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International Occupational Therapists Continuing Education Needs and Opportunities: A survey

Abstract

Occupational therapists (OTs) are expected to maintain up-to-date knowledge and clinical competence by engaging in continuing professional education (CPE). The objective of this research was to obtain information on CPE needs and opportunities in developed and developing countries. A survey was created and emailed to 520 OTs in various countries, asking questions about CPE requirements, opportunities, and the avenues of CPE available to OTs. One hundred-nineteen OTs from 17 different countries responded. Of the 119 OTs, 28 practice in developing countries and 91 practice in developed countries. Thirty-nine percent of the OTs in developing countries stated that they have certain requirements for CPE. In developed countries 73% of the OTs indicated such requirement were necessary to practice. In developed countries 67% of OTs reported that CPE was easily available, whereas in developing countries only 25% of OTs reported that CPE was easily available. Therapists in developed countries are more likely to participate in CPE activities, whereas their counterparts in developing countries are not. International OT stakeholders need to explore avenues to make CPE more available to OTs in developing countries and remote areas.

Keywords

Occupational Therapy Education, Continuing Education, Continuing Professional Development, International

Credentials Display

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All health-care practitioners, including occupational therapists (OTs), must demonstrate up-to-date clinical knowledge, skills, and attitudes. This is especially important in an ever-evolving health-care climate of increased complexity, demands for accountability, and drive toward evidence-based practice. New OTs demonstrate their clinical knowledge and competence by passing an initial certification exam. Practicing OTs are expected to maintain up-to-date knowledge and clinical competence by engaging in various forms of continuing professional development or continuing professional education (Gould, Kelly, & White, 2004; Munro, Cook, Crawford, & Kilbride, 2004).

Continuing Professional Development

Continuing professional development (CPD) is any post-basic clinical education aimed to engage the practitioner in a lifelong process of learning (Griscti & Jacono, 2006). The literature uses other terms, sometimes interchangeably, to refer to CPD, such as lifelong learning, continuous professional education, continuing education, adult education, recurrent education, and continuing clinical competence (Gopee, 2001). The goal of CPD is to continuously improve the quality of health-care practice and to facilitate career development and growth among clinicians. Health-care workers need to maintain up-to-date knowledge and skills to care for clients and meet the demands of their employers and professional organizations. CPD also provides opportunities for professional growth since entry-level health-care education is no longer sufficient for a lifetime of practice (Gould et al., 2004).

Practitioners engage in CPD for numerous reasons, such as professional knowledge improvement, personal satisfaction, and self-assurance. In a survey of 94 health-care professionals, respondents reported that professional knowledge is the prime motivator in seeking CPD (Ryan, 2003). Other motivators include updating existing qualifications, increasing the status of the profession, and demonstrating individual competence. Some professionals engage in CPD for external reasons, such as meeting licensure requirements or employer expectations (Murray, McKay, Thompson, & Donald, 2000). Some researchers linked CPD to improved skills and knowledge (Grossman, 1998). Conversely, other researchers suggested that there is a lack of evidence to indicate that CPD may improve clinical practice or even improve patient outcomes (Lundgren & Houseman, 2002); however, most clinicians are mandated to engage in some form of CPD for licensure and to maintain membership in professional organizations. Some professional organizations struggle with the decision about whether or not to require CPD. And, if they do require CPD, they struggle with how to quantify these requirements while balancing the interests of different stakeholders. In response to these concerns, many health-care professions joined forces in 1995 to address common CPD issues. An inter-professional workshop tackled four main issues related to CPD: The definition and evolution of CPD, the core clinical competencies versus specialized practice, the goals and responsibilities for ensuring compliance with CPD, and the

economics of CPD. These issues are vital to all health-care professions, including occupational therapy (OT).

Even with the recognized benefits of CPD, some health-care professionals choose not to participate in CPD activities. The reasons for not participating usually relate to availability, cost and relevance of continuing education, poor working conditions, and family commitments. Researchers suggested ways to improve participation and engagement. They recommended adopting participatory workshops and learner-centered approaches to education, catering to multiple learning styles, and implementing different teaching strategies (Griscti & Jacono, 2006).

Continuing Professional Education

Most professional organizations require their members to engage in CPD by participating in yearly continuing professional education (CPE). In the United States, these requirements vary among professions, and within the same profession in different states. Because OT is one of the newest health-care professions, OTs have a professional responsibility to exceed the requirements of their professional organizations, current employer, or local regulator (Lundgren & Houseman, 2002; McKinstry, Allen, Courtney, & Oke, 2009). CPE has been proven as a vehicle to enhance professional socialization and engagement, as a way to provide mentoring opportunities, and as a chance to address professional challenges and shortcomings in OT (Lundgren & Houseman, 2002). Researchers have concluded that CPE is very beneficial to OTs and that the profession can integrate research findings into practice by following up CPE with reflective learning.

In some countries, especially developing countries, CPE opportunities are scarce to non-existent (Griscti & Jacono, 2006). If such opportunities exist, they tend to be cost prohibitive and may not be at the breadth or depth needed. Shortage of CPE opportunities is of great concern to policymakers, the public, and other stakeholders. This shortage impacts health-care practices, limits access to evidence-based practice, and essentially threatens entire health professions. Various developed countries have adopted different strategies to provide adequate CPE avenues. In Jordan, nursing set a good example for other health-care professions when leaders in the nursing profession identified CPE as major national goal and priority (Hayajneh, 2009).

The Significance of this Research

To date, there is no research data that compares and contrasts the CPE requirements and availability in various countries. The aim of this research was to quantify CPE requirements and the availability for OT practice in different countries, investigate the ease and cost of access to CPE, and to determine which methods of CPE OTs most frequently use in their country of practice. By answering these questions, the international OT community will be more aware of the disparity in CPE opportunities in different countries, and the professional community can explore avenues to make CPE more accessible to all OTs.

Method

Instrument

The researcher developed a study-specific quantitative survey. The survey was designed to capture two sets of information: demographics about the OT practitioners and the requirements and opportunities for CPE. The survey asked OTs numerous questions about their country of current practice, the country from where they graduated, the required years to complete OT education, their current practice setting, CPE requirements, avenues of CPE availability, and their participation in any on-line forums. After receiving IRB approval, the researcher launched the survey using the PsychData website. Using the internet allowed the researcher to target OTs in as many countries as possible.

Participants

The contact information for 520 OTs was obtained through various internet websites and list servers, such as the World Federation of Occupational Therapists, the European Network of Occupational Therapy in Higher Education, the Occupational Therapy International Outreach Network, the British Association/College of Occupational Therapists, and the Canadian Association of Occupational Therapists. The researcher sent an email to the OTs requesting that they complete the survey. The link to the survey was embedded in the body of the email. The email was sent twice, and included a request for OTs to forward the email to fellow OTs, coworkers, other OTs within their professional organizations in an effort to snowball the sample. The final number of OTs who received the email with the link to the survey was unknown, as it was not possible to track how many times the email was forwarded to other OTs.

Results

Respondents

A total of 119 OTs from 17 different countries completed the on-line survey, resulting in a 23% response rate to the initial email. Countries where OTs are currently practicing include New Zealand, Jordan, Greece, Saudi Arabia, Sweden, USA, South Africa, Kuwait, Egypt, Chile, Tobago West Indies, Australia, Palestine, Finland, Uganda, United Arab Emirates, and Canada. Thirty-three of the 119 OTs, 27.7%, studied OT in countries other than the ones where they currently practice. The other 72.3% were practicing in the same country in which they were educated, which demonstrated the global mobility among the OT workforce.

To compare the availability of and the needs for CPE among countries, the researcher grouped the respondents into two groups based on the country of practice: OTs who practice in developed countries and OTs who practice in developing countries. The literature suggested disparity based on the level of development in the country (Griscti & Jacono, 2006). To classify the respondents' countries into developing countries versus developed countries the researcher used the classification of the International Monetary Fund (IMF) of 2011. That report acknowledges the difficulty of determining "where exactly to draw the line between developing and developed countries" (Nielsen, 2011, p. 3). Nielsen (2011) acknowledges the disagreements among economists and

development experts; however, for this research the classification of the IMF was sufficient. Twenty-eight of the 119 OTs, 23.5%, practice in developing countries. The remaining 91 OTs, 76.5%, practice in developed countries.

Summary of Results

The survey asked the OTs questions about the requirement and availability of CPE in their respective countries. On the one hand, 39% of the OTs in developing countries stated that they have requirements for CPE; however, they cited no specific number of contact hr or other concrete requirements. On the other hand, 73% of OTs in developed countries indicated that CPE is required to practice OT, with a mean of 24.6 contact hr annually, ranging from 13 hr to 30 hr a year. Twenty-five percent of OTs in developing countries cited no CPE requirements for OT practice, compared to 20 % of OTs in developed countries (see Table 1).

Table 1

Requirement and Availability of CPE Opportunities in Developed versus Developing Countries

Q-1 In which country are you currently practicing OT?	Q-2 Do you have any requirements for continuing education where you practice?	Q-3 If you answered yes, what are these requirements?	Q-4 Is continuing education easily available in your country?	Q-5 If you answered yes, is cost easy/affordable?
Developing countries *n* = 28	Yes: 11 (39%) No: 7 (25%) Not sure: 7 (25%) Other: 3 (11%) *	No specific contact hr were given. Answers were generic, such as having an OT degree.	Yes: 7 (25%) No: 20 (71%) Not sure: 1 (4%)	Yes: 3 (43%) No: 4 (57%)
Developed Countries *n* = 91	Yes: 66 (73%) No: 18 (20%) Not sure: 7 (7%)	Average of 24.6 contact hr a year. Ranged from 13 hr to 30 hr per year.	Yes: 61 (67%) No: 17 (19%) Not sure: 5 (5%) Other: 8 (9%) **	Yes: 25 (40%) No: 36 (60%)

* Such as maintaining OT license in country of origin or another country.

** Various general courses were available, however no specialty courses.

The survey asked the OTs about the availability of CPE where they practice. In developing countries, 25% of OTs reported that CPE was easily available, compared to 67% of OTs in developed countries. In developing countries, 71% of OTs reported that CPE was not easily available. Of those OTs, 57% reported that the cost of engaging in CPE was not affordable. In developed countries, only 19% of OTs said that CPE is not easily available (see Table 1).

The survey also asked OTs about their access to various CPE avenues, such as conferences, seminars, internet-based education, annual conventions, university-sponsored training, work-based training, or other avenues of CPE. They were asked about their preferred language of delivering CPE training and whether or not they subscribe to any on-line forums or list servers.

Examining Table 2 reveals that 71% of OTs in developing countries have access to conferences or seminars, compared to 98% of OTs in developed countries. Forty-three percent of OTs in developing countries have access to internet-based education, compared to 62% of OTs in developed countries. Eighteen percent of OTs in developing countries have access to annual conferences, compared to 68% of OTs in developed countries. Twenty-five percent of OTs in developing countries have access to university-sponsored training, compared to 40% of OTs in developed countries. Seventy-one percent of OTs in developing countries have access to work-based training, compared to 76% of OTs in developed countries. Eleven percent of OTs in developing countries indicated that they attend other forms of CPE, such as national meetings. Twenty-nine percent of OTs in developed countries chose other forms of CPE, such as journal clubs, university courses, workshops, reflections with colleagues, peer learning, and training from vendors (see Table 2).

Table 2

Available Avenues of CPE, Language of CPE, and On-Line Forums

Q-1 In which country are you currently practicing OT?	Q-6 What methods of continuing education materials (if any) are available in your country of practice? Check all that apply:						Q-7 What are the preferred languages for continuing education in your country?	Q-8 Do you participate in any on-line forums or list-serves, such as Occupational Therapy International Outreach Network or regional forums?
	Conferences/ Seminars	Internet-based education	Annual conventions	University-sponsored training	Work-based training	Other (please specify)		
Developing countries *n* = 28	20 (71%)	12 (43%)	5 (18%)	7 (25%)	20 (71%)	3 (11%)* total: 67/28 (1: 2.4 ratio) opportunities	English: 23 (82%) Others: 5 (18%) Arabic Spanish	Yes: 7 (25%) †, No: 19 (68%) Not sure: 2 (7%)
Developed Countries *n* = 91	89 (98%)	56 (62%)	62 (68%)	36 (40%)	69 (76%)	26 (29%)†† total: 338/91 (1: 3.7 ratio)	English: 72 (79%) Others: 19 (21%) Greek Malay Maori Afrikaans	Yes: 33 (36%) ‡‡ No: 37(41%) Not sure: 7 (8%)

* These included national OT meetings.

† listed 12 internet-based local, national, and international forums.

†† these included journal clubs, university courses, workshops, reflection with other colleagues, peer learning, training from venders, and professional organizations.

‡‡ these included national forums, wiki groups, specialty OT groups, WFOT forums, and other internet blogs.

Eighty-two percent of OTs in developing countries chose English as their preferred language for CPE. Other languages were Arabic and Spanish. In developed countries, 79% of OTs chose English as their preferred language. Others chose Greek, Malay, Maori, and Afrikaans. OTs who chose other languages as their preferred ones still chose English as a secondary language (see Table 2).

Discussion

Of the 119 OTs surveyed, 76.5% reported that they currently practice in developed countries, compared to 23.5% who practice in developing countries. OTs in developed countries are more likely than their counterparts in developing countries to participate in CPE activities. The former group, on average, has to spend 24.6 contact hr improving skills and knowledge to stay up-to-date with the changes in the field. OTs have access to different avenues of CPE at different rates. In both developing and developed countries, OTs have access to conferences, internet-based education, conventions, university-based training, work-based training, and other avenues. In developed countries, an OT may have access to more opportunities. Based on the available avenues of CPE per OT, an OT in a developed country has a 154% chance of accessing CPE opportunities compared to his/her counterpart in a developing country. Close examinations of the different avenues of CPE and the degree of access that OTs have in developing and developed countries reveals some interesting trends. Almost all OTs in developed countries and the majority of those in developing ones have access to conferences. However, there is a great disparity in access to annual conventions. Both groups have almost equal access to work-based training; this fact highlights the importance of the workplace as a source of CPE for OTs in developing countries. Various stakeholders should explore and discuss other alternatives to delivering CPE to OTs. Some researchers have suggested e-learning as a way to provide flexible, tailored, and timely methods of delivering learning to health professionals, especially to OTs in remote and isolated areas (Carroll, Booth, Papaioannou, Sutton, & Wong, 2009).

Participation in forums was weak to moderate in both groups. In developing countries only a few OTs reported participating in national or international forums; these forums were all on-line. In developed countries, OTs were slightly more likely to participate in forums with a mixture of on-line education, journal clubs, reflection groups, and peer learning.

Limitations

The researcher launched the PsychData using the internet, which means that it was most likely accessed and completed by OTs who are professionally connected and engaged. The participants may not have not been representative of the entire OT workforce in their countries. Also, the small sample size makes generalizing the findings ill-advised without further research with a larger, more representative, sample.

Implications for Further Research

Most licensing bodies in developed countries require CPE contact hours. However, the

literature found no evidence to suggest that requiring CPE improves patients' outcomes or services. To the contrary, some researchers found that requiring CPE makes health care more expensive, as the health-care workers try to recoup the expense by increasing fees. OTs in developing countries cited no specific CPE requirements. A lack of correlation between patient outcomes and CPE raises the question: Are OTs in developing countries missing anything by not participating in structured CPE activities? This research did not try to address this question.

Conclusions

The stated aims of this research were to quantify the required CPE in the OT profession across different countries, investigate the ease of access to and the cost of CPE, and examine methods of CPE most frequently used by OTs based on their country of practice. The response rate for the survey was 22.6%. The researcher categorized countries into developing and developed for ease of comparison. The results obtained from this research highlighted the need for more CPE opportunities for OTs in developing countries. The data highlighted the best avenues and language to disseminate such opportunities.

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