Document generated on 11/14/2026 7:29 a.m.

Canadian Journal of Bioethics
Revue canadienne de bioéthique

A Typology of Ethical Issues to Better Support the Development of Ethical Sensitivity Among Healthcare Professionals

Marie-Josée Drolet

Volume 7, Number 4, 2024

URI: https://id.erudit.org/iderudit/1114963ar
DOI: https://doi.org/10.7202/1114963ar

See table of contents

Publisher(s)

Programmes de bioéthique, École de santé publique de l'Université de Montréal

ISSN

2561-4665 (digital)

Explore this journal

Cite this article

Drolet, M.-J. (2024). A Typology of Ethical Issues to Better Support the Development of Ethical Sensitivity Among Healthcare Professionals. *Canadian Journal of Bioethics / Revue canadienne de bioéthique*, *7*(4), 96–101. https://doi.org/10.7202/1114963ar

Article abstract

For many healthcare professionals, identifying the ethical issues arising from their professional practice can be a challenge, for a variety of reasons. This paper presents a typology of six different types of ethical issues that can support the development of healthcare professionals' ethical sensitivity, i.e., their ability to identify ethical issues encountered in their day-to-day practice. In addition to defining each of these issues, i.e., ethical blindness, myopia, dilemma, temptation, silence, and distress, examples are given and possible solutions proposed.

© Marie-Josée Drolet, 2024

This document is protected by copyright law. Use of the services of Érudit (including reproduction) is subject to its terms and conditions, which can be viewed online.

https://apropos.erudit.org/en/users/policy-on-use/

This article is disseminated and preserved by Érudit.

Érudit is a non-profit inter-university consortium of the Université de Montréal, Université Laval, and the Université du Québec à Montréal. Its mission is to promote and disseminate research.

https://www.erudit.org/en/

Canadian Journal of Bioethics
Revue Canadienne de Bioéthique

M-J Drolet. *Can J Bioeth / Rev Can Bioeth.* 2024;7(4):96-101

COMMENTAIRE CRITIQUE / CRITICAL COMMENTARY (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

A Typology of Ethical Issues to Better Support the Development of Ethical Sensitivity Among Healthcare Professionals

Marie-Josée Drolet[a]

Résumé
Pour plusieurs professionnels de la santé, repérer les enjeux éthiques inhérents à la pratique de leur profession demeure un défi parfois important, et ce, pour diverses raisons. Cet article présente une typologie comprenant six types d'enjeux éthiques susceptibles de soutenir le développement de la sensibilité éthique des professionnels de la santé, à savoir leur capacité à repérer les enjeux éthiques rencontrés dans le quotidien de leur pratique. En plus de définir chacun de ces enjeux, c'est-à-dire l'aveuglement, la myopie, le dilemme, la tentation, le silence et la détresse éthiques, des exemples sont donnés et des pistes de solution sont proposées.

Mots-clés
typologie, éthique, moral, enjeu, tension, défi, problème, dilemme, compétence éthique

Abstract
For many healthcare professionals, identifying the ethical issues arising from their professional practice can be a challenge, for a variety of reasons. This paper presents a typology of six different types of ethical issues that can support the development of healthcare professionals' ethical sensitivity, i.e., their ability to identify ethical issues encountered in their day-to-day practice. In addition to defining each of these issues, i.e., ethical blindness, myopia, dilemma, temptation, silence, and distress, examples are given and possible solutions proposed.

Keywords
typology, ethical, moral, issue, tension, challenge, problem, dilemma, ethical competency

Affiliations
[a] Département d'ergothérapie, Université du Québec à Trois-Rivières, Trois-Rivières, Québec, Canada

Correspondance / Correspondence: Marie-Josée Drolet, marie-josee.drolet@uqtr.ca

INTRODUCTION

For many healthcare professionals, identifying the ethical issues arising from their day-to-day practice is not always straightforward (1). This challenge is unsurprising given that ethical issues are complex situations that often involve difficulty in balancing, or even potentially compromising, the relevant values for various reasons (2). Additionally, moral values are abstract concepts of an evaluative nature that are challenging to perceive (3). Complicating matters further, ethical issues are frequently embedded in structural dimensions, stemming from structural injustices or even systems of oppression that are intricate and challenging to discern and decipher (4-5). This complexity is pronounced for healthcare professionals, who are often privileged in different and potentially overlapping ways and may not be personally affected by these injustices or oppressive systems, making them less able to perceive the ethical issues arising from these systems. In addition, the lack of consistent and sufficient ethics training among many healthcare professionals contributes to the difficulty in recognizing ethical issues inherent to their practice (6-9). Therefore, it is not surprising that many healthcare professionals find it challenging to identify the ethical issues encountered in their practice.

This paper aims to address this challenge by proposing a typology of ethical issues to enhance the ethical sensitivity of healthcare professionals. Having studied different typologies of ethical issues over the last few years (10-12), six types of ethical issues emerge from the literature that are likely to support healthcare professionals in their day-to-day work (1,13-14). Drawing on Fulford's (15) value-based practice of medicine and Swisher et al.'s (2) model of ethical deliberation in physical therapy, this typology proposes six different types of ethical issues, i.e., ethical blindness, myopia, dilemma, temptation, silence, and distress. This typology has been presented to various professional audiences, although only in French, and received positive feedback regarding its efficacy in supporting the development of ethical capacity to perceive different issues in day-to-day professional practice.

A TYPOLOGY OF ETHICAL ISSUES

Although the concept of an ethical dilemma (i.e., being torn between two ethically desirable but irreconcilable options) is used extensively in bioethics (16), as well as in writings related to healthcare (17,18) and rehabilitation (12), to discuss a range of ethical issues experienced by many healthcare professionals, the ethical issues faced by healthcare professionals go far beyond ethical dilemmas. Indeed, in their daily practice, healthcare professionals are also confronted with other types of ethical issues, such as ethical blindness, myopia, temptation, silence, and distress (2,15). Even though these ethical issues are not mutually exclusive, nor do they cover all the ethical situations experienced in professional practice, their separation into distinct concepts can shed light on the complex ethical dimensions of professional practices; further, they are more likely than ethical

2024 M-J Drolet. Creative Commons Attribution 4.0 International License
ISSN 2561-4665

dilemmas alone to support the development of ethical sensitivity by healthcare professionals. The following sections define each of these ethical issues, supported by examples and possible solutions.

Ethical Blindness

Building on Fulford's (15) concept of "value blindness", which refers to a professional's inability to perceive the values at stake in a situation, ethical blindness occurs when a healthcare professional fails to recognize the presence of an ethical issue (1). In so doing, the professional is at risk of perpetuating or contributing to the situation, without being aware of the resulting harms. Ethical blindness can arise for various reasons, such as an individual's lack of ethical sensitivity, the privileges a person derives from a given situation or the maintenance of the status quo, or the socialization of a healthcare professional in a specific sociocultural context that normalizes certain injustices, discriminatory or oppressive practices (1). As a result, healthcare professionals may unintentionally exhibit ethical blindness by perpetuating certain injustices or adopting stigmatizing or discriminatory practices that stem from systems of oppression, such as ageism (19), ableism (20-21), classism (22), fatphobia (23), racism (24), sanism (21,25), suicidism (21,26), or transphobia (27), to name a few examples. It may be useful to specify that these systems of oppression are respectively related to age (ageism), abilities (ableism), social class (classism), weight (fatphobia), ethnicity/race (racism), mental health (sanism), sex (sexism), suicidal ideas (suicidism), and transgender identity (transphobia). Paradoxically, it is important to note that the expression "ethical blindness" is ableist and therefore in a way carries an ethical blindness, in that it presupposes that being blind to something is somehow negative. That being said, I have not been able to find a better term to name this issue. In summary, ethical blindness highlights a particular type of ethical issue that arises in professional practice, which is linked to potentially harmful implicit biases (28-30) that healthcare professionals may have. If unrecognized and poorly managed, this type of ethical issue is likely to engender harms, microaggressions or discrimination that can stem from various types of oppression, stigmatization, etc.

To unveil their own ethical blindness, healthcare professionals would benefit from: 1) becoming aware of their potentially harmful implicit biases and managing them appropriately (28-30); 2) cultivating their epistemic virtues, particularly epistemic humility (31), such that they never presume to possess innate knowledge nor to always be right; 3) engaging with and appreciating individuals who have characteristics, perspectives, and experiential or professional backgrounds different from their own (30); and 4) evolving within compassionate organizations that are open and receptive to the perspectives and contributions of marginalized groups in a context of transdisciplinarity (32).

Ethical Myopia

Intimately linked to ethical blindness, ethical myopia occurs when healthcare professionals wrongly assume that others share their values and beliefs, or that they should do so (15), because they presume that they have universal significance. In such situations, professionals may impose their values on others, thereby using their professional, moral, and epistemic authority in an abusive manner. This type of ethical issue is particularly common when healthcare professionals intervene in a sociocultural context different from their own. They are thus at risk of ethnocentrism and colonialist practices (24,33-34). For instance, when healthcare professionals impose a culturally situated view of health and well-being on individuals from a different culture, it constitutes a situation of ethical myopia (1), i.e, akin to demonstrating ethical imperialism.

Considering that theories, conceptual models, and clinical tools used by healthcare professionals mostly emerge from Western perspectives on health and human well-being (35), healthcare professionals are at risk of imposing Western views on Indigenous and racialized individuals, assessing their health or functioning based on standards rooted in their own culturally situated perspectives (24,33-34). By doing so, they risk basing their interventions on assessments lacking scientific validity, devaluing patients' cultural identity, generating cultural insecurity, and perpetuating profound health inequities (24,36). Healthcare professionals should strive to increase cultural diversity within their ranks to better address the needs of Indigenous and racialized individuals (37). Moreover, they would benefit from using assessments and interventions that respect the cultural identity of patients that were designed by, with and for these populations (38-40). To achieve this, more research is needed that includes the knowledge and experience of populations traditionally marginalized, discriminated against, or oppressed.

Ethical Dilemma

Generally better known to healthcare professionals, ethical dilemmas correspond to situations in which a professional is torn between two ethically desirable options, but which are irreconcilable or difficult to reconcile (2). In such situations, "two alternative courses of action may be taken, both of which fulfill an important duty, and it is not possible to fulfill both obligations" (2, p.5). A relevant way of describing these ethical issues is to assert, as Kidder (41) does, that they correspond to "right versus right" situations. Although, in this type of situation, the final decision will be based on an ethical good, that is to say, a moral value, the fact that one or more moral values will have to be set aside (because it is impossible to respect them all in the given context, as they are incompatible or even irreconcilable) makes this type of ethical issue agonizing for healthcare professionals.

To provide an example, situations that put the respect for the moral value of patients' autonomy in tension with moral values such as beneficence, safety, or life are often reported by various healthcare professionals (42-43). Situations that place the preservation of the therapeutic alliance, ensuring respect for professional confidentiality, in tension with the protection of individuals in vulnerable situations are also extensively discussed in the literature (44-47). To address these ethical issues, various methods of ethical deliberation and ethical frameworks are proposed in the literature to support the ethical reflection of healthcare professionals and their team (1,2,16,17,48-57).

Ethical Temptation

As summarized by Swisher et al., ethical temptation “involves a choice between a ‘right’ and a ‘wrong,’ and in which [a professional] may stand to benefit from doing the wrong thing” (2, p.5). Unlike an ethical dilemma, ethical temptation creates a tension between an ethically desirable option (option based on moral values) and an ethically undesirable option (option based on personal or organizational interests that compromises the needs, rights, or interests of patients or colleagues). In such situations, healthcare professionals are tempted to choose the ethically wrong path due to personal or organizational benefits associated with that option. In other words, ethical temptation resembles a conflict of interest. While it may not necessarily be unethical for healthcare professionals to act in their own or their organization’s interests, it becomes so when the needs, rights, and interests of patients are compromised in the process.

Generally, situations of ethical temptation are more likely to arise in private practice settings where financial or reputational interests conflict with the care and services provided to patients (45,47,58-60). Considering the various incentives (e.g., gifts, cruises, dinners, trips, etc.) offered by pharmaceutical companies or suppliers of different healthcare and rehabilitation devices (45,58,60), it can be tempting for a professional to recommend certain medications or devices to patients over others that may better meet their needs, or to favour certain suppliers regardless of their relevance. Clearly, the needs, rights, and interests of patients must take precedence over those of professionals, companies, and suppliers. The practices of pharmaceutical companies and suppliers unduly influencing the reasoning of healthcare professionals would benefit from better regulation to prevent conflict of interest situations, namely ethical temptations, that have the potential to negatively impact the quality of care and professional services provided, as well as professional independence. Regarding situations that can harm colleagues, it is possible that a professional does not disseminate information related to available training, posted positions, or promotion opportunities to prevent these advantages from being obtained by their colleagues rather than by himself or herself.

Furthermore, it is not always easy for professionals to determine if they are experiencing an ethical temptation or are in a situation of conflict of interest. To assess this, Kidder (41) has devised three questions or tests that professionals could ask themselves: 1) Is the action illegal or contrary to the code of ethics (legality test)? 2) Would it damage my credibility if this action were made public in the media (publicity test)? 3) Would a virtuous person avoid taking this action (virtue test)? When a professional answers affirmatively to any of these questions or tests, they are likely in a conflict of interest and thus faced with an ethical temptation to which they should not succumb.

Ethical Silence

Situations of ethical silence arise when adherence to moral values is compromised within an organization, and nobody speaks up for various reasons, allowing the ethical issue to persist unduly (2). In other words, an *omerta* may exist within a healthcare organization surrounding certain ethically problematic situations, with the result that these situations are tolerated and therefore persist. There are several possible reasons for this. For example, unequal power dynamics in a workplace may operate in a way that prevents anyone from daring to criticize authority. Healthcare professionals may also have doubts about their interpretation of the situation or fear job loss or reputational damage if they report these situations. Additionally, friendships among colleagues may hinder the reporting of ethically or legally questionable practices, as a professional may feel uncomfortable reporting the actions of a colleague who is also a friend. When situations of abuse, for example, are tolerated in an organization for various reasons, when undue privileges are given to certain patients on the waiting list because they are known to professionals and no one denounces the situation, or when organizational practices systematically disadvantage certain social groups in vulnerable situations (e.g., people who are homeless, poor, racialized) and no one denounces these practices, we are dealing with ethical silences that are likely to cause significant harm to patients.

More specifically, when professionals observe that a colleague is engaging in fraudulent practices (e.g., falsifying insurance receipts), bad professional practices (e.g., irresponsible conduct in research) or behaving in an ethically or legally questionable manner (e.g., intimate relationships with patients or abuse), but do not report the situation to the appropriate authorities, they are faced with an ethical silence. Trainees (45,61) and young professionals are particularly vulnerable to such situations, given their relative vulnerability. To resolve these issues, it is important to find a way to speak out and thus break the silence (2). Although this requires ethical courage (2), which can be very demanding of professionals, it is necessary to put an end to this type of ethical issue. To achieve this, professionals could firstly discuss the issue with trusted colleagues, to identify with them various strategies for lifting the veil on these ethically problematic situations which have the potential to turn into situations of ethical distress if they persist (2), while also causing significant harm to concerned patients.

Ethical Distress

Finally, ethical distress arises when professionals know what they should do to act ethically but lack the authority or power to do so (2), because they encounter barriers (usually organizational in nature) that prevent them from acting (4,62-63). As a result, they experience a range of negative emotions, such as anger, powerlessness, incomprehension, and a sense of lacking ethical integrity, to give just a few examples. Jameton (63) refers to these negative emotions as ethical residue, which in addition to impairing the professional’s quality of sleep and well-being at work, may ultimately lead to a period of professional burnout. In summary, situations of ethical distress resemble “David versus Goliath” scenarios, as they place healthcare professionals in situations where they have little power to act (5).

Increasing pressures on the healthcare system, particularly since the COVID-19 pandemic, have confronted many professional teams with productivity imperatives in a context of extreme scarcity of financial, human, material, and time resources. Many teams have been and are still being asked to do more and faster, with smaller and tired teams, even though they are often already overwhelmed with work (64). In this context, and where performance indicators consider only the quantitative dimensions of their work, many professional teams are forced to emphasize the quantity of care and services to the detriment of their quality or their accessibility to the most vulnerable populations.

To resolve situations of ethical distress or minimize their negative consequences, professionals should work with their colleagues and superiors to identify strategies for overcoming structural barriers to good professional practice. To do this, they will usually need to do advocacy. Moreover, these David-versus-Goliath situations require time, patience, perseverance, and ethical courage, as well as collective action carried out in concert with a large range of partners and collaborators, to be resolved. Various toolkits exist to support healthcare professionals' advocacy efforts (65-70). That said, it is often difficult to resolve such ethical issues fully and quickly; instead, one small change at a time may be the way to deal with such situations.

CONCLUSION

The aim of this paper was to provide a typology of six ethical issues often encountered in practice by various healthcare professionals. Ethical blindness, myopia, dilemma, temptation, silence, and distress were defined and illustrated with examples, and possible solutions proposed for dealing with these ethical issues. These concepts are not entirely mutually exclusive, in that ethical myopia often stems from ethical blindness, that ethical silence can be part of or lead to ethical distress if it is not broken, or that the ethical dilemma can, if unresolved, lead to ethical distress. Yet, putting words to the different ethical discomforts experienced in practice can not only be therapeutic, it can also help to avoid certain ethical issues or better resolve them. Why? Because the solutions to resolve these issues can differ, hence the relevance of properly identifying the issue that a professional is facing. To conclude, it is hoped that this typology will help healthcare professionals to identify the ethical issues inherent in their professional practice so that they can better resolve those that they experience or encounter in the course of their practice.

Reçu/Received: 8/3/2024

Publié/Published: 2/12/2024

Remerciements
Je tiens à exprimer ma gratitude à Anne Hudon, professeure agrégée dans les programmes de physiothérapie à l'École de réadaptation de la Faculté de médecine de l'Université de Montréal, qui m'a suggérée d'écrire cet article afin de rendre cette typologie accessible à un plus grand nombre de personnes. Je tiens également à remercier Sandrine Renaud, doctorante en philosophie avec une concentration en éthique appliquée, qui m'a fait remarquer à juste titre que l'expression « aveuglement éthique » était capacitiste.

Acknowledgements
I would like to express my gratitude to Anne Hudon, Associate Professor in the Physiotherapy Programs at the School of Rehabilitation of the Faculty of Medicine at the Université de Montréal, for her suggestion that I write this paper to make this typology available to a wider audience. I would also like to thank Sandrine Renaud, a doctoral student in philosophy with a concentration in applied ethics, who rightly made me aware that the expression "ethical blindness" was ableist.

Conflits d'intérêts
Aucun à déclarer

Conflicts of Interest
None to declare

Édition/Editors: Aliya Affdal
Les éditeurs suivent les recommandations et les procédures décrites dans le Code of Conduct and Best Practice Guidelines for Journal Editors de COPE. Plus précisément, ils travaillent pour s'assurer des plus hautes normes éthiques de la publication, y compris l'identification et la gestion des conflits d'intérêts (pour les éditeurs et pour les auteurs), la juste évaluation des manuscrits et la publication de manuscrits qui répondent aux normes d'excellence de la revue.

The editors follow the recommendations and procedures outlined in the COPE Code of Conduct and Best Practice Guidelines for Journal Editors. Specifically, the editors will work to ensure the highest ethical standards of publication, including: the identification and management of conflicts of interest (for editors and for authors), the fair evaluation of manuscripts, and the publication of manuscripts that meet the journal's standards of excellence.

Évaluation/Peer-Review: Christy Simpson
Les recommandations des évaluateurs externes sont prises en considération de façon sérieuse par les éditeurs et les auteurs dans la préparation des manuscrits pour publication. Toutefois, être nommé comme évaluateurs n'indique pas nécessairement l'approbation de ce manuscrit. Les éditeurs de la *Revue canadienne de bioéthique* assument la responsabilité entière de l'acceptation finale et de la publication d'un article.

Reviewer evaluations are given serious consideration by the editors and authors in the preparation of manuscripts for publication. Nonetheless, being named as a reviewer does not necessarily denote approval of a manuscript; the editors of *Canadian Journal of Bioethics* take full responsibility for final acceptance and publication of an article.

REFERENCES

1. Drolet MJ, Ruest M. De l'éthique à l'ergothérapie : un cadre théorique et une méthode pour soutenir la pratique professionnelle. Presses de l'Université du Québec; 2021.
2. Swisher LL, Arslanian LE, Davis CM. The Realm-Individual Process-Situation (RIPS) model of ethical decision-making. HPA Resource. 2005;5(3):1-8.

3. Drolet MJ. De l'éthique à l'ergothérapie. La philosophie au service de la pratique ergothérapique, 2e édition. Presses de l'Université du Québec; 2014.
4. Bushby K, Chan J, Druif S, Ho K, Kinsella EA. Ethical tensions in occupational therapy practice. A scoping review. British Journal of Occupational Therapy. 2015;78(4):212-21.
5. Drolet MJ, Ruest M. Chapitre 10 : Enjeux éthiques et défis professionnels dans un système de santé et de services sociaux en constante transformation. In: Gagnon F, Martin E, Morin M-H, editors. Le système de la santé et de services sociaux au Québec. Territorialité et santé des populations. Presses universitaires du Québec; 2023. p. 165-86.
6. Eckles RE, Meslin EM, Gaffney M, Helft PR. Medical ethics education: Where are we? Where Should we be going? A review. Academic Medicine. 2005;80(12):1143-52.
7. Hoskins K, Grady C, Ulrich C. Ethics education in nursing. Instruction for future generations of nurses. Online Journal of Issues in Nursing. 2018;23(1):3.
8. Hudon A, Laliberte M, Hunt M, et al. What place for ethics? An overview of ethics teaching in occupational therapy and physiotherapy programs in Canada. Disability and Rehabilitation. 2016;36(9):775-80.
9. Wong MK, Hong DZH, Wu J, et al. A systematic scoping review of undergraduate medical ethics education programs from 1990 to 2020. Medical Teacher. 2022;44(2):167-86.
10. Beauchemin É, Côté LP, Drolet MJ, Williams-Jones B. Conceptualizing ethical issues in the conduct of research: Results from a critical and systematic literature review. Journal of Academic Ethics. 2021;20:335-58.
11. Côté LP, Drolet MJ. Conceptualizing ethical issues of the humanitarian aid practice: Results from a critical literature review. Canadian Journal of Bioethics/Revue Canadienne de Bioéthique. 2021;4(1):152-67.
12. Goulet M, Drolet MJ. Les enjeux éthiques en réadaptation. Un état des lieux de la conceptualisation de notions éthiques. Canadian Journal of Bioethics/Revue Canadienne de Bioéthique. 2018;1(3):9-21.
13. Drolet MJ, Gaudet R, Pinard C. Comment préparer les étudiants aux enjeux éthiques de la pratique privée de l'ergothérapie à l'aide d'une typologie éthique ? Actualités ergothérapiques. 2017;19(2):9-10.
14. Drolet MJ. Six types de situations éthiques inhérentes à la pratique nutritionnelle : les comprendre pour mieux les repérer et les solutionner. Nutrition – Science en évolution. 2019;17(2):9-13.
15. Fulford KWM. Facts/values. Ten principles of values-based medicine. In: Radden J. The Philosophy of Psychiatry. Oxford University Press; 2004. p. 205-34.
16. Beauchamp TL, Childress JF. Principles of Biomedical Ethics. Oxford University Press; 2019.
17. Legaut GA. Professionnalisme et délibération éthique. Presses de l'université du Québec; 2008.
18. Saint-Arnaud J. L'éthique de la santé. Gaétan Morin; 2019.
19. World Health Organization. Ageing: Ageism; 18 Mar 2021.
20. Robertson J, Larson G. Disability and Social Change. A Progressive Canadian Approach. Halifax, NS: Fernwood Publishing; 2016.
21. Drolet MJ. Repérer et combattre le capacitisme, le sanisme et le suicidisme en santé. Canadian Journal of Bioethics/Revue Canadienne de Bioéthique. 2022;5(4):89-93.
22. Gouvernement du Québec. La pauvreté et les inégalités sociales, de graves menaces à la santé des populations. Mémoire des directeurs de la santé publique de Montréal et de la Capitale nationale Déposé dans le cadre de la consultation du gouvernement du Canada en vue de l'élaboration d'une Stratégie canadienne de réduction de la pauvreté; 2017.
23. Collectif vital. Grossophobie. Association pour la santé publique du Québec; 2023.
24. Allan B, Smylie J. First Peoples, Second-Class Treatment. The role of Racism in the Health and Well-Being of Indigenous Peoples in Canada. The Wellesley Institute; 2015.
25. LeFrançois BA, Menzies R, Reaume G. Mad Matters. A Critical Reader in Canadian Mad Studies. Canadian Scholars' Press; 2013.
26. Baril A. Les personnes suicidaires peuvent-elles parler ? Criminologie. 2018;51(2):189-212.
27. Nicole M, Drolet MJ. Les injustices occupationnelles vécues par des personnes trans : perception croisée de personnes trans et d'ergothérapeutes du Québec-Canada. Revue francophone de recherches en ergothérapie. 2023;9(2):41-63.
28. Banaji MR, Greenwald AG. Blindspot: Hidden Biases of Good People. Bantam Books; 2013.
29. Désormeaux-Moreau M, Drolet MJ. Le piège des biais implicites préjudiciables: comment les éviter pour assurer la pertinence de l'évaluation ergothérapique. In: J Criquillon-Ruiz, F Soum-Pouyalet, S Tétreault, editors. L'évaluation en ergothérapie. Concepts, méthodologie et application. De Boeck Supérieur; 2023. p. 123-46.
30. Fenley M. Comment surmonter les biais implicites? Université de Neufchâtel; 2022.
31. Fricker A. Epistemic Inustice. Oxford University Press; 2007.
32. Renaud S, Drolet MJ. ÉDI : au-delà des efforts symboliques d'inclusion, la mise en place d'une véritable collaboration transdisciplinaire est nécessaire. La Conversation. 11 janvier 2023.
33. Drolet MJ, Goulet M. Travailler avec des patients autochtones du Canada? Perceptions d'ergothérapeutes du Québec des enjeux éthiques de cette pratique. Recueil annuel belge francophone d'ergothérapie. 2018;10:25-56.
34. Grenier ML. Cultural competency and the reproduction of White supremacy in occupational therapy education. Health Education Journal. 2020;79(3):633-44.
35. Hammell KW. Engagement in Living: Critical Perspectives on Occupation, Rights, and Wellbeing. CAOT Publication ACE; 2020.
36. Pooley EA, Beagan BL. The concept of oppression and occupational therapy: a critical interpretive synthesis. Canadian Journal of Occupational Therapy; 2021;88(4):407-17.

37. Groupe d'action antiraciste en orthophonie et en audiologie (GAAROA). Rapport sur l'impact du racisme systémique dans la profession d'orthophonie et d'audiologie au Québec; Aug 2020.
38. Gerlach A. Examiner les approches socialement responsables pour la réadaptation des enfants chez les communautés, les familles et les enfants autochtones. Centre de collaboration nationale de la santé autochtone (CCNSA); 2018.
39. Iwama MK, Thomson NA, Macdonald RM. The Kawa model: The power of culturally responsive occupational therapy. Disability and Rehabilitation. 2009;31(14):1125-35.
40. Sterman J, Njelesani J. Becoming anti-racist occupational therapy practitioners: a scoping study. Occupation, Participation and Health. 2021;41(4):232-42.
41. Kidder RM. How Good People Make Tough Choices: Resolving the Dilemmas of Ethical Living. Fireside; 1995.
42. Drolet MJ, Maclure J. Les enjeux éthiques de la pratique de l'ergothérapie : perceptions d'ergothérapeutes. Approches inductives. 2016;3(2):166-96.
43. Matusek JA, Wright MO. Ethical dilemmas in treating clients with eating disorders: A review and application of an integrative ethical decision-making model. European Eating Disorders Review. 2010;18(6):434-52.
44. Abela S. Management of a dilemma involving sharing of confidential information and professional conduct. In: Abela S. Leadership and Management in Healthcare. A Guide for Medical and Dental Practitioners. Springer International Publishing; 2023. p. 181-86.
45. Callahan AJ, Lass NJ, Richards KL, et al. Ethical dilemmas in audiology. Contemporary Issues in Communication Science and Disorders. 2011;38:76-86.
46. Duncan RE, Hall AC, Knowles A. Ethical dilemmas of confidentiality with adolescent clients. Case studies from psychologists. Ethics & Behavior. 2015;25(3):197-221.
47. Flatley DR, Kenny BJ, Lincoln MA. Ethical dilemmas experienced by speech-language pathologists working in private practice. International Journal of Speech-Language Pathology. 2014;16(3):290-303.
48. Barsky A. A conflict resolution approach to teaching ethical decision making: bridging conflicting values. Journal of Jewish Communal Service. 2008;83(2-3):164-69.
49. Delany CM, Edwards I, Jensen GM, Skinner E. Closing the gap between ethics knowledge and practice through active engagement: an applied model of physical therapy ethics. Physical Therapy. 2010;90(7):1068-78.
50. Enck G. Six-step framework for ethical decision making. Journal of Health Services Research & Policy. 2014;19(1):62-64.
51. Ferrie S. A quick guide to ethical theory in healthcare: solving ethical dilemmas in nutrition support situations. Nutrition in Clinical Practice. 2006;21(2):113-17.
52. Ghazal L, Saleem Z, Amlani G. Resolving ethical dilemma: an application of a theoretical model. Khyber Medical University Journal. 2014;6(3):135-38.
53. Hunt MR, Ells C. A patient-centered care ethics analysis model for rehabilitation. American Journal of Physical Medicine & Rehabilitation. 2013;92(9):818-27.
54. Jankowski J, Seastrum T, Swidler RN, Shelton W. For lack of a better plan: a framework for ethical, legal, and clinical challenges in complex inpatient discharge planning. HEC Forum. 2009;21(4):311-26.
55. Park EJ. An integrated ethical decision-making model for nurses. Nursing Ethics. 2012;19(1):139-59.
56. Rushton CH. Defining and addressing moral distress: tools for critical care nursing leaders. AACN Advanced Critical Care. 2006;17(2):161-68.
57. Van Denend T, Finlayson M. Ethical decision making in clinical research: application of CELIBATE. American Journal of Occupational Therapy. 2007;61(1):92-95.
58. Handelsman JA. Professional ethics. In: Hudson MW, DeRuiter M. Professional Issues in Speech-Language Pathology and Audiology. Plural Publishing; 2019.
59. Drolet MJ, Pinard C, Gaudet R. Les enjeux éthiques de la pratique privée : des ergothérapeutes du Québec lancent un cri d'alarme. Ethica. 2017;21(2):173-209.
60. Hawkins DB, Hameil T, Kukula J. Ethical issues in hearing. Audiology Today. 2006;18(4):22-29.
61. Kinsella EA, Park AJS, Appiagyei J, Chang E, Chow D. Through the eyes of students: Ethical tensions in occupational therapy practice. Canadian Journal of Occupational Therapy. 2008;75(3):176-83.
62. Drolet MJ, Goulet M. Les barrières et facilitateurs à l'actualisation des valeurs professionnelles : perceptions d'ergothérapeutes du Québec. Revue ergOThérapie. 2018;71:31-50.
63. Jameton A. Nursing Practice: The Ethical Issues. Prentice-Hall; 1984.
64. Drolet MJ, Lalancette M, Caty MÈ. Brisées par leur travail ! OU Au bout du rouleau. Réflexion critique sur les modes managériaux en santé. Canadian Journal of Bioethics/Revue Canadienne de Bioéthique. 2020;3(1):103-7.
65. Centre de collaboration nationale des déterminants de la santé. Le plaidoyer et l'équité en santé… Parlons-en. Antigonish, NS. Centre de collaboration des déterminants de la santé, Université St. Francis Xavier; 2015.
66. Chaput S et le groupe de travail du RÉFIPS sur le plaidoyer en santé. Plaidoyer pour la santé. Un guide pratique. Réseau francophone international pour la promotion de la santé (région des Amériques). Collection Partage; 2021.
67. UHC2030. Advocacy tools.
68. WFOT. Advocacy tool kit; 2024.
69. Coffman J, Beer T. The advocacy strategy framework — A tool for articulating an advocacy theory of change. Center for Evaluation Innovation; Mar 2015.
70. Stachowiak S. Pathways for change: 10 theories to inform advocacy and policy change efforts. Center for Evaluation Innovation; Oct 2013.