these antecedents requires adequate understanding, not only of scope of practice, but also of what constitutes essential skills and safe practice. It is suggested that employers either ensure that their managers, supervisors, and clinical leaders have this knowledge, or consider bringing professionals into the organization who do. Other useful initiatives might include career laddering opportunities for occupational therapists which current program management structures tend to discourage.

Professional Organizations, and Academic Institutions.

Professional bodies, academic institutions, and associations have similar obligations in promoting the professional commitment and professional development of Canadian occupational therapists. That obligation is to collaborate, each bringing their unique mandates, expertise, and resources to the table for the development of a comprehensive systems approach to enhancing professional commitment and

professional development. As health and education are provincially regulated, an infrastructure bringing these entities together is best organized and managed at the provincial level. However, this in no way negates the important resources available from the national occupational therapy association and other expertise and support available at the national and international levels.

Regulatory bodies. The primary mandate of regulatory bodies is to ensure the public receive competent, ethical, and safe health and social care services. They are thus responsible for ensuring that practicing occupational therapist are aware of and meet specified standards (e.g., (Alberta College of Occupational Therapists, 2009) and competencies (Association of Canadian Occupational Therapy Regulatory Organizations, 2000) irrespective of their practice context and the demands of their work environment (Brockett & Bauer, 1998). One of the ways of ensuring competent, ethical, is through the implementation of *continuing competency programs* designed to ensure that individual practitioners regularly self-evaluate themselves on specific competencies, set appropriate professional development goals, and take steps to meet them. As feelings of increased competency have been shown to enhance professional commitment (Meyer & Allen, 1993), continuing competency programs themselves have the potential to enhance professional commitment.

Knowing that professional commitment is an important predictor of professional development, regulatory bodies might also consider explicitly providing services that promote professional commitment to their members. For example, initiating forums for members to network with each other to participate in the development of position statements in their area of expertise, and providing education programs that help

practitioners keep abreast of current evidence and evolving practices, each have the potential to contribute to professional commitment (Brockett & Bauer, 1998). This dimension of the professional services of regulatory colleges, for the most part, is not addressed.

Academic institutions. The education system may be one of the best arenas for promoting professional commitment (Breeden et al., 2000). Educational institutions can play an important role in fostering professional commitment in students throughout their academic program, for example, beginning with the selection of applicants who's résumés demonstrate their social responsibility via volunteering and charitable or other community activities. Of course this may require evidence regarding which personal and other characteristics might be predisposing factors for future professional commitment.

The pedagogical approaches and curriculum content that foster professional commitment in occupational therapy students is beyond the scope of this discussion. There is however considerable literature discussing this topic including, Clouder, 2003; Cook, Gilmer, and Bess, 2003; Ikiugo and Rosso, 2003; Raveh, 1995; Sabari, 1985; and Sommerlad, 2007. Clark, Sharrot, Hill, and Campbell, cited in Breeden (2000), found a significant relationship between educational level of entry into practice and involvement in professional organizations, which has been viewed as a proxy for professional commitment (G. Blau, 1999; Morrow & Goetz, 1988). Academia's recent move to an occupational therapy master's level entry degree should therefore help in fostering professional commitment.

Lastly, occupational therapy education programs can collaborate with regulatory bodies and professional associations to promote and nurture the professional commitment

of current practitioners through courses, seminars, and mentoring opportunities. University programs have the physical and human resource infrastructure in place to assist in supporting communities of practice that bring together practitioners who share a commitment to a particular specialty. Communities of practice are reported to enable regular interaction and the sharing of resources, experiences, stories, tools, and ways of managing one's practice (Wenger, 2006) and as such, can contribute to professional commitment and professional development.

Professional associations. The primary role of professional associations is to advance the collective interests of the profession, including but not limited to identifying and responding to identified professional needs and taking a lead role in the coordination of educational activities. Both provincial and national professional associations are in a position to organize educational and scientific conferences, to sponsor courses and workshops, to facilitate professional networking and other activities that meet the expressed needs of their memberships. Each of these forums provides opportunities for exchange of ideas that build professional commitment and stimulate ideas for professional development (Brockett & Bauer, 1998).

In summary, regulatory bodies, academic institutions and professional associations can join forces to nurture and promote professional commitment. Professional bodies however, are no more than a way of organizing and sharing professional issues for and with their members. The ultimate accountability rests with the individual occupational therapist.

Individual Occupational Therapists

As described in Chapter 2, occupational therapists have a professional obligation to maintain their competencies. (Association of Canadian Occupational Therapy Regulatory Organizations, 2000). Legally and ethically, professional autonomy and accountability rest with individual occupational therapists. Challenges in competency maintenance within current practice environments were discussed in this thesis. Notwithstanding organizational barriers (which do need to be addressed) my findings demonstrated that commitment to the profession of occupational therapy may be the most important predictor of professional development.

In Canada, most occupational therapy professional associations are structurally separate form regulatory bodies, and professional association membership is voluntary. In his seminal work on what constitutes a profession, Hall (1968) identified the use of the professional association as a major referent by its members as one of five key attributes. Snizek (1972) said of professional associations that they "reinforce the values, beliefs, and identity of the profession" and that "by attending professional meetings, and by reading professional journals, practitioners develop colleague consciousness; once the practitioner acquires such consciousness, he is thought to be strongly influenced by the standards of his profession" (p.109). The individual decision to join local, provincial, and national professional organizations is an important step in, and potentially evidence of, professional commitment, development, and competence.

Finally, my findings and those reported by other researchers (Cyr, Arturi, Séguin, & Egan, 2001; Grapczynski, 2000) indicate that occupational therapists' professional

development needs extend beyond the explicit needs of their employing organization. Grapczynski (2000) reported a strong thread of concern, among respondents in her study, that the formal professional development available to occupational therapists is too focused on technique and multi-skilling, and not sufficiently on the theoretical/professional constructs that guide actual practice. Although select "techniques" are used in day-to-day practice, the profession of occupational therapy is not one of technical components. Rather, occupational therapists practice from a distinct theoretical perspective, using professional reasoning to select the conceptual practice models that are appropriate to a given environmental and client population context.

Though generic professional development, for example case management, cardio-pulmonary resuscitation, or computer training may be important, there is also a need for profession-specific professional development. Individual occupational therapists may need to negotiate with their employers for the opportunities and supports they require to participate in professional development that meets their professional needs. Research comparing the impact on practice outcomes of technique versus profession-specific development would assist in their negotiation and decision-making.

Recommendations for Future Research

My examination of the enactment of professional development, predicated on the person-environment-occupation construct, and framed by commitment theory and perceived organizational support theory, was intended to contribute to understanding the underlying psychological mechanisms that motivate Canadian occupational therapists. Using the contemporary occupational therapy paradigm, i.e. that the engagement in occupations "is the point when the person, the environment, and the person's occupation

intersect" proved to be a fruitful endeavor. Results from my study suggest that the contemporary occupational therapy paradigm holds true with respect to the enactment of professional development.

The results of this study suggest that further research must look beyond the structural characteristics of professions and of work settings in order to gain a more comprehensive understanding of the factors affecting professional development. Although recognizing the important role played by professional commitment begins to explain the enactment of professional development, there remain significant gaps in our understanding of the process. Identification of these gaps provide direction for future research.

The development of a valid, reliable tool to measure professional development behaviours in occupational therapy and other self-regulated health professions is required. Psychometrically sound tools for measuring professional development in occupational therapy and other self-regulated health professional would add to the validity and reliability of any future quantitative and/or qualitative research.

Also very important is further examination of how professional commitment develops. For example, research into how employing organizations, academic programs, and professional bodies can support and enhance professional commitment.

My findings present a strong case for the inclusion of professional commitment as both a direct and indirect factor in future research related to the enactment of professional development. Future research on the professional development behaviours of occupational therapists risks specification errors if individual professional commitment is not taken into account. In addition, research is required that further elucidates how

these links between professional commitment and professional development can be applied to organizational policy, education planning, and work environments.

Another direction for investigation concerns the direct relationship between both perceived organizational support and human resource management practices, and professional development. My findings raise research questions such as: Does organizational support provided to individuals who are not committed to their profession predict the frequency of known benefits of commitment, including discretionary behaviours such as professional development? and, Are organizational outcomes positively impacted by tangible support (funding and time) provided to individuals who are committed to their profession versus those who are not? Of course there are many other variables involved in these inter-relationships, but again, consideration of professional commitment is indicated.

Further research might include qualitative investigation focussing on roles of employing organizations in promoting both professional commitment and professional development. For example, participant action research might be a useful approach to investigate the changes needed to enhance professional commitment and professional development, and/or case studies could provide insights as to how occupational therapists negotiate with their managers and human resource departments for appropriate support.

Research on the outcomes of selecting applicants to occupational therapy positions, and to occupational therapy education programs, based on personal characteristics and previous experiences that are known to correlate with, or to be predisposing factors for, professional commitment may be helpful to educational

institutions and employers. Finally, there is potential for the model presented in my study to be applied to other health care professionals.

Conclusion

The profession of occupational therapy is founded on the belief that the quality of life of all persons are significantly influenced by the occupations they engage in every day and that occupation is the context in which people develop skills, express feelings, construct relationships, create knowledge, and find meaning and purpose in life (Townsend & Polatajko, 2007). As demonstrated in Chapter 2, the principle role of occupational therapists is to enable occupation for all regardless of whether the clients are individuals, groups, or populations. Because we believe this work is beneficial and possibly indispensible to society, occupational therapists have a professional and moral obligation to apply their knowledge and skills to societal needs, and must do so in the most efficacious manner possible. Professional accountability demands personal responsibility on the part of occupational therapists to participate in life-long education in order to ensure evidence-based practice (Association of Canadian Occupational Therapy Regulatory Organizations, 2000). Recognition of this responsibility implies professional commitment.

My findings demonstrate the key role played by individual professional commitment in the enactment of professional development in current organizational contexts. Employers benefit in a variety of ways from having committed, knowledgeable, and competent occupational therapists in their employ. Nurturing professional commitment in combination with formal and informal support for professional development would be to their advantage. My findings demonstrate that perceived

organizational support and development-oriented human resource management practices also have a role to play in promoting professional development, and that organizational supports have different effects based on the extent to which individuals are committed to their profession.

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Appendix A

Sample Size Calculation

Variance estimation for continuous variables:
Where:
t = value for selected alpha level of .05 (2-tailed);
s = estimate of sd in the population;
d = # of points on scale * acceptable margin of error (.03).

For 7-point scales:

$$n_0 = \frac{(t)^2 * (s)^2}{(d)^2} = \frac{(1.96)^2(1.167)^2}{(7 * .03)^2} = 118$$

For 5-point scales:

$$n_0 = \frac{(t)^2 * (s)^2}{(d)^2} = \frac{(1.96)^2(1.25)^2}{(5 * .03)^2} = \frac{3.84(1.56)}{.023} = 260$$

Variance estimation categorical variables:
Where the acceptable margin of error is .05

$$n_0 = \frac{(t)^2 * (p)(q)}{(d)^2} = \frac{(1.96)^2 (.5)(.5)}{(.05)^2} = \frac{3.84 (.25)}{} = 384$$

Regression Analysis: (table for determining minimum returned sample size for a given population size; Bartlett et al., p.48).

For continuous data = 119
For categorical data = 370

Given:
-a population size of approximately 11,000,
-a target sample size of 400

Assuming a return rate of 20%,

2200 questionnaires were mailed.

Reference: Bartlett, Kotrlik & Higgins, 2001

Appendix B

Introductory Letter

Dear Therapist,

This is an invitation to participate in a research project. Your name and address were obtained from your provincial regulatory college, or if there is not one in your constituency, from the Canadian Association of Occupational Therapy.

I am a doctoral candidate in Rehabilitation Science at the University of Alberta and my thesis supervisor is Dr. Vivien Hollis. **My research is on the ability of Canadian occupational therapists to maintain their continuing professional development in their various restructured work environments. I am asking your assistance by completing the attached questionnaire and returning it to me in the stamped pre-addressed envelope at your earliest convenience. The questionnaire should take approximately 15 to 20 minutes to complete. Receipt of the completed questionnaire will be interpreted as consent to participate in this study.**

All information you provide will be held private and will be kept in a locked filing cabinet at Corbett Hall for at least five years after the study is completed. Only aggregate data will be used in presentations and publications of the study results. The information gathered for this study may be looked at again in the future to help investigate other questions. If so, the ethics board will review the study to ensure the information is used ethically.

There are no known adverse effects associated with participation in this study. It is hoped that the results will assist occupational therapists and their employers in understanding how current management structures and human resource practices affect the professional behaviours of occupational therapists. Results will be submitted for publication in select occupational therapy and management journals.

Thank you in advance for sharing your experiences. If you have questions or concerns regarding participation, please do not hesitate to contact me at 492-2342 or email me at arivard@ualberta.ca. If you have concerns about the conduct of this study please contact Dr. Paul Hagler, Associate Dean (Graduate Studies and Research) Faculty of Rehabilitation Medicine at 780-492-9674.

Sincerely,

Annette Rivard, MScOT, OT (c)
Doctoral Candidate
Faculty of Rehabilitation Medicine
University of Alberta
Tel: 780-492-2342
arivard@ualberta.ca

Enclosed: Survey Questionnaire; Stamped self-addressed envelope

APPENDIX C

ETHICS APPROVAL

Health Research Ethics Board

213 Heritage Medical Research Centre
University of Alberta, Edmonton, Alberta T6G 2S2
p.780.492.9724 (Biomedical Panel)
p.780.492.0302 (Health Panel)
p.780.492.0459
p.780.492.0839
f.780.492.7808

HEALTH RESEARCH ETHICS APPROVAL FORM

Date:	July 2005
Name of Applicant:	Dr. Vivien Hollis
Organization:	University of Alberta
Department:	Occupational Therapy
Project Title:	**Occupational Therapists' Continuing Professional Development in Current Health Care Environments**

The Health Research Ethics Board (HREB) has reviewed the protocol for this project and found it to be acceptable within the limitations of human experimentation. The HREB has also reviewed and approved the subject information letter and consent form

Special Comments:

Glenn G. Griener

Dr. Glenn Griener, PhD
Chair of the Health Research Ethics Board
(B: Health Research)

AUG 0 4 2005
Date of Approval Release

File Number: B-390705

UNIVERSITY OF ALBERTA Capital Health CARITAS HEALTH GROUP

Appendix D

Study Measures

Respondents were provided with the following directions:

Unless otherwise stated, all variables were measured by participants' responses to the question Please indicate your agreement or disagreement by circling a number between 1 (*strongly disagree*) and 7 (*strongly agree*). If you work in more than one area, please answer in relation to the area in which you spend the most time.

Continuing Professional Development. Developed by the author for this study. Questions (a) to (c) were answered on a 7-point *strongly disagree-strongly agree* scale; questions (d) to (f) were measured on a five-point *never-frequently* scale.

How frequently do you:
(a) volunteer for training and development opportunities offered within your organization,
(b) try to learn new knowledge and skills on the job from others or through new job assignments,
(c) develop knowledge and skills by taking courses on your own time,
(d) consult literature that is relevant to your clinical area,
(e) reflect on and identify areas requiring new knowledge and skills,
(f) consult your professional peers to access new knowledge about practice?

Two *close-ended* questions based on the Hall Professionalism Scale, as revised by Snizek (1972), were developed to probe respondents' self-reported, actual participation in professional development activities. The questions read as follows:
(g) On average *how many* courses related to your practice do you attend per year,
(h) *how many* different profession/clinically related journals do you read on a regular basis?

Perceived Organizational Support (POS) – Selected from Eisenberger et al., 1997.

My organization:
… willing to extend itself to help me perform my job
… strongly considers my goals and values
… wishes to give me the best possible job for which I am qualified
… would grant reasonable request for a change in my working conditions
… cares about my general satisfaction at work
… takes pride in my accomplishments at work

Appendix D (cont'd)

Study Measures

Support in Time and Dollars (HRM 1) – Developed by author based on findings by Lysaght, 2001

My organization:
… provides support in time for professional development activities.
… provides financial support for professional development activities.

Performance Management and Feedback (HRM 2) Developed by author based on Commitment HRM literature (Whitener, 2001).

1. My performance review includes professional goal setting.
2. My performance review includes the identification of continuing development needs.

Affective Professional Commitment. Selected from Meyer et a., (1993)

1. Being an occupational therapist is important to my self-image.
2. I do not regret having entered the occupational therapy profession.
3. I am proud to be in the profession of occupational therapy.
4. I like being an occupational therapist.
5. I identify with the occupational therapy profession.
6. I am enthusiastic about occupational therapy.

Qualitative Data - Open-ended Question.

In your experience, what is the impact of your current management context and its human resource management practices on your professional development activities? (Please feel free to write on the back of this page if you require more space)

Appendix E *French language Responses to Open-ended Question*

Code (*definition*)	Sub-categories	Representative Statements	Essence Description
Professional Commitment *(a stabilizing or obliging force that gives direction to behaviour in the absence of extrinsic motivation such as salary and benefits (Meyer & Herscovitch, 2001) "a person's belief in and acceptance of the values of his or her chosen occupation or line of work" (Irving, Coleman & Cooper, 1997)*	Affective Commitment to Profession	Je ne pense pas que l'employeur nous incite à se perfectionner « pratiquement ». Il faut un désir personnel, une conscience professionnelle, et il faut accepter de défrayer. Toutefois, [ne pas recevoir de support] crée une très belle synergie au sain de notre équipe d'ergothérapeute. On se soutient +++ Nous sommes ~ 12 ergos et avons des réunions de discipline 1X/6 sem. entre ergo où chacun amène des informations, des mises à jour sur notre pratique, des résumés de formation lorsqu'une ergo y a assisté … nous nous fixons des objectifs de groupe et individuel p/r budget et formation, aux intérêts. Nous consultons beaucoup nos collègues ergo ou autres pour nous permettre de s'améliorer et ↑ connaissances. Équipe dynamique avec beaucoup d'entraide ce qui facilite notre appartenance à l'équipe et nous motive. Nous avons par contre une bonne autonomie dans la réalisation de nos interventions auprès du client et nous gravitons autours d'une belle équipe de professionnels. Activités de développement professionnelles sont en lien davantage avec une motivation personnelle. Je suis très autonome; je fais mes demandes qui souvent ne suivent pas les directives qui s'appliquent mal à ma situation. J'essaie de toute manière de faire demande même si le 100$ annuel moyen est dépassé. Je fais souvent des suggestions de partage des coûts. Quant à mon développement professionnel, je m'en occupe personnellement. J'assume les frais d'inscription, mon temps, mon déplacement etc. Je choisi moi-même mes activités de développement en lien avec mon travail actuel.	Many respondents reported that their commitment to their profession, to lifelong learning and to quality patient care were the primary reasons for their professional development. In some cases regulatory requirements were specifically mentioned.

Heureusement nous avons une très belle équipe et un bon soutien entre nous. Nous croyons en notre profession mais vivons beaucoup d'isolement.

Je considère les activités de développement professionnel comme étant indispensables et cela fait partie de ma responsabilité professionnelle d'y assister.

Il faut être proactif pour se maintenir à jour et demander les formations pertinentes et les partager avec nos collègues.

Professional Regulations

Je partage mes objectifs avec ma collègue ergothérapeute. Je dois compléter un portfolio professionnel à chaque année pour démontrer le maintient et le développement de mes compétences.

Depuis qu'il y a des obligations ↑ vis-à-vis de la formation des ressources humaines, l'employeur y porte une attentio plus importante. Les outils recommandés par l'Ordre EQ (port folio …) nous aident à établir un projet de formation continue plus formel mais je crois qu'il faut au départ y croire et s'assurer que l'on intègre cette partie de travail dans priorités quotidiennes.

… les gens doivent se former eux-mêmes car OEQ exige 9 hrs/an de formation officielle, plus la participation dans d'autres activités permettant l'amélioration connaissance (lecture personnelle, réunion, stagiaires)

Je détermine mes objectifs de formation grâce à la nouvelle procédure de l'OEQ et avant de façon non formelle et je fais mes demandes qui jusqu'à maintenant ont é le + souvent accordées.

Depuis 2004 avec l'OEQ, rédaction du portfolio professionnelle qui permet l'établissement d'objectifs.

Je fais ma propre auto-évaluation en fonction des exigences de l'[Ordre des ergothérapeutes du Québec].

Je le fait par le biais du portfolio exigé par l'Ordre des ergos. [Le facteur organisationnel] influe peu puisque mes besoins de développements sont déterminés par l'évaluation de mes compétences et responsabilités professionnelles établie par l'Ordre des Ergothérapeutes du Québec.

	Commitment to clients Ma satisfaction au travail se ------ avec la satisfaction de mes clients p/r au service reçu. Mon évaluation de rendement passe par l'expression de la satisfaction de mes clients.	
Perceived Organizational Support (*the global beliefs of employees concerning the extent to which an organization values their contributions and cares about their well-being)*	Feeling NOT Supported Je me sens peu supportée par le superviseur dans un contexte de surcharge de travail et de manque de ressources en ergo. J'ai l'impression que mon superviseur ne reconnaît pas l'importance de l'apport d'une équipe de réadaptation. Peu de reconnaissance de l'employeur face à mon travail. Je passe trop de temps à des activités non-cliniques (gestion liste d'attente, gestion équipement) ce qui est un irritant.. … surcharge de travail et manque de temps pour faire développement prof. et réfléchir sur pratique - sentiment que la valeur de l'ergo n'est pas reconnue. Le manque de direction générale dans l'orientation globale des services à donner provoque une démotivation dans la poursuite d'activités de développement. Le manque de consultation dans les processus décisionnels provoque aussi une démotivation. Les changements constants des structures organisationnelles, le manque de considération et de reconnaissance face à la profession ont aussi le même effet. J'appréhende que l'ergothérapeute en psychiatrie soit en voie d'extinction, soit remplacé par des psycho éducateurs. L'indicateur le plus important pour l'employeur est les statistiques et non la qualité des interventions. Plusieurs de mes collègues …'aiment pas autant leur pratique qu'ils l'auraient cru. 2 ont même déjà abandonné leur emploi. J'ai donc bien hâte de voir les résultats de votre enquête. Mon employeur ne valorise pas le maintien ou l'accroissement des habiletés en ergothérapie. Il nous trouve bon comme on est. Déficit budgétaire, pénurie de personnel, surcharge de travail ++, donc peu d'importance accordée à l'ergothérapie,	A considerable proportion (approx 70%) of comments relating to perceived support were expressions of disenchantment and not feeling valued and supported. Therapists who did express feeling valued frequently cited support for professional development as the reason for their positive feelings about their organization.

formation, rétention de du personnel, promotion de la réadaptation.

Actuellement, aucune emphase et encouragement ne sont fait par l'employeur pour la formation continue. … une rétribution pour supervision de stagiaire (de l'Université de Montréal) est entièrement mise dans le budget du CRSC sans être remise aux ERGOS où à leur service.

L'absence de supervision clinique, l'isolement professionnel et l'organisation de travail influence ma motivation au travail. Les besoins multiples de la clientèle … font en sortent que ma formation continue n'est jamais suffisante. Régulièrement, je me sens dépassée et peu soutenue.

Nous n'avons plus de superviseur .2000 et depuis, les problèmes quotidien sont mis de côté et pèsent sur le moral de l'équipe à la longue. Étant donné que personne a l'autorité de les régler (surtout des [problèmes] avec le personnel) ; personne s'en occupe et cela pèse lourd. C'est un gros fouilli, mais on continue à tenir le fort du mieux qu'on peut.

Les préoccupations administratives sont actuellement de l'ordre de modifier les structures et non cliniques, ce qui démotive grandement la base.

… en amenant de fréquents modifications de poste, en changeant l'aspect organisationnelle (gestion par programme), en nous faisant perdre le sentiment d'appartenance à notre organisme.

Le soutien de l'employeur est important mais avec les années je m'en suis détachée. Je suis ergothérapeute par plaisir les gens, les bénéficiaires et non pour satisfaire l'employeur.
J'aime les bénéficiaires; je ne me soucie pas des problèmes administratifs sans importance à ma survie.

Il y a un très faible budget de formation. On est dans une ère de 'productivité' qui laisse peu de place aux développements personnels et a la reconnaissance professionnel. Il y a très peu de temps pour le ressourcement professionnel; il faut le faire en dehors des heures de travail et c'est difficile car on a une vie familiale.

Selon eux, l'ergothérapeute est bonne pour un rôle, le reste des interventions sont manifestement moins valables à comparer aux autres professionnels de l'équipe. C'est la vision de l'employeur (médecin) dans ce milieu.

La surcharge est présente. Nous avons dû nous débattre pour obtenir un préposé et ½ poste ergo. « burnout » -

l'ergo la plus jeune a quitté sa profession.

Le programme de réadaptation au travail rapporte beaucoup d'argent au centre hospitalier (organisme payeur SAAQ) et je dois me battre souvent pour qu'une partie de l'argent serve au développement de personnel … d'avantage qu'à épargner le déficit au budget annuel.

Peu d'encadrement aux employés/intervenant. Peu de support aux employés/intervenant. Peu d'encouragement pour développement professionnels.

Les coupures budgétaires amènent une pénurie de ressources en ergothérapie et chez les intervenants avec lesquels nous collaborons. Deux alternatives sont alors mises en œuvre: a) ↓ de la prise en charge des clients avec ↑ liste d'attente ce qui affecte bcp notre sens des responsabilités cliniques ou b) maintien de la prise en charge (surcharge de travail) qui amène ↓ motivation, ↓ valorisation dans l'emploi, ↑ stress et des répercussions en dehors du milieu de travail. Les activités de développement professionnelles sont, d'une façon ou d'une autre, reléguées au 2^{e} rang des les priorités.

Je crois que mes gestionnaires comprennent l'importance de la formation continue et de l'encadrement entre collègues, mais le manque d'argent et le temps sont des facteurs limitatifs. Je me sens donc à l'occasion bien seule dans mon CCSC et j'ai trouvé cela très difficile en début de carrière d'apprendre sur le tas. Un meilleur encadrement des ergothérapeutes finissantes serait souhaitable et nécessaire.

Nos employeurs stimulent très peu la formation dans notre établissement. Nous devons constamment justifier nos demandes de formation même si elles touchent directement à notre clientèle. Nous devons prendre, à l'occasion, des journées sans solde et défrayer la formation de nos poches.

Feeling Supported

Dans mon milieu de travail nous devons superviser 2 étudiants/année. L'Université verse un montant d'argent au service d'ergothérapie de l'hôpital pour chaque jour de stage (~17$/jour) que notre service distribue au 2/3 dans un fond personnel servant à notre formation continue. Ainsi, par exemple, au cours de la dernière année, j'aurai accumulé > 1000$ dans mon fond personnel … Cette procédure nous donne donc l'occasion de s'inscrire à des formations coûteuse ou dispendieuses auxquelles nous ne songerions pas à suivre autrement!
En ce sens je considère que mon employeur favorise le perfectionnement de ses employés.

De façon informelle je reçois du support positif et je sens que je suis apprécié pour tout le travail que je fait.

La communication avec mon chef de programme et mon directeur (du CRDP) font en sorte que je me sens écoutée et considérée. Il travaille présentement pour ↑ les effectifs d'ergo ce qui améliorera le service à la clientèle et nos conditions de travail et le temps de développer ma pratique (ex. suive systématique avec mes clients) et d'accéder à plus de formation.

Étant dans un milieu de pratique en lien avec l'Université Laval, la formation continue est fortement encouragée. De plus, étant dans un milieu où il y a ~ 20 ergothérapeutes, le partage d'expertises et de novelles connaissances se fait facilement. Nous avons d'ailleurs une réunion mensuelle d'une demi-journée prévue à notre horaire pour être tenu au courant des développements administratifs er cliniques.

Beaucoup de latitude m'est laissé quant à mes objectifs et à l'organisation de mon travail, ce qui est facilitant.

Nous avons beaucoup de liberté mais on ne prend pas toujours le temps de l'utiliser.

Le facteur organisationnel est un bon stimulant pour moi. Malgré une hiérarchie importante, je me considère écoutée et respectée dans mes besoins.

… riche milieu de formation scientifique et clinique pluridisciplinaire (milieu universitaire) ; sollicitations pour former stagiaire, étudiants UdeM, résidents médecine et autres professionnels donc développement professionnel encouragé pour mise à jour visant l'enseignement.

[supportée] par la reconnaissance de ma profession et de mon rôle dans l'équipe multidisciplinaire. Reconnaissance de mon rôle face à la clientèle. Formation de comité d'expert dans différents domaines ex: soins palliatifs, soin de plaie, prévention de chutes, donc le personnel est incité à développer son expertise professionnel selon le comité auquel il est adhéré.

… me permettent d'évoluer constamment dans ma profession tant sur le plan de mes compétences professionnelles que personnelles.

Il y a un comité de formation en place qui évalue chaque nouvelle demande. Plusieurs critères entrent en ligne de compte, soit la possibilité de transmettre l'infos aux d'autres, le coût, si on a le statut temps plein/temps partiel, etc.

Disons que mon employeur a une certaine ouverture!

Mon superviseur actuel me permet d'évoluer au point de vue clinique en me laissant beaucoup de liberté dans l'organisation de mon travail.

Employeur ouvert à la formation continue et pose des actions concrètes en ce sens (accord pour participer à des activités de formation, soutien financier).

A chaque année la directrice générale présente à tous les employés (3 shifts) les objectifs et la mission de l'hôpital. On peut aisément y poser des questions et par la suite, dans l'année. Les propositions que l'on fait qui sont en accordance avec ces derniers sont les bienvenues.

L'équipe participe au développement professionnel en prenant des incitatives de partage d'info informelle. Bcp de formations sont affichées ou distribuées. En mars, notre coordonatrice nous encourage à faire un bilan. Nous ne faisons pas un suivi formel mais elle se montre toujours ouvert aux discussions et suggestions.. Elle essaye de nous accorder se qui correspond à nos goûts et nos priorités. Les réunions de service ramènent l'équipe et donnent l'occasion d'échanges et prises de décision importante pour le développement professionnel.

Dans mon milieu de pratique, j'ai la chance d'avoir une supérieure immédiate ergothérapeute mais aussi une direction qui reconnaît l'importance de la réadaptation et qui le prouve par des gestes concrets.

On encourage beaucoup les échanges avec les autres intervenants du réseau de la santé. Le développement des compétences est très valorisé.

Rencontres plus fréquentes avec suivi serré des dossiers. Patron s'occupe de la technicalité ce qui nous laisse + de temps à la clinique. Le désir du patron d'améliorer le service à la clientèle nous amène à donner nos idées pour les améliorations ou changements à apporter.

Énormément! privilégie les formation (interne & externe). Nous sommes encouragés à suivre des formations et valorisés [et] partageons le contenu en sous-service. Souhaite beaucoup motiver les gens.
Mon employeur actuel a, jusqu'à maintenant, favorisé nos activités de développement professionnels en nous permettant de participer à des regroupements d'ergothérapeutes, en nous permettant d'aller dans d'autres milieux pour voir la pratique quotidienne des ergoth. dans des domaines particulier (néo natalité).

HRM 1: Support in time and funding *(these are one example of 'high commitment' HRM practices that aim to facilitate professional development for employees)*	<u>Support Received:</u> Je n'ai pas de difficulté à obtenir de la formation continue en ergothérapie. … en me fournissant les ressources financières pour participer à la formation continue. En me libérant pour participer à des rencontres entre ergothérapeutes de différents domaines. Le climat de travail (équipe) et la disponibilité de l'employeur (écoute , confiance, support) est vital. Parce-que mon superviseur croit en l'équipe et croît en la formation, je bénéficie d'un support inestimable. Il y a beaucoup d'ouverture à la formation et à la recherche. Les activités de développement personnels: il existe des réunions cliniques en ergothérapie, échange clinique, discussion, pairage clinique, etc.; des présentations et échange de formation. la formation continue dépend d'un budget fixe par programme reparti selon les besoins. L'accès est limité. Mes activités de développement professionnelles sont bien supportées en terme d'aide financière à accéder à des formations à l'extérieur. Un budget au formation supplémentaire m'a été alloué puisque je dois partir le dépt d'ergo du centre, ce qui m'a grandement permis d'↑ mes compétences. Mon employeur me donne accès à de la formation et des rencontres avec paire. Favorise le développement professionnel. Je n'ai jamais eu de refus p/n à la demande de formation continue ce qui est apprécié. Mon employeur a toujours accepté de payer les formations pertinents auxquelles je désirais participer. Organisation de rendez-vous de la réadaptation portant sur différents sujets. Affiche sur le réseau informatif des formats offerts par le centre, les universités … chef de programme qui nous envoie des articles pertinents à notre pratique. Depuis 4 ans mes demandes de formations sont toujours acceptées et mon supérieur immédiat les recommande.	Therapists' reports regarding receipt of support in funding and time for professional development were distributed between *positive* (15), *negative* (11) and *mitigated* (39). The 'in-between' responses identify issues related to support not available for occupational therapy-specific professional development, heavy workloads, and various issues due to organizational structure and policies as factors that mitigated on professional development enactment. It is notable that the tone of the responses indicates that what is deemed adequate for some is deemed inadequate by others.

Bien sûr j'ai un soucis pour en demander qui correspondent à mes besoins en fonction de ma clientèle en soutien à domicile.

Possibilité - 1 formation/année payée par l'employeur. Par la suite, nous donne la libération mais devons assumer les coûts (formation et déplacement). Libération possible pour implication sur différents comités.

Me laisse toute liberté des choix de perfectionnement. Accorde 1 formation payée pour mes objectifs professionnels. Accorde 1 formation payée pour des objectifs d'établissement. M'accorde si je paye du perfectionnement, en payant mes journées de travail.

Certaines formations sont offerte à l'intérieur de l'établissement et sont obligatoires. Un à 2 cours/année sont payées par l'employeur. Le choix de ces cours est laisser à notre discrétion.

… facilitation en terme de libération clinique ; facilitation dans la mesure où la formation est rediffusée dans notre milieu (présentation)

Le facteur organisationnel est très important car toutes nos demandes de formation continue sont sujets à être approuvé au niveau du contenu (malgré que la personne qui décide n'est pas une ergothérapeute) et au niveau de budget (maximum par année pour le département d'ergo). Alors ceci nous permet d'assister à toutes les formations pertinentes.
Bonne organisation. Il contribue à mon développement professionnel.

Présentement, nous recevons des étudiants des universités et recevons en échange un montant d'argent. → Fond étudiant que nous utilisons pour payer nos formations (week-end - journée non-payées 7h/j), → une formation annuelle est payée par notre département et porte sur des intérêts communs des ergos

Je travaille dans un programme traitant des blessés de la route dont les références principalement proviennent de la SAA ? (agents payeurs). Le contrat stipule que chaque intervenant a droit à 6 jours de libération pour formation par année. Un budget maximum par ergothérapeute est établi pour 3 ans.

Ma gestionnaire est très ouverte à notre besoin de formation. Elle a un budget pour le département ergo, physio, psychologue, conseiller en orientation er éducateur physique) car elle sait que nous devons ajuster notre pratique pour mieux desservir notre clientèle (réadaptation au travail).

Un budget annuel m'est alloué (1% de ma masse salariale) et on paie ma journée lorsque j'assiste à des formations payés par moi.

Mon employeur est très compréhensif et si je fait la demande pour du matériel ou pour formation qui fait partie de mon travail clinique ou encore de mon développement professionnel, les demandes sont acceptées.

Mon employeur nous libère l'équivalent de 5 jours payés (FTE employées) pour la formation continue. Il y a aussi plusieurs fonds afin de financer une formation continue qui sont disponibles au [McGill University Health Center]..

Considérant le piètres ressources financières disponibles pour la formation continue des professionnels, mon établissement accepte de partager les frais en nous libérant avec rémunération lors de la formation tout en demandant au professionnel de défrayer de sa poche les frais d'inscription à la formation et les dépenses inhérentes.

Support NOT Received

Influence négative des facteurs organisationnels sur mes activités de développement professionnels. Peu de formation offerte. Pas de revues scientifiques et/ou cliniques disponibles ni de temps accordé pour faire les lectures pour augmenter les compétences.

Auparavant, l'employeur contribuait beaucoup à mon développement par son aide financière pour assister à de la formation continue à l'extérieur. Avec le déficit actuel, très peu de budget est disponible pour ma formation, laquelle s'élève rapidement car je suis en région éloignée.

Très peu de ressources financières, donc peu de soutien pour le développement professionnel.

Le manque de fonds réduit considérablement les possibilités de formations.

L'employeur accorde très peu de soutien financier pour la formation et le développement professionnel.

… la situation économique de Réseaux de Santé fait qu'aucun soutien financier est offert.

Nous ne recevons aucune revue scientifique ergo au travail.

Actuellement [pas] de $ pour formation et peu de démarches faites pour remplacer 3e ergo en congé de maternité.

Le principal facteur limitant est le budget. En effet, il n'y a pratiquement pas d'argent pour la formation et le développement. Donc, la majorité des activités de cette nature est à mes frais.

… selon employeur, temps personnel doit être alloué au développement professionnel.

Il y a peu de budget pour la formation, donc on doit se payer nos activités de formation.
En situation de compression budgétaire il est très difficile d'obtenir du support financier (cela couvre à peine le coût de l'inscription et c'est moi qui a toujours absorbé les frais de déplacement et hébergement.

Aucune formation actuellement est possible sans l'accord de DG (autant celle avec un coût ou non).

En raison des limites financières, les ergos ne peuvent pas assister à toutes les formations qu'ils/elles veulent, même si elles concernent notre pratique directe.

Mitigated support – restricted to non-OT specific professional development
L'employeur se concentre sur l'organisation de formation pour les employés en général pour répondre aux exigence de l'agrément. Ainsi pour le moment je n'ai pas accès à une formation qui rejoindrait mes objectifs personnelles.

Les formations sont souvent déjà ciblées par l'employeur, ce qui laisse moins de possibilités de choisir des formations qui répondent à mes intérêts ou besoins spécifiques.

… peu de formation ergo spécialisée dans le milieu hospitalier et environnement proche.

Les gestionnaires ont tendance à donner des formations pour que nous ayons tous reçu les mêmes. Ils ne visent pas les spécialités.

L'employeur, les médecins qui prennent les décisions dans mon principal milieu de travail reconnaissent peu les rôles de l'ergothérapie. Le développement est peu préconisé sauf si il est vers leur approche (psycho dynamique). Par contre, certaines formations plus générales sont proposées à l'occasion et nous sommes invités régulièrement à y participer.

Formation de masse (tout l'établissement) peu pertinents mais vident les budgets de formation de l'établissement.

Les formations offertes consistent en familiarisation avec de nouveaux logiciels ; réticence ++ à accorder de la formation clinique depuis que je travaille pour cet employeur même si j'ai acquis une bonne compréhension des services à domicile.

J'ai donc accès au soutien pour une formation justifiée en lien avec mes tâches et clientèle mais pas si c'est global comme le congrès mondiale des ergos.

… l'employeur offre des séances d'information qu'il nomme « formations » et qui répondent à des objectifs organisationnels, la plus part du temps.

Le budget actuellement accordé aux formation est attribué en fonction d'objectif d'équipe et non pour le développement de chaque profession. Cela fait que les formations accordés sont souvent d'ordre général et non spécifique à notre champ de pratique. Il devient donc difficile d'être à la fine pointe, surtout lorsqu'on travaille dans un milieu avec multiples clientèles

Peu de temps et surtout d'argent nous est alloué afin que l'on participe à des activités de formation ou tout simplement de faire la lecture d'articles de revue … p/r à la pratique en ergothérapie.

La plupart des budgets de formation sont attribué à d'autres disciplines ou des formations générales sont offerts du type 'utilisation du logiciel informatique pas l'ensemble du CLSC'. Des formations spécifique à l'ergothérapie sont difficiles à obtenir surtout si les frais sont importants.

<u>Mitigated support – hampered by workload</u>
La surcharge de travail ne favorise pas le développement professionnel.

Longue liste d'attente entrainée par ressources trop peu nombreuse vs les besoins des clients entraine peu de temps pour le développement professionnel. Il y a coupure dans l'emploi de personnel (avant il y avait 6 ergos temps plein, maintenant il y en a 5). Nous n'avons pas le temps ni l'énergie à se développer.
Le manque de temps me limite pour faire des recherches littéraires (evidence-based practice) dans mon travail et je dois le faire dans mon temps hors travail.

… la charge de travail importante rend très difficile la mise en place d'une planification annuelle à cause du manque de temps.

En raison de la difficultés à trouver des remplacements en ergothérapie, les ergo de l'établissement ne vont presque jamais en formation de plus de 1-2 jours.

Je suis débordée de travail alors quand une formation est possible je ne la prends pas toujours car, n'étant pas remplacée, ma charge s'accumule (au retour j'ai encore plus de travail).

… il y a aussi le fait que nous sommes seulement 2 ergothérapeutes au département. Donc, étant donné les ressources en personnel restreintes, il devient difficiles de nous libérer.

Si nous sommes sous-employés (c'est-à-dire si des ergothérapeutes sont en congé de maternité et qu'il n'y a personne pour les remplacer) il est très difficile de faire de la formation continue parce que nous devons voir plus de patients pour compenser le manque d'ergothérapeutes ce qui nous laisse pas le temps pour le développement professionnel.

Toutefois les habiletés et compétences nécessaires [pour un poste de cadre] sont différentes de la pratique clinique. Je me soucie beaucoup du développement professionnel des ergothérapeutes travaillant à mon programme mais suis actuellement trop débordé pour me soucier du mien

Charge de travail importante donc peut être difficile de se libérer.

J'ai accès aux activités de développement prof. mais le temps est limité pour faire les démarches pour une action concrète continue. Si je fais la démarche de formation et qu'elle est reliée à la clientèle et tâches d'ergo, j'aurais droit à la formation. Mais lorsque je vais à une formation, personne ne palie à mon absence au centre.
De plus, aucun remplacement n'est accordé alors il faut que nos collègues absorbent notre tâche en notre absence pour la formation. Nous travaillons actuellement avec une surcharge de travail. Il nous manque 6.1 ergothérapeutes dans notre établissement et ce X 7 ans.

L'employeur considère parfois que nous sommes trop surchargés de travail pour être libéré pour des formations.

Vue la pénurie d'ergothérapeute (postes vacants) nous devons compenser et combler ce manque, donc ↓ notre temps pratique dans notre domaine donc ↓ mon expérience et mon développement dans mon domaine

… souvent une surcharge de travail car il est difficile de refuser - en ce moment en ergo dans notre milieu ; plusieurs congés maladie/maternité pas remplacés tout de suite.

Nous sommes en manque de personnel donc en surcharge de travail ce qui rend plus difficile de prendre du temps pour se questionner sur la pratique et mettre à jour nos connaissances.

Mitigated support – hampered by organizational structure and policy
Auparavant l'équipe était petite (+/- 10 professionnels). Le montant permettait donc à chaque professionnel d'avoir 2-3 formations par année. Maintenant l'équipe comprend ~ 35 professionnels donc il est parfois difficile d'en avoir 1. Par contre étant une des + anciennes (il y a 2 + anciennes) je ne peux pas me plaindre, étant privilégiée sur les moins anciennes.

Il s'agit d'une grande organisation, donc la prise de décision a/n administratif est très longue…
Le montant annuel du syndicat permettait également de se payer une formation de plusieurs jours pour toute l'équipe. Ce n'est plus le cas car nous sommes affiliés à un autre syndicat. Donc la possibilité et qualité de la formation professionnelle est ↓.

Mon employeur ne me remplace pas lorsque je m'absente. Je dois me limiter dans mes formations et dans mon implication autre que ma profession, ex : représentante syndicale.

Peu de contact avec autres collègues faute de temps et pas les mêmes lieux physiques, donc je travaille plutôt en ___ clos.

Mon supérieur immédiat a une charge de travail très important et ne peut pas toujours offrir le support désiré ou nécessaire.

Chaque fois que je veux une formation je dois faire plusieurs demandes avec plusieurs justifications.

Pour le moment, n'avons pas vraiment de 'patron' direct étant donné période de restructuration du CSS. La DSI a le mandat d'être la personne ressource de façon temporaire. Ne la connaissons pas vraiment et elle non plus. Pour le moment, tel que mentionné à certaines questions, nous n'avons pas de 'patron direct'. La fusion des différents établissements et le départ de nos 'patron' amènent beaucoup de changements et la structure organisationnelle n'est pas encore définie.

Mon supérieur immédiat est ergothérapeute et comprend bien les besoins de formation continue. Par contre, la culture de l'organisation a une vision très médicale qui ne valorise pas et ne soutien que très peu les intervenants en réadaptation.

Contexte et ambiance de travail difficiles ces temps-ci à cause du contexte de fusion des établissements, un manque de communication patron-employé et un manque de ressources humaines et matérielles.

… il n'a malheureusement pas un système de communication efficace permettant de partager connaissances avec les collègues

Suis à l'emploi depuis janvier 2003. Il y a eu un changement de cadre (employeur) en mars 2005. Avant, c'était une infirmière qui comprenait et prônait l'ergothérapie, avait confiance, nous consultait er nous faisait participer. Maintenant ce sont 2 infirmières (2 paliers) qui dirigent sans consulter, sans nous impliquer, orientés sur les budgets et non sur les clients/intervenants.

Les ergothérapeutes dans un contexte de rareté des ressources humaines et financières, sont devenues des « machines à soin. Il reste très peu de place pour d'autres activités professionnelles. L'organisation est devenu trop grosse, trop lourde.

Je suis *occasionnelle* et je ne peux avoir un soutien financier pour de la formation continue. Je dois prendre un congé sans solde et payer de ma poche la formation. Et si j'étais permanente, je n'aurais droit qu'à 300$ par année (non - cumulatif d'une année à l'autre). Il m'est donc plus difficile sur le plan financier de participer à de la formation continue.

On manque d'argent, de ressource humaines, d'équipement. Le personnel avec qui on travail (ex : préposées) est mal formé, peu collaborateur. Employeur fait peu de suivi, plutôt dépassé par la réorganisation (CSSS).

L'organisation de l'administration et des ressources humaines amène souvent un frein à notre développement professionnel en ergothérapie. On doit se battre pour faire valoir nos besoins spécifiques en lien à nos obligations de formation continue, dictés par l'OEQ. Certaines années, aucune formation n'a été payé et ils refusaient même de nous payer les journée de temps travaillé si on payait nous-mêmes les formations. Et maintenant, on a un budget annuel alloué pour les formations, mais le budget est non-renouvelable et doit être redemandé et rejustifié à chaque année.

Dans le contexte actuel notre employeur mise à sortir du déficit budgétaire. Ainsi il a mis un moratoire sur la formation. Nous devons sans cesse faire des demandes mais nous assumons plusieurs refus. L'organisation est de plus en plus grosse et nos demandes moins entendues

… par un budget restreint. Par des délais de réponse parfois long de sorte qu'il n'y a plus de disponibilité pour la formation.

Je considère le département d'ergothérapie relativement instable en raison des congés de maladie et des vacances des ergothérapeutes non-remplacées. Je suis la dernière ergothérapeute embauchée, la moins ancienne. Donc je suis appelée à changer souvent de secteur dans la même organisation pour répondre aux besoins de l'employeur et de mon équipe. Il est difficile pour moi d'identifier/satisfaire mes besoin de développement professionnels.

Il est clair … que le superviseur direct, dirigeant 4 ergos, 4 thérapeutes en réadaptation physique et environ 20 infermières accorde plus de temps aux pratiques infirmières. Sa formation d'infirmière influence également cela.

Les gestionnaires ont changé et les activités de développement professionnel ne constituent pas leur priorité # 1. Il est actuellement plus difficile d'obtenir de la formation professionnelle en milieu de travail.

Pour l'instant notre [Centre Hospitalier] est en déficit. Cela crée énormément de tension dans l'ensemble des services. Aucune formation actuellement est possible sans l'accord de DG (autant celle avec un coût ou non).

Considérant les budgets de formation restreint, les allocations sont souvent remis suivant l'ancienneté des professionnels. Ainsi, les professionnels les plus anciens sont souvent davantage formés que les nouveaux

Comme la structure syndicale des ergothérapeutes exige l'allocation de postes selon le niveau d'ancienneté et non selon les compétences, des changements d'équipe de travail (surtout de clientèle) sont … fréquents, ce qui nécessite des mises à jour parfois majeures des connaissances des ergothérapeutes qui sont affectés à une nouvelle clientèle quelque fois inconnue. La spécialisation des professionnel est ainsi plus difficile pour des ergothérapeutes sans poste permanent et les coûts inhérents et indirect à la mise à niveau sont souvent très importants (ex, non productivité pour les premiers mois).

Depuis la fusion des établissements (CLSC devenu CSSS), la gestion des ressources humaines est devenue très impersonnelle. Les gestionnaires changent tout le temps (3^{e} supérieure en 10 mois) ce qui ne permet pas d'établir

	un suivi régulier des activités. Les gestionnaires n'ont pas le temps de faire des suivis réguliers. De plus, la structure administrative est rendue tellement lourde que nous ne faisons plus de demandes de formation de développement (nombreux papiers à remplir, plusieurs personnes à contacter, plusieurs permissions à demander…) Actuellement le processus de regroupement CSSS limite le développement professionnel en raison du blocage des formations et de toutes les procédures administratives - le changement implique le gèle des procédures. On est un peu 'perdus' les ergo à travers les infirmières et [travailleur social] qui sont bcp + nombreux et ont un 'pouvoir' de négo + grand a/s formation de plus grand nombre. On vit une fusion qui complexifie les choses. Les décisions sont davantage centralisées et assez loin du terrain. Autrefois il y avait une gestion plus participative dans laquelle l'ergothérapeute avait une place de choix étant donné notre formation globale. Aujourd'hui nous nous sentons des exécutants. Dans le cadre des fusion d'établissements (hôpital, CLCS au Québec) la communication avec les gestionnaires est difficile et c'est un sujet qui ne fait pas partie des priorités budgétaires de moment. Nouveau fonctionnement par programme plutôt que par sévices (ex. service ergo). Tous les professionnels sont divisés dans les différents programmes et aucun chef commun pour défendre les intérêts de tous. Donc 1 ergo a/s 1 programme à pas de poids contre 5 + TS, 2 physio plus 15 médecins et 200 inf + …	
HRM 2: Performance Management and Feedback *(also an example of development-oriented HRM)*	<u>Performance management and feedback received.</u> <u>Performance management and feedback NOT received.</u> Peu de temps pour rencontrer le coordonateur du programme de réadaptation. Pas d'évaluation de mon rendement en cours d'emploi. Toutefois il y a peu de feedback officiel sur le rendement. On a peu de soutien dans mon organisation professionnelle. Je dois évaluer moi-même ma pratique et me fixer des	Almost without exception, therapists report either not receiving performance reviews at all or not frequently enough, or receiving them from non-credible sources. Professional goal setting and monitoring is hampered by the fact that therapists are managed within a structure and by persons

objectifs de perfectionnement.

Au Québec l'évaluation des compétences cliniques relève de l'Ordre des ergothérapeutes. Il n'y a pas d'évaluation de rendement fait dans mon établissement.

Nous n'avons pas accès à un coordonnateur clinique qui pourrait nous supporter et nous donner une rétroaction sur notre rendement.

Il serait bien d'avoir un certain 'feedback' sur mon rendement et l'appréciation du travail procuré.

Le rendement n'étant pas évalué régulièrement, ni la qualité des services aux clients, il est plus difficile de savoir dans quel aspect il serait pertinent de développer notre pratique professionnelle.

Je travaille pour une grande organisation et je me sens loin des décideurs. Je me sens également laissée à moi-même dans le développement et le maintien de mes compétences professionnelles et mon rendement n'est pas évalué.

Frequency of Feedback
Employeur qui fait par contre peu de retour sur notre rendement professionnel au travail.
De plus, nous sommes présentement en période de fusion d'établissement. Donc, leur plan d' organisation est encore en développement et personne sait de quel secteur il relève.
Actuellement la gestion des ressources humaines prend de [plus] en [plus]de place au sein de mon organisation, mais le lien avec les activités de développement professionnel est encore à développer. Pour le moment les formations offertes ne sont pas suivie de près par l'employeur et le professionnel est souvent laissé à lui-même.

Relevance and Applicability of Feedback
Le contexte récent de fusion (CH & CLSC) et contexte région éloignée influence beaucoup de notre profession. Les fusions ont permis d'être plusieurs ergos regroupées ensemble et d'avoir un superviseur en réadaptation qui prône ↑ heures en ergo et la ↓ perte de temps dans des act connexes qui sollicitent peu leurs compétences ergo (ex. réparer bain banc → soutien technique maintenant disponible).

Mon superviseur est une bonne personne mais n'a pas les compétences pour me superviser alors je suis laissé à moi-même avec mes collègues, ce qui nous va très bien.

who do not possess knowledge of the transformation process involved in their day-to-day work and the accomplishment of outcomes. Workload on the part of both managers and therapists was frequently cited as a barrier to effective performance management and feedback.

Une des principales façons de l'employeur d'évaluer le travail fait par son employée est le nombre de clients rencontré à chaque période statistique (rendement).

Malgré l'intérêt que je porte à ma pratique de l'ergo en centre de réadaptation, il y a plusieurs lacunes dans mon travail : [pas] de superviseur connaissant bien mon travail et pouvant me guider;