



OCCUPATIONAL THERAPY

OCCUPATIONAL THERAPY INTERNS EXPERIENCES OF CULTURAL COMPETENCE DURING PATIENT CARE IN A TERTIARY CARE HOSPITAL: AN EXPLORATORY STUDY

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ABSTRACT

This article discusses about the importance of awareness of cultural competence among Occupational Therapy Interns; in order to ensure optimal quality of client centred practise.

This explorative qualitative study was carried out with an aim to explore occupational therapy intern's perceptions & experiences about cultural competence during patient care in a tertiary care hospital.

The study was conducted on 23 interns from 4 different occupational therapy colleges in Mumbai through Focus Group Discussions (FGD'S).

The data from the FGD's was transcribed by verbatim and analysed by thematic analysis technique.

The results of the study indicated how aspects like language, gender & religion act as both enablers & barriers to client centred practise.

Inclusion of texts relevant to Indian culture & practise, organising workshops & lectures for better understanding of cultural competence, were some of the suggestions made by participants.

KEYWORDS : Occupational Therapy, Cultural Competence, Focus Group Discussions, Interns.**INTRODUCTION**

Cultural competence in medical education is defined as a set of attitudes, knowledge & skills that are necessary for the health care providers to effectively interact with culturally diverse populations.

Cultural Competence is a 6 stages continuum that explains the unhealthy and healthy values and behaviours of persons, policies and practices of organizations. The first 3 stages showing cultural incompetence while the last 3 moving towards positive cultural competence. (Terry L. Cross and et al, 1989) [1]

The stages of Cultural Competence Continuum are as follows:

- Cultural Destructiveness → Attitudes, policies and practices those are destructive to other cultures; dehumanizing of other people, assumptions of superiority. Example – Undervaluing the role of traditional medicines (Ayurveda, Unani).
- Cultural Incapacity → Suppression of other cultures unintentionally, creating fear and assuming a paternalistic approach.
- Cultural Blindness → Cultural differences are ignored “Treat everyone the same” is the approach. This approach is detrimental as it gives justice only to culturally dominant groups and injustice to the minority culture.
- Cultural Pre-competence → Cultural issues are explored. Needs of Individuals and Organisations are assessed.
- Cultural Competence → Individual and cultural differences are recognised. Advice is sought from diverse groups. Unbiased staff is hired.
- Cultural Proficiency → It is the ability to build strong cross-cultural relationships through effective communication skills and developing skills to interact in diverse environment.

Occupational Therapy is a profession that relies on communication between the therapist and the client. The client's difficulties are a combination of various things that affect his/her life including their cultural background. Occupational therapists interact with their clients on long term basis; including the hospital stay along with their home care management, hence the need for cultural sensitivity is inevitable here.

It has been seen that lack of cultural competence in the therapist can have an effect on the therapeutic outcomes, intervention process, implementation of therapy, compliance and follow up. It is thus important that occupational therapist bridges the gaps of language and cultural differences to make the therapeutic effect more impactful.

Increased awareness and knowledge could lead to personal open mindedness and non-judgemental views. (Margaret Jamieson and et al, 2017) [2]. A study reveals that the students suggested that classroom instructions on cross cultural communication can change the level of student's cultural awareness and sensitivity. The students improved in their recognition and there is a growing demand for O.T services from ethnic minorities. (Sierra Grady and et al, 2018) [3].

Studies have emphasised that statutory bodies should act as positive factor for influencing the cultural competence in healthcare by developing common practices and system to be followed for cultural competence. (Raman Kumar and et al, 2019)[4]. Students expressed how aspects such as language and race, religion serve as barriers to client centred practice. The main theme emerged from the analysis was, “Culture is easily defined but not easily described”. (Inge Sonn and Niki Vermeulen, 2018)[5].

India houses a variety of cultures, lifestyles & ethnicities. Health inequalities related to culture & ethnicity is a rising concern. The root cause of this problem may be the fact that there is no specific training given to the health care providers when it comes to treating population belonging to minority or multifaceted culture. A lack of cultural competence in therapist leaves many patients feeling dissatisfied with health service, less confident in their therapist and is less likely to adhere to treatment plan. Hence it is crucial to inculcate cultural competence in health care professionals.

Hence, this study was performed to assess the cultural sensitivity among student population of Occupational Therapy; in order to understand its awareness & the approach of the students. Also, it will help to understand the preparedness of the students to reach out & treat diverse population as professionals.

METHODS

Aim: To explore Occupational Therapy Interns' experiences about their cultural competence during patient care in tertiary care hospital.

Procedure: This study followed a qualitative research methodological approach with an exploratory descriptive design. An explorative design was used to gather narratives of experiences within the topic and to gain a full understanding of the participant's views. After obtaining ethics approval from the Institutional Ethics committee (II) of Seth G.S. Medical College and K.E.M. Hospital on 31st January 2020, the study was begun. Purposive sampling for this study was taken from the Occupational Therapy School & Centres of four Medical Colleges in Mumbai. The selection of the participants (i.e. Interns) was done by the gate-keepers (i.e. the HOD of the respective Occupational Therapy School) as per the inclusion criteria.

From each college 4 to 6 interns were selected to form a Focus group discussion.

Four Focus Group Discussions (FGD) each comprised of 4-6 Interns from the respective colleges for the time duration of minimum 1 hour. Thus, a total of 20 to 24 interns were the approximate sample size.

INCLUSION CRITERIA:

- I. O.T. interns from four different Schools/Colleges of Occupational Therapy in Mumbai.
- II. Interns from diverse background that speak different languages and hail from variable cultural and zones of the state.
- III. Those willing to participate in the study with Informed Consent Document (ICD).
- IV. Those permitted by the Gatekeepers to participate in the study.

Focus Group Discussions (FGD) was conducted in a distraction free room allotted by the Colleges. The Principal Investigator with time keeper conducted Focus Group Discussions. The participant views were recorded as per a unique code consisting of participant's college name and number (GS1, GS2, GS3....) to maintain confidentiality and not to disclose identity. The table 1 shows data of all the participants. The investigating team were instructed to maintain confidentiality of the views expressed by the participants.

Table 1: Table representing participant's data

Participants	Area	Mother tongue	Religion
DY Patil 1	Solapur	Marathi	Hindu
DY Patil 2	Mumbai	Marathi	Hindu
DY Patil 3	Dubai/Mumbai	Hindi	Muslim
DY Patil 4	Mumbai	Gujrati	Muslim
DY Patil 5	Kerala	Malayalam	Christian
DY Patil 6	Mumbai	Hindi	Muslim
DY Patil 7	Mumbai	Gujrati	Hindu- Jain
TNMC 1	Mumbai	Hindi	Muslim
TNMC 2	Mumbai	Hindi	Muslim
LTMC 1	Mumbai	Hindi	Muslim
LTMC 2	Mumbai	Gujrati	Hindu- Jain
LTMC 3	Nanded	Marathi	Hindu
LTMC 4	Kerala	Malayalam	Christian
LTMC 5	Mumbai	Marathi	Hindu
GSMC 1	Mumbai	Hindi	Muslim
GSMC 2	Mumbai	Marwadi	Hindu – Jain
GSMC 3	Mumbai	Kutchi	Hindu – Jain
GSMC 4	Africa/Jaipur	Hausa	Muslim
GSMC 5	Nagpur	Marathi	Hindu
GSMC 6	Mumbai	Gujrati	Hindu
GSMC 7	Mumbai	Marathi	Hindu
GSMC 8	Mumbai	Konkani	Christian
GSMC 9	Mumbai	Punjabi	Sikh

Data were collected through a focus group with each of the cohorts of Interns which was facilitated by the researchers. Semi-structured questions were formulated with the aim to ease responses, build the participants confidence and establish rapport. Questions focused on the participants' understanding of culture and how they identified their own cultures personally, and extended to their perceptions of the role of culture in a professional context. The researchers also explored the participants' understanding of professional identity and their perceptions of whether culture could impact on its development. The discussion was further progressed with the questions and probing the

questions as per the data received from the participants. Four of the investigators were from the same populations hence bias was reduced by bracketing through reflexive writing prior to data collection.

As part of the data analysis stage, all focus groups were audio-taped and transcribed verbatim. All investigators were involved in the data transcription process. The process of thematic analysis was used to analyse the data and examine similarities between concepts and ideas by means of coding. The coded data were then grouped into categories which allowed the researchers to form themes within the research. Trustworthiness was ensured through applying the constructs of credibility, transferability dependability and conformability through the use of data triangulation, the specific sampling strategy of purposeful sampling, the use of audit trail and researcher reflexivity.

RESULTS:

The results are discussed by highlighting the data received from the focus group discussions with Interns of Occupational Therapy. The table 2 represents the three main themes and the subthemes and codes derived from the discussion.

Table 2: Themes & codes

Themes	Codes
1) Perception of Cultural Competence	<ul style="list-style-type: none"> Understanding. Culture
2) Hinderances to being culturally competent	
I. Communication Barrier	<ul style="list-style-type: none"> Difficulty in communicating, mixing of languages, inability to understand client's spoken language.
II. Gender Barrier	<ul style="list-style-type: none"> Unwillingness.
III. Sexual beliefs & Sexuality	<ul style="list-style-type: none"> Opposite gender.
IV. Cultural Beliefs.	<ul style="list-style-type: none"> Confused, role of OT's in sexual problems, inadequate knowledge, ignorance.
V. Lifestyle Barriers.	<ul style="list-style-type: none"> Client's faith, Cultural norms, Holy objects, Adamant.
	<ul style="list-style-type: none"> Poor income, Crowded spaces, Open mindedness, differences in rural & urban lifestyles.
3) Preparedness for cultural competence.	<ul style="list-style-type: none"> Practical Knowledge Texts relevant to Indian scenarios.

Theme 1: Perception of Cultural competence

This theme discussed the Intern's personal understanding of culture and aspects of culture that promote or hinder their therapy program.

The majority of the participants defined cultural competence as meeting the needs of the patient or understanding the Activities of Daily Living (ADL) and house set up of the patient.

“Understand patient's perspective as well as you should compare your own perspective.”

While only a few participants could define the term but weren't able to describe the term cultural competence.

“Understanding the culture of the patient.”

Theme 2: Hinderances to being culturally competent

This theme expresses the various limitations that the interns felt they faced due to varied cultural backgrounds and lifestyles of the client due to their inadequate knowledge to cope with the same. Five subthemes emerged: (i) Communication barrier, (ii) Gender barrier, (iii) Sexual beliefs and sexuality, (iv) Cultural beliefs, and (v) Lifestyle barriers. These responses reflected what the occupational therapy interns considered to be the obstacles while trying to be more approachable for the patients.

Communication barrier

A majority of the participants expressed this to be the barrier affecting their therapy process and evaluations. On one hand, the participants expressed the hurdles they faced because of the inability to understand

or speak the language spoken by the client. On other hand, they also faced difficulty in communicating with clients speaking the same language due to varied accents.

"Just because I don't know Marathi, I cannot communicate with them well, and because my friend could talk in Marathi the patient gave him the correct answers."

There were also a few participants that expressed the difficulty they faced to communicate with the client because of mixing up two languages while giving instructions.

Gender Barriers

The participants emphasized the client's unwillingness to receive therapy from opposite gender professional. While a few participants expressed that they usually experienced these problems more in home care settings than in government hospitals/community settings. Some of the intern's views revealed that it was observed in some communities.

"And usually considering Muslim community, when it comes to their hospitals, they only consider one thing; Female therapist will see my wife, male therapist is not allowed to see my wife."

Sexual Beliefs and Sexuality

The analysis revealed that the role of Occupational Therapy in sexuality and sexual problems weren't quite known to the clients; while it was also expressed that the interns also had difficulty managing the problems of the queer population because of lack of knowledge and ignorance. It was also seen that from the intern's side, that they faced difficulty to ask certain questions due to cultural beliefs and the norms of the culture.

"We are not educated in that topic means 'how this system goes', 'what challenges are faced by transgenders?', 'What are faced by homosexuals?' So even we don't know exactly what issues..... If we know what the problems are, we can ask more openly.... Even they face problems, because they aren't open and the therapist is not open too."

The interns conveyed that they had problems because the patients were confused about the role of Occupational Therapy in sexual problems as they felt their personal space was being invaded.

"That is their personal space about like you can say sexual history or anything like that. That usually they don't like talking about."

It was also observed by the interns that the clients were uncomfortable while talking about the sexual problems but were quite open with the therapist of same gender.

"There was a hesitancy which was from the therapist's side as well as the patient's side."

Cultural Beliefs

The study revealed how the beliefs of the clients and their families or the community they live in affect the therapy protocol and are prone to be a limitation on the treatment.

The interns indicated that the norms, roles and faith of client's culture had a drastic impact on the approach of the therapist.

"She was basically a backache patient and we advised her not to sit on the floor. But she was reluctant, I cannot sleep on bed, I have to sleep on ground and also I can't pray. So, I have to pray, so I have to bend down directly; even I am from Muslim background but then I advised her, you can use a stool and not do that. But she was adamant."

Also, another participant quoted, "Patient underwent THR and we advised not to sit down and sit on chair or bed, she was like It's not culturally accepted because her in laws and all the family members will not be okay with her sitting up and others sitting down."

The interns also conveyed that they had difficulty in using certain tools for therapy as the client refrained touching certain object by feet as they were regarded as sacred.

"I wanted to give paper crumbling by feet but the patient denied, because unke religion paper ko Vidya (knowledge) maante hai"

Life-style Barriers

This subtheme expresses the effect of the financial condition and the geographical location of the client playing a role in the therapy process and rehabilitation of the clients.

The participants mentioned that for the patients coming from a low socio-economic stratum not only was it difficult to prescribe any adaptive devices due to low finances but also had difficulty in prescribing mobility aids due to the constricted spaces they lived in.

The main reason why most of the therapist are not usually prescribing the adaptive devices to poor socio-economical patients; because they know the patient cannot usually afford that much; so they just give something in replacement of that.

"Ma'am wheelchair ke liye toh unka space itna kam hota hai like one room kitchen vagera ki woh log bolte hai ki wheelchair use karna is impossible. Woh outdoor mobility ke liye thoda comfortable rehta hai but indoor ke liye wheelchair nahi use karte toh who ek problem hai"

Another aspect of life style barriers that was revealed was difference between the population coming from rural and urban areas. It was expressed that one hand open mindedness was seen more in the patients coming from urban areas while on another hand negligence in child rearing was also more in population in urban areas as compared to those in rural areas.

"A mother, who comes from two different cultures, may portray their roles as completely different. Both play the same role but their cultural background definitely makes a different."

"Matlab abhi she's the official breadwinner of her family so humare yaha aisa nhi hota hai ...mai wohi soch rahi thi ki yaha pe hai acceptance.. aur uska unke married life pe koi impact nhi hota so male ego hamesha waha pe zyada hota hai but they are okay with it"

Theme 3: Preparedness for Cultural Competence

This theme highlights the concepts the interns felt should be a part of the theoretical and practical knowledge imbibed by them.

The participants expressed that there should be more texts available that would be relevant to Indian culture.

For example, as quoted by a participant, "Jo bhi books hamare paas hai vo foreign ka hai, usme ADL jo bhi functioning hai vo foreign ka hai. Abhi hum yahan India mein practice karte hai toh vo hum yahan ke patients ko nai suggest kar paate. Toh aesa koie book ho ya manual ho jisme India ke population ko use ho sake."

The participants also conveyed that having more of rural postings would make a difference in their understanding of the culture and would help them be more culturally competent.

DISCUSSION:

The aim of the study was to explore & understand Occupational therapy Intern's experiences & perception of culture during their fieldwork practice.

The importance of this study lies in the fact that it might provide suggestions that could help the Interns to be a culturally competent Occupational Therapist.

The findings of the study highlights on the Interns' perception of culture & the challenges that were experienced by them in cross cultural settings that acted as a barrier to attain qualities of optimal client centred practice.

As such three main findings were derived which emphasize on Intern's understanding of cultural competence, barriers faced in their practice & pre requisites for cultural competence; which will be discussed further.

As reported in the results, our first finding indicates that; the proficiency to describe cultural competence, among the OT interns was not adequate.

This can be attributed to the fact that there is limited understanding of the topic, due to lack of awareness about it in the settings that they have been practicing.

And also disregard to cultural aspects when planning therapy, because of high workload & limited time, in the tertiary care set up.

Similar findings have been reported by a study conducted by Inge Sonn & Nikki Vermeulen (2018)[5], where the main theme derived from the analysis was, culture is easily defined but not easily described.

This is echoed in the study conducted by Margaret Jameison & et al (2017) [2]; that increased awareness & knowledge could lead to personal open mindedness & non-judgemental views.

The second finding mainly emphasizes on various factors that act as a hurdle to being culturally competent. Multiple reasons can be noted that render as an obstacle to being culturally competent such as communication barriers, gender biases, cultural faiths, mindset towards sexual problems & sexuality & lifestyle disparity.

The participants reported that they faced difficulty in communicating with the client due language barrier; i.e. they weren't able to effectively converse with the client because of differences between spoken language of the client & the therapist.

Considering that, the study was conducted in the region of Mumbai; which is a metropolitan city housing numerous tertiary care hospitals; hence people from interiors of Maharashtra seek specialty care here & as recruitment of students through national level exams from various regions of country occurs; there disparity in regional language of the students & the clients, further adding to the problem.

The participants also reported that they weren't able to understand the client's language due varied accents of the same language which caused difficulty.

They also said that, during initial years they faced difficulty in communicating with ease; but developed certain tactics, like using gestures, demonstrations & learning some prominent words of the client's spoken language etc over the period of the course to tackle such problems.

The gender biases also caused hurdles in effective administration of therapy; the results reported that the gender of the therapist played a vital role here.

Due to multicultural facets of the Indian society & certain religious norms (such as the parda or ghongat customs) the females are generally not more open towards male therapists, as observed in certain communities.

This can also be attributed to client's own comfort level; the clients are more comfortable with therapist of same gender as they can identify with them, giving them utmost cooperation thus facilitating the examination process ultimately leading effective therapy & vice versa. The study also revealed that some rigid cultural convictions of the client can affect the assessment process thus hampering the therapy outcome.

The clients own cultural beliefs such as refraining from touching certain objects by feet or adapting alternate sitting postures for praying as opposed to the existing harmful posture affects the quality of therapy.

Thus, the client's unwillingness to adapt due to their strict cultural faiths or norms further decreases the quality of care.

The results were suggestive that the participants felt that sexual problems & sexuality were the least discussed topics.

The interns felt that they weren't ready or equipped to address these issues; hence leading to dissatisfaction as their roles of a therapist towards sexual problems.

The reasons for these issues can be due to the client's discomfort or shyness to talk about these problems, also hesitancy on the therapist's as well as on the client's side to speak up on the topic.

The tertiary care centres wherein the Interns were working; had ample of out-patients & confined spaces harbouring heavy crowds & therefore; one client was surrounded by many people around adding to more hesitation.

The participants reported that diverse lifestyles of the client also affected the goals & outcomes of the therapy.

Lifestyle of the Indian population is greatly influenced by the culture they follow & changes are made in the way of living in accordance to their cultural beliefs & norms.

There is disparity in lifestyles of the rural & urban population of the country, leading to differences in approach towards health & treatment.

Certain therapy methods are not accepted or used as they cannot be adapted in a particular rural setting for example technologically advanced tools and equipment are too difficult to be used in rural settings due to confined spaces, limited technological & handling knowledge & rigid ways of life.

Therefore, culturally appropriate & suitable lifestyle modifications must be suggested or adapted.

As Current trend in medical health care is towards prevention rather than treatment; therefore, if culture is not incorporated during therapy intervention it will further hamper the prevention strategies causing set back to the recent advances of health care practice.

Similar findings were reported in a study conducted; occupational therapy student's experiences & perceptions of culture during fieldwork by Inge Sonn & Nikki Vermeulen (2018)[5], which reported that the students expressed how aspects of language & race, religion serve as barriers to client centred practice.

The study results also showed that the interns were ready or felt the need to be prepared to become culturally competent.

Most of the participants expressed that there is a need to be culturally competent, catering to the fact that they have to deal with a culturally diverse community.

The results were suggestive that the participants felt there should be an initiative to change the formal & informal curriculum which in turn would help them to become more culturally competent & also help them gain confidence in dealing with culturally diverse population.

This was echoed in a study conducted by Sierra Grady & et al (2018)[3] ;which reported that classroom instructions on cross cultural communication can change the level of student's cultural awareness & sensitivity; the students improved in their recognition & there is an increase in demand for O.T. services from ethnic minorities.

The Interns revealed that due to limited exposure to interiors of the country they have small database regarding the community life in various parts of their country; & hence required more exposure.

Similar findings were reported by Darawsheh & et al (2015) [6], which suggested that exposure may be used as a strategy for promoting cultural competency as long as it leads to awareness about cultural differences as well as preparedness to encounter them.

CONCLUSION

This study was aimed at exploring the Interns' perceptions of barriers and enablers that Culture presents during fieldwork practice.

The findings of this study thus reveal the level of awareness regarding cultural competence among the OT interns, the obstacles faced in being culturally competent & the level of preparedness to be culturally competent. Need was expressed to enhance Occupational Therapy education programs to focus on developing the skills and strategies required to be culturally prepared to engage in culturally diverse settings.

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