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Original Research

PROFESSIONAL CULTURES: NEW ZEALAND OCCUPATIONAL THERAPISTS EXPERIENCE OF AN INTERNATIONAL INTERNSHIP.

Dr Mary Butler, Fenja Jones, and Dr Susan E. Ryan

INTRODUCTION

We know little about how therapists educated in a New Zealand context understand the provision of therapy within Indian rehabilitation clinics. This study draws on a qualitative research about an internship in India by recent occupational graduates from New Zealand. It aims to provide a preliminary analysis of the complex freedoms experienced by novice therapists in their clinical practice within different ethnic and professional cultures. The experience challenged NZ students to think deeply about the paradigms that underpin their approaches and models of occupational therapy. They came to learn that there was not only cultural difference associated with ethnicity and nationality but also a distinct culture of occupational therapy in each country. They learned to value the differences and the fact that this highlighted gaps in their knowledge. They also described how the experience taught them to appreciate their knowledge and skills. We recommend internships of this kind for their ability to promote the development of skills and knowledge and to gain exposure to new cultures of occupational therapy, cultural contexts and promote transformative learning.

Background

The impact of globalization on healthcare is an increasingly difficult issue to ignore, nor is it in our best interests to do so with such a wealth of knowledge to be gained from diversity. A worldwide trend of globalization has provided an increase in both the opportunities for working internationally with a steady flow of healthcare workers resulting from increased global mobility (Mu, Coppard, Bracciano, Doll, & Matthews, 2010). Alongside this opportunity is the challenge or need for practitioners to develop skills to serve increasingly diverse populations in the home country in a way that is culturally appropriate (Horton, 2009). Both Canadian Association of Occupational Therapists (CAOT) and World Federation of Occupational Therapists (WFOT) recognise the impact of internationalisation and call for an international perspective on education (Barker, Kinsella & Bossers, 2010). Similarly, Mu et al., (2010) cite The Centennial Vision of the American Occupational Therapy Association (AOTA) which has called for occupational therapy to be globally connected.

Alongside the recognition from professional bodies is a need for education providers to prioritise the effect of globalization on population health and the delivery of healthcare to include more teaching on international health (Simonelis, Njelesani, Novak, Kuzma & Cameron, 2011; Schwarz, 2001). Similarly there are a growing number of student health professionals wanting to gain clinical and cultural experience through international fieldwork placements (Edwards, Rowson & Piachaud, 2001).

One suggested model for delivery of teaching in international health is through developing partnerships with schools in developing countries (Edwards et al., 2001). This mobility within education provides an opportunity to promote interaction between people and ideas from differing backgrounds. Student mobility, with students going abroad for part of their training, is the most common approach to internationalization in education (Niemantsverdriet, van der Vleuten, Majoor & Scherpbier, 2006).

Occupational therapy education programs are now aiming to foster an understanding of the responsibilities of being a global citizen and promoting the development of core professional values such as social responsibility, justice, and altruism (Lattanzi & Pechak, 2011; Horton, 2009). These programs are also valuable in enhancing the cultural awareness of students, who gain elements of cultural competence (Simonelis, 2011; Wells, 2000) within the context of professional practice. Humbert et al., (2012) identified a growth in cultural awareness of participants in acknowledging and contrasting the differences between the new environment and their own.

The culture of professional graduates is not only the culture of their homeland but also the culture of the profession that they belong to (Webster, 2011). Hammell (2009) asserts occupational therapy practitioners acquire specific knowledge, beliefs, concepts, perspectives, ideas, norms, assumptions, and values during education. This socialization informs the culture of occupational therapy and influences service provision in specific ways that are often no representative of the culturally diverse populations they serve (Shelly, 2010). The profession as a whole is increasingly open to the critical examination of cultural norms that shape occupational therapy (Iwama, 2006).

However, within this dialogue, there is an underlying assumption of the universal nature or similarity of occupational therapy internationally. For example, all occupational therapists have the right to practice abroad if they have trained at a college accredited by the World Federation of Occupational Therapy (WFOT). WFOT also describes global mobility as essential to promoting the development, evolution, and sustainability of the profession (WFOT, 2008), suggesting that global movement provides an opportunity for valuable learning. However, there has been very little questioning about how the concept of culture may challenge assumptions about the universal nature of practice. If professional culture leads to differences in the way a profession practices internationally (Niemantsverdriet et al., 2006) it is necessary to consider the culture of the profession of occupational therapy and how this changes across the world.

It is essential to understand how history and culture have shaped occupational therapy in different parts of the world. The culture of occupational therapy in New Zealand has its roots in both European and American schools (Hammell, 2009; Iwama, 2006). Consequently, occupational therapy is reflective of the underlying assumptions, worldview and values of a specific perspective usually referred to as 'western.' Iwama (2006) argues that there is little acknowledgment that occupational therapy knowledge and practice is culturally biased.

Participants in this study were part of a team of eight students involved in the development of an internship in India, which was set up for the first time. Together with the first author they chose two Schools of occupational therapy in India as representative of the public and the private educational sectors in that country: five OTs went to one school and three to the other. This study examines the perspectives of two of these students; Julie went to a private university, which takes students from 55 countries, so western students were a common occurrence; Sally went to a public hospital where neither staff nor patients were accustomed to seeing non-Indians as clinicians.

METHOD

The internship was carried out under the auspices of a New Zealand / India Research Institute Research Award, granted to the author in 2013 to establish voluntary clinical placements/internships between India and New Zealand. Approval from the Otago Polytechnic Ethics Committee was gained in August, 2014. A qualitative descriptive method was used (Sandelowski, 2000) and thematic analysis (Braun & Clarke, 2006) guided the analysis. Convenience sampling was used to access the participants and this research looks at the perspectives of two new graduate occupational therapists as they negotiate an internship in India and it specifically examines the ways that this experience challenged their assumptions about the culture of occupational therapy.

FINDINGS

The first author signed a "Study Abroad" agreement with the Schools of Occupational Therapy. Each student was asked to write a letter to the college principal, asking for a 'clinical observer ship' and explaining their prior experience. The 'clinical observer' role was agreed because it did not create expectations that the interns were either students or registered occupational therapists. Prior to leaving New Zealand each intern sent a full C.V., a medical certificate and a copy of their passports to the college; they paid a fee of $350 for four weeks clinical experience, and $100 per week for accommodation. The visa status of the interns was unclear, and at the private hospital, they were asked to get student visas, whereas this was not a requirement at the public hospital. Once at the hospital the interns rotated through a range of specialty areas including hand therapy, neurology, mental health, and paediatrics. The first author visited both places either during or just after the internship.

In India, a bachelor's degree in occupational therapy involves four and a half years of study. It is only after four years they have six months of placement, where they are allowed to have cases on their own. The clinics were all on-site at the universities, and these units were run by master degree students in their second year, with supervision by a specialist occupational therapist who had overall responsibility. Occupational therapists in India tend to stay in the same specialist area for their whole career. In comparison, New Zealand has a three-year degree, and students are sent all over the country on short intensive placements from their first year. Occupational therapists in New Zealand tend to be generalists, and they expect to change role regularly during their career.

The use of a 'medical model'

The first difference that participants noted was the fact that Indian OTs practiced what they identified as a 'medical model.' They rapidly identified the knowledge and skills of Indian occupational therapists as something that they admired. From the outset, they were aware of the different scope of the training. The interns recognized that there was knowledge that they did not have, and at times this threatened to overwhelm them. However, Julie responded with admiration for the education of the Indian students:

> *I really admired the undergraduate students and masters students' both for their knowledge, it was expansive! ... I would have loved to have learned more about what they knew about!*
>
> (J)

The experience became an opportunity for participants to reflect on the strengths of their training:

> *There were lots of things that they just had such an in-depth knowledge of the medical dysfunction, but on the other hand, we had that occupation/function perspective.*
>
> (J)

At the same time the interns noted that, in a reversed situation, Indian students might also struggle:

> *We gained more I think, but if they were to come here they would gain more, they probably would too. In our eyes, they know so much, but then I think they would be confused with our system, you know, going round to people's homes.*
>
> (S)

Challenging professional boundaries

The relationship with clients was something that was different. Julie and Sally were accustomed to a client-centred approach, within the context of a liberal society. They struggled with warnings about boundaries, and what was considered appropriate with clients:

> *They used to tell us we weren't meant to talk to him. I just didn't get why we had to ignore him and the only time we could talk to him was if we were asking questions about his illness.*
>
> (S)

Interns were required to wear white medical coats, which is not an expectation in New Zealand. The interns associated the wearing of white coats as aligning professional values with a medical profession which is something that New Zealand occupational therapists have distanced themselves from for many reasons, including making patients feel more at ease. At times wearing white coats was seen as counterproductive:

> *White coats, which we all wore because of the hierarchal thing was kind of unnecessary. I don't even know why we needed a white coat. Many children were scared of the white coat, so I don't know why we wore one, but we did…*
>
> (J)

Lacking a focus on occupation

The interns rotated around many areas, but the one that they all found most challenging was mental health. They experienced the approach as particularly stigmatizing for the patient, and they were upset when patients were forced to do activities even if they didn't want to. In this case, the therapist coerced a patient to play cards:

> *I was annoyed because it completely defeated one of the main things we are taught which is about meaningful, productive occupation. She was going, 'I don't want to play this game.' I hold that value in autonomy and it was upsetting to see all their choices taken away from them. You want to give them some kind of choice…*
>
> (J)

Interns observed that there was a lack of individualization of treatment:

> *They'd treat to the condition or, they don't actually individualize the treatments or anything, it's not client-centred, it's just more diagnosis-centred…*
>
> (S)

They both described how the primary focus was on physical remediation, and often this meant that therapy never involved meaningful:

> *As long as the person was physically all right and able to go home, they didn't actually really care about other stuff that we would maybe think about…*
>
> (S)

There was a large volume of patients in both settings, and this led to time pressures for therapists. The interns began to see just how difficult an individualised approach to therapy would be in that context:

> *Sometimes because they were so rushed between people that maybe they didn't really think about that. They were thinking about the physical dysfunction before they were thinking about occupation*
>
> (J)

Sally also highlighted how a client-centred approach was something of a luxury within that context:

> *Over there they don't get, I guess, the luxuries of what we get here, of being able to see our patient in their homes, and go, you know, out to their houses and observe them, and work on things that are meaningful as well as ADL's (Activities of Daily Living)*
>
> (S)

However, in other areas like paediatrics, they found that the focus on occupation was more like the practice in New Zealand:

> *In paediatrics I got the most hands-on experience. It was play-focused so we had a lot of opportunities to play*
>
> (J)

They also began to see that culture of everyday activities influences an occupation-based approach:

> *Their culture and their tradition is just so rich when it comes to activities of daily living. Those three occupations of toileting eating and dressing are just so completely different to what you would do in New Zealand.*
>
> (J)

The influence of the system on the practice

The interns were struck by the lack of note taking in all areas of service provision, not just for occupational therapy:

> *Notes were literally just the date this person had treatment and whether they paid. They did mention the diagnosis, and that's it. There were no notes to carry on a therapy session from another, so you had no idea what another therapist had done before you. So you just had to go off what you knew…*
>
> (J)

Additionally, the lack of a booking system meant that participants were unable to prepare for sessions:

> *We would be just sitting there and then all of a sudden, a patient would come in, and we would just have to be ready on the mark. And then all of a sudden everyone would get up off their feet, and we would go into the room, and we would begin therapy…*
>
> (J)

Eventually, the interns learned to adapt to the lack of a booking system, and they could even see the benefits from the perspective of the patient:

> *I sort of thought, 'Oh my god' people not having appointments, I thought that was kind of horrendous, but then I did learn that it actually can be more beneficial if people can come in when they want…*
>
> (S)

The impact of carrying out therapy in a country where there were myriad cultures was a new experience for the interns. The language barrier was endemic to the practice of health care in this context. Students and patients are from all over India, and in the area of the private university, there were at least three different languages. Health professional had a range of strategies, including using some English or finding students or other patients to translate:

> *The language barrier was huge because it was in-between everybody. It was between the medical staff, the patients, the students, everybody. That was one of the biggest things…*
>
> (J)

The importance of healthcare to the population became apparent in a whole new way:

> *People are so willing to come from miles. They would have those sort of barriers, and they have to save up just to go to the clinic…*
>
> (S)

The clinics were part of a "user-pays" system, and this influenced the scope of occupational therapy practice. The patient might not distinguish between different therapies, and so the occupational therapist would capitalize on that confusion to create a generic approach:

> *Patients literally chose whether they want occupational therapy or physical therapy and they paid them. So if you are an OT, then you want to convince your patient to choose and pay for your service. So you might do some kind of physiotherapy, and then you go on and do the occupation based stuff…*
>
> (J)

The focus of treatment was all hospital focused, and neither of the interns identified any element of community-focused practice. Patients had to return to hospital for any further treatment:

> *It is sad to know that they don't have sort of facilities to follow up people. It means that his life will be just circulating between hospitals and out in the community, and back around.*
>
> (S)

However, the lack of community services also created a particular kind of family-oriented therapy that the interns had not experienced before. Families came to all therapy sessions, and it was part of the culture to expect help from family members if there was a disability or injury:

> *I had my first real shock when I learned that the patient we had been seeing was sent home from the ward. He had been in a coma for 30 days and had been receiving OT input passively for 20 days. As soon as he was able to open his eyes and say yes/no he was gone! There wasn't other help that you can get in the community. Then it just had to be family members. You just had to make do…*
>
> (J)

Some other things shocked the interns, for example, the use of a single brush for multiple patients in the context of treatment using sensory integration as a modality.

> *We came from a middle class and were lucky enough to have toothbrushes cheaply dispensed at any place, and I guess that was the whole context…*
>
> (J)

In the end, for the interns, it was important that they felt that they managed to maintain their own sense of values in a very different environment:

> *I'm proud of the outcome. I know that I stuck to my morals and my beliefs, and my values. But I still managed to remain respectful of others and I know I built really good relationships…*
>
> (J)

DISCUSSION

Most voluntary internships available for those working in the health field involve placement with Non-Government Organisations (NGO) for community development projects. Internships with NGOs provide valuable experience, but they do not provide skilled professional supervision for therapists, who are looking to develop specific therapeutic skills. Humbert (2012) describes a tension between being a learner and volunteer in a different cultural context, similar to the liminal space inhabited by the interns as they tried to juggle to the role of being a learner and therapist. They found that being a graduate came with an expectation of skills and knowledge which made them feel intensely inadequate at times. In fact, New Zealand graduates have been perceived in the past to have a weakness in the more practical skills of occupational therapy and intervention (Nayar et al., 2013; Gray et al., 2012; Robertson & Griffiths, 2009). However, it is difficult to distinguish whether the perceived inadequacy would be a typical experience for every new graduate, or whether it was specific to an international experience. This study makes it clear that placement in an educational clinic in India can develop skills in NZ trained occupational therapists.

The internship described in this paper is different from most international fieldwork placements, which usually involve supervision from the home country. Local supervision meant that the interns were exposed to the judgments of the Indian therapists and needed to prove themselves as valuable members of the team. Usually, international placements are completed with supervision from the participant's faculty (Simonelis et al., 2011; Mu et al., 2010). However, local supervision represents integration within a different cultural context, and also within a distinct culture of occupational therapy itself. Julie identified local supervision as important in understanding the diverse nature of occupational therapists role in India. The provision of supervision and support by local host therapists was particularly valuable in creating a sense of dissonance regarding issues related to professional culture. Dissonance is the "incongruence between participants' prior frame of reference and aspects of the contextual factors" that shape the international experience (Kieley, 2005, p. 8). Confronting this dissonance was a significant challenge for the interns that eventually enabled reflections on cultural difference both of occupational therapy and the broader contextual influences of culture on health. The domains of occupational therapy and the cultural context should therefore not be seen as separate entities but as interconnected aspects of the same experience.

The acknowledgment of differences in occupational therapy practice brought about an appreciation of the strengths of the host country. The interns strongly valued the biomedical knowledge of the Indian occupational therapists, particularly in the areas of neurology and hand therapy. This finding is in contrast to Barker (2010) who found a 'western' approach was incompatible with rural practice in India. There were fewer differences in paediatrics and interns felt they gained valuable practical experience in this area, which concurs with previous research identifying the universal nature of play (Humbert et al., 2012; Ekelman et al., 2003).

Other areas were less compatible, notably mental health. Interns were particularly conflicted by an approach to mental health that was reminiscent of practice in New Zealand before de-institutionalisation in the early 1990s (O'Brien & Kydd, 2013). Perspectives on disability are culturally mediated (Simonelis et al., 2011), and interns responded by aligning themselves with deeply felt values around using the social model, incorporating meaningful activity and being client-centred.

WFOT (2008) describes global mobility of occupational therapists as essential for the development, evolution, and sustainability of the profession. Immersion is a crucial factor in the learning associated with international

experiences because of exposure to new skills, new knowledge, and different client bases when navigating a foreign culture (Mu et al., 2010; Kieley, 2005; Ekelman et al., 2003). International experiences offer an opportunity to challenge assumptions (Leung, 2003; St. Clair & McKenry, 1999). For participants this meant adapting to cultural norms, re-evaluating and re-affirming their own beliefs, and accepting their own potential limitations. Faced with situations that differed widely from their values, interns responded by asserting their values (Kieley, 2005), for example, client-centred practice. At other times, when there was only a small incongruence with participants' values, they adapted to the expected cultural norms (Barker et al. 2010), for example, agreeing to wear a white coat. Both participants emphasized the importance of remaining open-minded while still adhering to one's code.

Barker et al., (2010) questioned, from an ethical perspective, the transferability of occupational therapy, suggesting an incompatibility between developed and resource-poor countries. In contrast, Iwama (2006) denies that practices are incompatible, but argues that reflection and acknowledgment of the cultural bias of occupational therapy are necessary, both to progress as a profession and to be more culturally inclusive. We must critically examine the cultural norms that shape occupational therapy to determine its relevance to specific social contexts. In this study, interns came to acknowledge the many pragmatic factors that limited the scope of practice in India, for example, sheer numbers of clients as well as the geographic space militated against the development of community rehabilitation. On the other hand, the challenge of having little time to prepare promoted the development of clinical reasoning whereby the interns were required to react to novel situations quickly and decisively (Simonelis et al., 2011; Mu et al., 2010).

An obvious limitation of the present study is the small number of participants and the fact that interviews were carried out about eight months after the participants returned home. However, the experience became a powerful memory, and the stories of these interns give an invaluable insight into the possibilities of future communication between occupational therapists in India and New Zealand. The fact that the interns rotated across several specialty areas gave them significant insights into the areas where their practice could be genuinely enhanced, while also capturing the full range of potential practice. The weakness of this approach was that the interns did not reach a position where they could feel expert in their practice.

We recommend internships of this kind for future graduates because of their ability to foster cultural learning, gain appreciation of the culture of the profession of occupational therapy, understand the broader societal influences of health, and to increase exposure to new skills and conditions. Recommendations for future internships (or clinical placements) would include focusing on the areas of most robust practice, such as paediatrics, neurology and hand therapy.

This study has added to the literature by describing a unique experience of 'the voluntary internship.' It speaks to the unique experience of being a new graduate and describes the value of a learning experience that goes beyond 'voluntary service' by situating itself within a relevant clinical context. It also describes an experience that may enhance the potential for international fieldwork that accepts the expertise of occupation therapists who happen to practice differently. Occupational therapy has increasingly recognised the challenge of cultural bias (Hammell, 2009; Iwama, 2006) and the experience of these interns is another way that the profession can build bridges across cultures to enhance our global connectivity.

Most importantly this study has demonstrated that cultural experiences are made up of both the cultural differences within the profession of occupational therapy and also within the broader "other cultural" context. Accreditation by the World Federation of Occupation Therapy gives a mandate for occupational therapists from diverse schools to travel the world. However, the cultural context will always shape occupational therapy practice. The internship challenges the temptation to insularity, by giving an example of what it feels like to take on the role of an outsider, and to gradually learn the rules about how to 'fit in'. Occupational therapy manifests in different ways across cultures and embracing this awareness is a way of enabling the profession to explore new possibilities and ways of being.

Mary Butler is Principal Lecturer and Coordinator of the Master's program at the School of Occupational Therapy, Otago Polytechnic. She is an active advocate for all matters to do with low vision rehabilitation and is a Board Member of the Vision Impairment Charitable Trust Aotearoa.

Fenja Jones is an Honours Graduate from the School of Occupational Therapy, Otago Polytechnic. Fenja currently works as an occupational therapist at the Kari Centre in Auckland, a community service for children and adolescents who may be experiencing mental illness

Susan Ryan has a career spanning Australia, the USA and the UK. She is an Emerita Professor at University College Cork as well as a Conjoint Professor at The University of Newcastle, Australia. Susan is an active member of the profession and she continues working during her 'retirement'.

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