

Research paper

Culture and physiotherapy

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What is known on this subject

- Culture is a significant consideration in effective healthcare provision.
- Physiotherapists face professional and personal dilemmas when working in a cross-cultural setting.
- Cross-cultural working is often ineffective.

What this paper adds

- Physiotherapy should be considered as a cultural practice, but one which is not yet clearly defined.
- Cultural competence, in practice, is complex as a result of the presence of multiple truths.
- To be clinically effective, these sometimes competing truths have to be known, accepted and integrated.
- Cross-cultural working must realistically consider the organisational and political environment in which we work.

ABSTRACT

Physiotherapists, whether through international work or within the multicultural societies where many clinicians live and work, are exposed to cultures that differ from their own. Clinical interactions in a cross-cultural situation highlight the complexities of culture in practice. Three specific areas are highlighted and explored: the culture of physiotherapy practice; cultural competence within the profession; and the culture of the employing organisation. Cultural competence is further developed and analysed at three levels: awareness of different cultures; acceptance of multiple truths and knowledge; and collaboration to avoid the potentially destructive power of the dominant culture. Current literature allows a

theoretical framing of the issues, which indicates that physiotherapy should be considered as a cultural practice. The investment of western concepts such as *autonomy* and *individualism*, as well as the objectification inherent within the medical model, lead to significant dilemmas in the cross-cultural context. However, a significant lack of detailed ethnography of practice is also a weakness in the debate. Resultant areas for future research are highlighted.

Keywords: cultural competence, international development, physiotherapy

Introduction

One episode taken from field notes, and later field placement reflection, highlights a number of significant issues and dilemmas that face physiotherapists and other therapists in clinical work (see Box 1). Whether it is through work overseas, as with the example given, or in the multicultural society in which we now live,

clinicians are exposed to cultures that differ from their own. The importance of this is known: there are ongoing concerns that culture is related to differential access to healthcare in the UK (Ahmad, 1993), there is increasing awareness of the lack of effectiveness of health programmes run by international agencies

(Pigg, 1995; Ingstad, 1999; Kendall *et al*, 2000), and anthropologists and sociologists have clearly illustrated that culture is an essential component of healing (Kleinman *et al*, 1978; Kleinman, 1980; Young, 1982; Helman, 1985; Lock, 1993; Masin, 1999; Noorderhaven, 1999; Noronon *et al*, 1999). However, although the cultural basis of our own universal biomedicine has been demonstrated (Foucault, 1973; Good, 1994; Martin, 1994), therapies have been slow to examine the social and cultural aspects that directly affect their approach to treatment or to explore issues of social cultural relevance to their clients (Hunt *et al*, 1988; Anderton *et al*, 1989; Groce, 1999; Leavitt, 1999b; Hammell, 2006).

Anthropologists studying clinical interactions consider the encounter to involve a number of cultures or Kleinman's (1980) related *explanatory models*. The case cited in Box 1 presents a multitude of cultures: that of the therapist, the client and the two systems of understanding healing and recovery, as well as the culture of

the organisation in which the therapist is based, for example governmental or non-governmental. While it is imperative that all sides are considered, the client is not the focus in this paper. Our main aim in this paper is to explore the complexity of cross-cultural therapeutic activity, through a review of the practice and organisational culture of physiotherapy. Literature on this topic is sparse, and consequently we have drawn on sources of an extended period of time from 1977 onwards.

Physiotherapy: art, science, physical therapy, or one of the caring professions?

Despite being the fourth largest healthcare profession in the UK, physiotherapy has generally escaped the analytical gaze of social scientists. Therapists themselves

Box 1 Extract from field notes April 2005

Through our community village workers, we met a young woman today who had evidently fractured her leg in the tsunami, now four months ago. She was being nursed on a mattress on the floor of her family home. Every third or fourth day her brothers would lift her on the mattress to the back of a truck and transport her to the home of the local bone healer. I was excited about the opportunity to meet him and discuss collaborative work that we could potentially do in the community in my capacity as physiotherapist with an international disability aid organisation. There, in front of an audience, he massaged and manipulated her leg, while she clenched her fists and bit onto her sheet. Her obvious pain made me feel sick. Her leg was covered in herbal paste and fixed with cotton, wooden supports and sheet bandages. He predicted the fractures would heal in three more months. At that point his expectations of collaboration were for us to provide walking aids or teach some exercises. He said he knew what physiotherapy was and was happy to work with us.

Reflection

The opportunity to assess and develop community therapy resources in Indonesia provided a chance to observe and work with the local healer, trusted by the local community, and presented an ideal learning experience. Working with him provided exposure to his role in healing and some insight into why this individual and family were adamant that they were not going to be treated by anyone else, despite a free hospital and outreach service. From an anthropologist's perspective, the choices were comprehensible and justifiable. He was part of the community life, had worked for a number of years in that village and had clearly had success. The patient had been deeply traumatised by her experience of the tsunami and he offered healing and care that went above and beyond the physical mending of the bone. Financially the family was not well off, and although services in the hospital were free at that time, the costs of transportation, food and carers were not insignificant. The political situation in the region had been unstable for many years, and consequently distrust of government institutions was an important consideration in health-seeking decisions. The young woman was unmarried, making a local consultation with a male known to the family more appropriate.

From a physiotherapist's perspective I (MN) was silently screaming. While there were no X-rays to judge the extent of the damage, it was hard to comprehend a healing period of several months for a fracture that would routinely heal in a couple with standard alignment and immobilisation. The effect of total immobilisation for the duration of the proposed healing period on her entire body, as well as on her social functioning, was galling to my conception of rehabilitation and prevention of disability. Her evident pain, re-enacted every few days, was heart wrenching. By the aims of the programme I was there to develop, this case was a failure. But what does failure, success or rehabilitation mean in this context? While these fundamental questions may be relevant to all clinical work, in cross-cultural situations different perspectives should force us to seriously consider our own understanding of such concepts if effective collaboration is to be achieved.

have undertaken a limited number of reviews to try to elicit underlying models of practice, paradigms and the culture of physiotherapy (see for example, Pratt, 1989; Tyni-Lenné, 1989; Roberts, 1994; Stachura, 1994).

Physiotherapy is theoretically closely aligned with the biomedical framework. The study of the physical body, pathologies and physical treatment procedures has dominated, and continues to dominate, undergraduate professional training. It is argued that this alignment with biomedicine is based on politics, funding, professionalisation and respectability (Roberts, 1994; Stachura, 1994), a heritage that suggests that physiotherapists have an *explanatory model* similar to that of the medical profession (Pratt, 1989; Klaber-Moffett, 1994; Roberts, 1994). The consequences are the objectification of the individual and the disowning of experience, rendering the person unimportant and invisible (Eisenberg, 1977; Harris, 1980; Hauser, 1981; Gaines and Hahn, 1985; Fuller and Toon, 1988; Leder, 1992; Good and DeVechio Good, 1993; Kleinman, 1993; Osborne, 1994; Sinclair, 1997; Young, 1997). Physiotherapists have similarly been accused of working within the remit of the mind/body split indicative of Cartesian duality (Pratt 1989; Sim 1990; Dekker *et al*, 1995; Klaber-Moffett and Richardson 1997; Jorgensen 2000).

Roberts (1994) argued that the profession is not comfortable with the relationship between physiotherapy and a dominant medical model, demonstrated in the 'growing claims that physiotherapy practice is based on something other than the medical model' (Roberts, 1994:365). She proposes that the approaches are inherently incompatible. Other authors have claimed that physiotherapy is based broadly on science and humanism, and that therapeutic relationships and communication are as important as the techniques in achieving healing (Noronon and Wikstom-Grotell, 1999). It is argued that such an approach to the *person as lived* is a corollary to the profession's commitment to client-led goals and the implicit need for the client to take personal responsibility and be motivated in the rehabilitation process (Becker and Kaufman, 1995; Mattingly, 1998b; Payton *et al*, 1998; Broberg *et al*, 2003). As evidence of this, extensive study of occupational therapists in practice indicated that *therapeutic employment*, the process by which therapists and their clients create story-like structures within rehabilitation, resulted in the therapist moving beyond the purely physical to engage with the person and their disrupted narrative, a point the author acknowledges is common to other therapies (Mattingly 1994, 1998a). More specific studies based on physiotherapy clinical practice are less emphatic. Becker and Kaufman (1995) and Wiles *et al* (2004), for example, both found that physiotherapists were involved with the personal and emotional consequences of serious illness for their clients. When put in the context of goals for recovery,

however, the aims differed with therapists setting measurable markers in relation to movement quality and daily activity functioning, and the clients being more interested in meaningful activities of significance to their previous lives. Parry (2004) found that client-led goals, although stated as important, were an ideal rarely pursued in practice. She suggests that rather than being evidence of a power imbalance where the therapists impose their model of care, this is actually as a result of social interactions in which clinicians *and* the patients are active agents, and indeed quotes research that indicates that some patients do not want to be involved in the decision making.

Through her study of clinical interactions, Thornquist (2006) found that therapists had differing understanding of the body and, as a result, a variable capacity to engage with the patients' experiences of their problems. More radical critiques of rehabilitation in general suggest that written and verbal commitments to client-centred care are based more on political correctness than actual practice, and that therapies in general remain bounded by the cultural investments of scientific knowledge, individualism, normalisation and the maintenance of their own power (Hammell, 2006). Indeed, Hammell (2006) argues that these ideologies are by their nature so pervasive that therapists may not even know they hold them.

From the literature it is clear that physiotherapy researchers, theorists and critical reviewers remain unclear about the dominant paradigm, humanistic or biomedical, in clinical practice. This lack of consensus is problematic when reviewing their interactions with clients who hold other cultural viewpoints. Whether physiotherapy invests in science or humanism, both are firmly embedded in western culture. Explanatory models are influenced by education and socioeconomic background, a fact that may strengthen the assertion that physiotherapy is based on white, middle-class ideologies. Historically, and to the present day, physiotherapy in the UK has been dominated by white, middle-class women. Seventy-six percent of physiotherapists graduating in 2007 were women; over 90% were Caucasian (Chartered Society of Physiotherapy, 2008). This homogeneity has been noted as being significantly unrepresentative of the multicultural society in which it is based (Harvey and Newman, 1993), and its influence on the cultural practice of physiotherapy has been largely unexplored.

Consequently, concepts such as *individualism, personhood, autonomy, responsibility for action* and *human rights* are understood to be universals which are rarely acknowledged or questioned. As Becker and Kaufman (1995:182) summarise, 'health practitioners evaluate their own roles and judge behavior according to fundamental American values that stress personal autonomy, control over the environment, productivity and perseverance'. As a result, while the arguments

between science and humanism, medicalisation and social models continue to bubble, all parties are in effect singing from the same cultural hymn sheet (Beresford, 1996; Hughes and Paterson, 1997; Miles, 2002; Saadah, 2002). For the 80% of the world's population, which includes the vast majority of the world's disabled people, who do not hold western viewpoints, this is a hymn that may not be recognised; or when it is, the harmonisation is of an altogether different nature. For the interdisciplinary clinician and anthropologist, it is this level of culturally influenced viewpoints and expectations within the therapeutic interaction that is most intriguing. It is the least problematised, and yet vitally critical to the therapeutic process. Equally, from a heritage of a colonising nation, the cross-cultural context is evident in implicit judgements about social functioning over time and response to pain which run counter to western-held notions of care (see Box 1).

The culture of healing and levels of cultural competence

However universal we like to think our therapeutic concepts are, each culture has a different understanding of the body, health, illness and healing (Kleinman *et al*, 1978; Kleinman, 1980; Young, 1982; Helman, 1985; Lock, 1993; Groce, 1999; Leavitt 1999a; Masin 1999; Mattingly and Lawlor, 2000). This difference has been repeated and rephrased in almost every article on cultural influences within studies based on health, ill health and disability. Often it is stated and then all serious considerations of what it actually means are left unexplored (see Kay *et al*, 1999 and Pensri *et al*, 2005). Indeed, in a review of papers written on community-based rehabilitation (CBR) in developing countries, an area of practice one would assume would necessitate cultural understanding, Finkenflugel *et al* (2005) found that of 128 articles only 19 explicitly discussed knowledge, attitudes and traditional beliefs. Nearly half of these came from one author (Miles, 1995, 1996, 1999, 2000, 2002) and are theoretical. *Cultural competence* in healthcare was introduced in an attempt to resolve this disparity of realities.

Cultural competence is a relatively new concept in healthcare, but has been widely written about, an indication perhaps of the challenges faced in the clinical setting and the political desire to resolve some of the inequalities in healthcare access (see for example Acheson, 1998). Many models have been developed, both theoretically and in the field of training and practice (for example, see Papadopoulos *et al*, 1998; Purnell and Paulanka, 1998; Purnell, 2002; Suh, 2004; O'Shaughnessy and Tilki, 2007), most specifically in

the field of nursing. Each model varies in its definitions and underlying assumptions, although there are common features in many, including cultural awareness, knowledge, understanding, sensitivity and skill. However, it is not the aim of this paper to review these models (see Shen, 2004; Bhui *et al*, 2007 for targeted reviews), but to explore further some of the dilemmas faced by physiotherapists when trying to achieve *cultural competence*.

Leavitt (1999:3) states that cultural competence 'acknowledges and incorporates – at all levels – the importance of culture'. It is the idea of levels of competence that we focus on to expand and explore the evidence of therapists' engagement. Iwama (2003) and Awaad (2003), both occupational therapists, have been clear about the importance of such an engagement, the latter stating that without it:

we may be counterproductive or dangerous for those who do not share our realities ... unwitting agents of oppression, colonizing cultures with ideologies that have dubious meaning and run counter to a given culture's core values.

It is important to note that while occupational therapists have actively engaged with a debate on this topic, the amount of literature pertaining to physiotherapy has been much more limited.

However, awareness alone is insufficient. Awareness of the client's cultural position does little to either mediate thoughts of efficacy or suggest a practical solution that would meet all requirements (see Box 1). To understand and accept that others have a different understanding is one level of cultural competence, and the one that is most easily covered by training and exposure to different cultures. Mattingly and Lawlor (2000) for instance suggest that the narrative approach embedded within rehabilitation itself facilitates this understanding. To respect or wholly accept that a client's understanding is as valid as the therapist's is another. Clinicians who are trained with the dissected physical body and the 'rigors' of scientific 'evidence' and/or are committed to a sense of autonomy and individual rights would find this acceptance deeply challenging. Evidence of such is not only in wanting the young woman with the fractured leg to have the treatment 'known' to be efficacious, but also in the near-universal calls for training of local people in 'appropriate' western treatment techniques (see, for example, Kay *et al*, 1999; Thorburn, 1999; Bourke-Taylor and Hudson, 2005; Armstrong and Ager, 2006; Box 1). Pigg (1995), in her critique of local training in Nepal, eloquently describes this 'universalistic model cloaked in a different coat'.

There is a significant issue here of what we in the west hold up as 'knowledge', while everything else that does not fit into that paradigm is constituted as 'beliefs' and, therefore, implicitly has less value. This issue has

been discussed more fully by Good (1994), including the changes in meaning of belief over time. He highlighted the dangers of both an empirical and a relativistic point of view, neither of which is appropriate for effective cross-cultural clinical care. From a therapy perspective, Hammell (2006) uses the work of Foucault to illustrate similar issues of 'truth' and 'beliefs' and how therapists 'lay claim to factual knowledge'.

Consideration of this issue poses the biggest challenge of all – the ability to work effectively within two or more frames of reference without doing violence to either of them. This is the challenge that is placed before clinicians practically every day, and one, given the evidence to date, we do not effectively engage with. In their exploration of cross-cultural physiotherapy practice in the UK, Jaggi and Bithell (1995) found significant problems with communication that went beyond language and poor compliance in treatment regimes. They also commented that the therapist's knowledge of the cultural group they were treating did not necessarily equate to ease of treating. This suggests that the issue is not with awareness of difference *per se*, but lies in an ability to switch epistemologies, which is extremely challenging if we neither adequately understand our own nor accept that ours may not be the only 'truth'. They further added that the personal impact on the therapists was one of frustration. The emotions and the consequences of such to both the clients and the therapists are critical issues. *Burn-out* and *caring fatigue* are phrases bandied around in conversation, but there has been little interest to date in the psychological impact of therapy on physiotherapists.

In the overseas context, criticisms have been levelled at therapists for exporting western ideals (Miles, 1996) and for using ethnic differences as an explanation for treatment difficulties (Bourke-Taylor and Hudson, 2005). A number of papers that describe interventions overseas illustrate the investment in western approaches with little discussion as to their appropriateness and interaction with local understanding of the body and healing (see for example, Kay *et al*, 1999 and Pensri *et al*, 2005).

Any cross-cultural considerations therapists may have for practice are further complicated by the culture of the institution in which they are based. The result of the requirement to 'serve two masters' (Hammell, 2006) not only affects the therapists' ability to engage with the client at an experiential level, a point that has been used in the arguments surrounding their inability to invest more in a social model (Parry 2004 and Mattingly 1998b), but also has an effect at a cultural level. This is explicit in both local and international practice and, as indicated in the case study, has a deeply significant impact on the concepts of 'success'.

An organisational culture of healing

Therapeutic success is generally seen as a 'return to independent, meaningful and satisfying life' (Payton *et al*, 1998:211). Yet for many of the organisations within which therapists work, short waiting times, efficient discharge dates and reduced bed days are the keys to the greatest measure of success and financial balance. These agendas often do not match, and while it has been stated that they can have deleterious effects on each other (Parry, 2004), the impact on the client, organisation or therapist is rarely discussed. Equally, while the controlling nature of institutions has been investigated, the structure of institutions to reflect powerful ideologies, and also to protect individual clients from the potentially more damaging intentional or unintentional agendas of individual therapists, has remained under-explored. As with the practice of physiotherapy itself, how the therapists interact with the environment in which they are employed lacks critical review. There is a further aspect that needs discussion – the competing cultural assumptions embedded within organisations and the cultural background of the physiotherapist. This point is most effectively made in the context of physiotherapy in overseas development activities.

Therapists engaging in overseas development work are often involved with rehabilitation programmes that are in theory designed to meet the needs of people living in the community, rather than in institutions. Such a commitment to 'community-based practices' can be argued as serving 'western' ideals of service delivery, and can lead to assumptions of where best rehabilitation can occur, which is often socially an incorrect assumption and against the wishes of the local people themselves. This has often put the concept of community-based services in direct opposition with the concepts of human rights, themselves a western construct, as applied to disabled people (Thorburn, 1999).

Following the initial claims of the appropriateness of CBR, and an increasing plethora of articles about particular programmes and their 'success', a number of studies have been published to indicate that all is not well. Many factors are seen to constitute barriers to effective implementation: funding opportunities or time between financial request and release (Crishna, 1999; Simister and Younis, 1999; Turmusani *et al*, 2002); internationally set mandates and criteria for success (Simister and Younis, 1999; Miles, 2002; Pfeiffer, 2003); use of expatriate staff with a high turnover in their placements (Pfeiffer, 2003); fundamental concepts of empowerment and community

participation (Kendall *et al*, 2000, Turmusani *et al*, 2002); and insufficient knowledge and utilisation of local systems (Crishna, 1999; Ingstad, 1999; Simister and Younis, 1999; McConachie *et al*, 2001; Miles, 2002; Judd, 2003; Pfeiffer, 2003). Whether it is through the direct control and power that is maintained through being the budget provider, or indirectly by the lack of awareness/utilisation/respect for local practices, or even through the largely western concepts of empowerment, individual agency and 'disability rights', *cultural competence* remains at the heart of effective and efficient international work. The very fact that so many authors indicate that 'implementation' is key to CBR objectives indicates the asymmetrical nature of intended action. Miles (1996:495) states that 'many Westerners believe there is much to offer, rather less think there is anything to learn'. The western appropriation and control of overseas rehabilitation is particularly well articulated by Hartley (2001). CBR was 'an informal, flexible strategy with its origins in local community practice and based on local knowledge, is converted into a formal, well structured programme which is then marketed internationally to overcome a "lack of services" in the very same communities from which it came' (Hartley, 2001:27). The irony of this situation is most clearly illustrated by Ingstad's (1999) review of a programme in Botswana, in which the western 'knowledge' that had been presented by the World Health Organization's (WHO's) CBR programme ran at odds with the Tswana way of understanding and was, therefore, ineffective in making a significant difference to disabled people's possibilities. Yet still in a critique of CBR in which they quote Ingstad's work, Turmusani *et al* (2002) discuss how the issue was partly related to insufficient time for the people of Botswana to incorporate western ideas within their system of understanding. The inference was that they had not had time to shift their frame of reference rather than that there was a need for any reciprocal change from the implementers' point of view.

What 'we' decide is efficacious intervention is not only questionable in long-term development programmes. While there is almost no published documentation on therapy in emergency situations, one article by Roy *et al* (2005) gives pause for thought. Following the Gujarat earthquake in 2001, a number of national and international agencies entered the area to provide assistance. Surgeons working with acute injuries were one group. Hundreds of operations were undertaken to assist in physical recovery from fractures and other serious injuries. Of those followed up two years later, a staggering 56% of those that had had implants had been re-operated on. The conclusion from the authors was that the techniques utilised had been unsuitable for the rural situation because of a significant deficit of agencies willing to carry out the long-term rehabilitation. 'Success' had been seen

solely as the number of people assessed and treated, rather than a more meaningful commitment to the fuller and socially impacted rehabilitation that is required after serious injury. Given these statistics, perhaps the young woman in the case study chose the most efficacious treatment after all (see Box 1).

Conclusion

We have argued that physiotherapy must be considered as a cultural practice, with the necessary attendant awareness of the implications that follow. We have suggested that the investment in both the disembodied 'science' of biomedicine and western concepts of humanism encourage the profession to situate itself as a conduit of culturally situated 'knowledge'. In the face of that 'knowledge', other practices and explanations, which are encountered through cross-cultural working, are presented as 'beliefs', thereby immediately being placed lower in the hierarchy of acceptability and 'truth'. As a result of this, 'success' in therapeutic programmes is measured in predominantly western-framed outputs. The implicit power acquired by the therapist engendered by such an approach, and the profession's lack of transparency regarding its own cultural history, ensures that significant collaboration and mutual learning are very seldom achieved and personal dilemmas and frustrations in the clinical field are unresolved. While this may be acknowledged at some level, there is a lack of detailed information and public debate, making it difficult to critically analyse and thereby challenge current practice.

The changing demographic profiles and the rise in chronic disease and disability, as well as the phenomenal increase in conflict and disaster-related injuries, have raised the need for physiotherapy and rehabilitation practice. The effectiveness of the contribution of the profession could be enhanced by a critical challenging of the very nature of what is offered and how it is offered, within the context of the rich tapestry of the clients and their settings. To operate without challenging these components of the delivery of therapy is to run the risk of both being the unwitting catalyst of cultural hegemony and of engaging in cultural apartheid; in both instances therapy is rendered ineffective. Furthermore, a lack of debate in these areas ensures that the very personal experience and dilemmas of cross-cultural working remain hidden. Such silence cannot do the professions, the organisations engaged in development work, the individual therapists, or the people they aim to assist any justice.

This article highlights some key areas for future research. First, there is an urgent need for more detailed ethnographies of physiotherapy practice. Second, there is also a need for further study on the impact that practising

physiotherapy has on physiotherapists themselves. Finally, and most significantly, is the need for further examination of how cultural competence is integrated into physiotherapy practice at all three levels identified: those of awareness, respect and acceptance, and mutual collaboration.

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CONFLICTS OF INTEREST

None.

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