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Stories and Cultural Humility: Exploring Power and Privilege through Physical Therapists' Life Stories

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STORIES AND CULTURAL HUMILITY: EXPLORING POWER AND PRIVILEGE THROUGH PHYSICAL THERAPIST LIFE HISTORIES

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ABSTRACT

The purpose of this study was to explore how life experiences, set within their social, cultural, and historical contexts, shape the development of cultural humility in physical therapists (PTs). Cultural humility involves health professionals being actively engaged in an ongoing process with patients, colleagues, communities, and themselves to make sense of the complexities of social and culture differences within relationships in practice. Given demographic trends and health care disparities, it has become critically important to better understand the dynamics of developing trusting relationships to provide quality care.

This study was influenced by relationship-centered care, sociocultural, and insurgent multiculturalism theories. A qualitative, life history study was designed to answer four major research questions: (1) What types of life experiences do PTs perceive frame the way they address cultural differences and build relationships? (2) What contextual influences do PTs perceive have facilitated or constrained their development of cultural humility? (3) How do PTs' life histories elucidate how they attend to or resist facing issues of privilege and power in relationships? (4) What are the implications that attention to one's own culture, privileges, and biases from a life history perspective hold for health professional curricular and pedagogical choices? Eight PTs participated in this study. The primary research method used was one-on-one semi-structured interviews. Data were coded and analyzed for themes through constant comparison and constructing concept maps.

Five major themes centered on the development of cultural humility and building trusting relationships could be traced through the life histories: (1) being open-minded and listening attentively as patients tell their stories; (2) responding to a person's emotions matters; (3) focusing care around a patient's goals and needs; (4) teaching to engage and empower; and (5) evolving awareness of community needs and assets. Taking into account how participants used their life stories to make experiences and contextual influences meaningful, this study offers a framework for educators who are interested in using narratives to foster professional development. By virtue of ongoing reflection on practice and ones biography, including ones privilege, health professionals can be habitually engaged to action to build trusting relationships across difference.

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CHAPTER 1. INTRODUCTION

> *To be deprived of stories is to be deprived, as well, of certain ways of viewing other people. For the insides of people, like the insides of stars, are not open to view. They must be wondered about. And the conclusion that this set of limbs in front of me has emotions and feeling and thoughts of the sort I attribute to myself will not be reached without the training of imagination that storytelling promotes.* (Nussbaum, 1997, p. 89).

Background and Significance

Over my twenty-five plus years of calling as a physical therapist and an educator I have grappled with the tension between the biomedical and sociocultural dimensions of health and illness. As I have increasingly become involved in pedagogical practice to educate skilled, compassionate, caring physical therapists, I have felt challenged to explore how well practitioners care for patients from diverse backgrounds. Demographic trends make it likely that the majority of current and prospective healthcare providers will treat clients who look different than they do, who have different world views, and come from different types of communities (Koehn & Swick, 2006). A biomedical-oriented approach alone cannot help a patient struggle with the loss of health and ability to participate in desired roles in society. Along with biomedical competence, healthcare professionals need the ability to listen to the "narratives" of the patient, to process and respect their meanings, and to be moved to mindful practice using concepts of relationship-centered care (RCC) (Sierpina, Krietzer, MacKenzie, & Sierpina, 2007). In the RCC framework relationships between patients and practitioners (patient-clinician) are central; however, the framework also focuses on the interactions of clinicians with themselves (clinician-self), with colleagues (clinician-clinician), and with the community

(clinician-community) (Beach, Inui, & the Relationship Centered Care Network, 2006).

There needs to be an awareness that health care providers carry their own life histories and cultural backgrounds into every clinical and community encounter. Advocates of the RCC framework for conceptualizing health care stress that to care authentically for others and be culturally responsive, practitioners must understand their own stories and "clinician relationship with self" (Beach et al., 2006; Dobie, 2007). The dimension of "clinician relationship with self" has been defined as the provider's capacity for self-awareness, depth of self-knowledge, and capacity to create and sustain personal integrity in complex and challenging circumstances (Beach et al., 2006, p. 56). Thus, a practitioner entering into any positive relationship with patients, families, or colleagues first requires self-awareness and integrity to foster being open to knowing others on their cultural terms.

One of the challenging circumstances of being a clinician is addressing the incredible potential for power imbalances in the patient-health professional dynamic when faced with the complexities of social and culture differences (Wear, 2003). There is a need to build on the counterdiscourse that cultural differences are often about power-charged social relations rather than characteristics of the other person about which one can acquire knowledge (Beagan, 2003; Kumas-Tan, Beagan, Loppie, MacLeod, & Frank, 2007). Tervalon and Murray-Garcia (1998) have made a key distinction that cultural humility versus cultural competence ought to be the professional and institutional goal when defining outcomes for multicultural medical education. Cultural humility is a construct which emphasizes that developing cultural

competence is not defined by a finite body of knowledge or discrete endpoint, but is encompassed within a lifelong process which includes three prongs (Tervalon & Murray-Garcia, 1998; Wear, 2008). The three prongs of cultural humility are commitment to: self-assessment, addressing the power imbalances in the patient-health practitioner dynamic, and developing mutually beneficial partnerships with communities on behalf of individuals and defined populations (Tervalon & Murray-Garcia, 1998, p.118).

To date, there has been a lack of research conducted on how health care providers grapple with the complexities of social and culture differences within relationships in practice. Reflections from a medical anthropology perspective have emphasized that addressing the effect of culture on relationships in health care settings has been problematic, since the culture of medicine and medical education has historically been assumed to be a "culture of no culture" (Taylor, 2003). The culture of medicine has envisioned clinical decision-making to be largely value neutral and based on scientific evidence (Wear, 2003); which is also seen as cultureless. There has been a lack of formal discussion regarding how the professional culture of medicine with its customs, methods of communication, focus on biomedical competence, and organizational hierarchies affects treatment of patients of diverse social and cultural backgrounds (Boutin-Foster, Foster, & Konopasek, 2008). In the recent decade as cultural competence approaches have begun to evolve, several medical scholars have additionally expressed concern with the trend for oversimplification of culture into "digestible units" of multicultural education or culture competence training in academic, clinical, and continuing health

professional education (Boutin-Foster, Foster, & Konopasek, 2008; Brody & Hunt, 2005; Wear, 2003, 2006a, 2006b). Instead of oversimplifying the effect of culture on relationships and decision making in health care settings, these same scholars encourage deeper and more dynamic critical explorations of the effects of power and privilege in health care and the professional culture of medicine as advocated by the insurgent multiculturalism theoretical lens (Wear, 2003).

Wear (2003) introduced insurgent multiculturalism to medical education based on the writings of Giroux (2000). Insurgent multiculturalism perspectives as outlined by Wear place greater importance on how unequal distributions of power lead to inequities in health care. Wear states:

> Insurgent multiculturalism moves inquiry away from a focus on nondominant groups to a study of how unequal distributions of power allow some groups but not others to acquire and keep resources, including the rituals, policies, attitudes, and protocols of medical institutions (Wear, 2003, p. 549).

How do the unequal distributions of power really affect groups and a person's ability to deliver or receive care? A person's experience with power is a key influence on development (Williams & Barber, 2004). The experience of being oppressed or privileged impacts what a person learns about self and the way the world works. Privilege is the unearned access or rank in any system that leads to benefit or advantage, often take for granted by members of dominant cultures (Anderson & Middleton, 2005; McIntosh, 1988). Health professionals are commonly granted entitlement, power and advantage from being members of the dominant United States culture, as well as the medical professional culture. Oppression is linked to privilege and is the systematic and improper control of people by persons with more power

(Harvey, 2000), often to obtain or retain social, political, economic, and cultural resources (Black, Stone, Hutchinson, & Suarez, 2007; Gostin & Powers, 2006). Harvey (2000) has emphasized the need to be aware of not only the power associated with the just distribution of the goods under social control, however also to be cognizant of relationship power. He states,

> Society is not composed of individual, isolated lives and life situations, but a vast network of relationships, some consolidated into institutions big and small, some on a more intimate level, and the advantages of the socially privileged include power over other people in various relationships (Harvey, 2000, p. 181).

Overall, those who are oppressed experience the frustrations of limited opportunity, while those from privileged backgrounds may consciously or unconsciously benefit from the oppression of others. In health care there is a need to acknowledge, recognize, and challenge the many forms of oppression that contribute to the disparities in health and well-being we witness today (Kumas-Tan et al., 2007), and to further explore relationship power in the health care setting.

A definitive report by the Institute of Medicine (Smedley, Stith, & Nelson, 2003) provides overwhelming evidence of racial, ethnic, and social class-based disparities in healthcare in the United States (US) in the diagnosis and treatment of patients with a variety of medical conditions. The reasons for these disparities are not entirely clear. The quality of relationships in health care, the social environment, individual patient factors, and health care institutional structural barriers have all been implicated to be factors influencing disparities in health care (Anderson et al., 2003; Betancourt, Green, Carrillo, & Park, 2005; Brach & Fraser, 2000; Cooper, Beach, Johnson, & Inui, 2006; Lefebvre & Lattanzi, 2007). Although the reasons for

disparities in care are multifaceted, this study focused on how physical therapists wrestle with the complexities of social and culture differences within relationships in practice. Conceptually, both the RCC and insurgent multiculturalism theories helped shape this study which explored the development of cultural humility. Both theoretical frameworks assert that for health care providers to cultivate critical, dynamic views on the importance of culture on relationships in health care, they must first appreciate the processes that frame their own attitudes about health, illness, and social responsibility and then question their prior assumptions (Dobie, 2007; Wear, 2003, 2008). Using this principle, the study used a life history approach to explore PTs' clinician-self relationship, the self-awareness of their cultural life stories and their sense of accountability.

Medical education scholars have recently turned toward narrative inquiry and biographical approaches, such as life history, as a means for understanding how practitioners' perceptions of health and professionalism are formed (Clandinin & Cave, 2008; Kumagai, 2008; Sierpina et al., 2007). From a narrative inquiry standpoint, how a practitioner makes sense of experiences in relation to the social, cultural, and historical contexts of situations is important in understanding the how they form relationships (Taylor, Gambourg, Rivera, & Laureano, 2006). Historically, an overreliance on individualistic, cognitive-oriented psychological models of learning in medical education has likely inhibited issues like addressing disparities in health care from a relationship oriented, sociocultural perspective (Bleakley, 2006). For example, Schön's theory of reflective practice (Schön, 1987) and Kolb's theory of experiential learning (Armstrong & Parsa-Parsi, 2005; Kolb,

1984) are individualistic oriented models commonly espoused by health professional curricula. Both learning approaches focus on the individual learner's worldview and assume the mind is functioning independently of its social context (Swanick, 2005). Using individualistic learning theory approaches when reflecting on one's own culture, a practitioner may not see themselves in a privileged position in the health care system. Since sociocultural theory focuses on the social and cultural factors that mediate learning in particular contexts, this theory served as a lens for conceptualizing the development of cultural humility in physical therapists (PTs) in the present study.

Based on the work of Rogoff (1990, 1995, 2003) sociocultural development can be envisioned to occur on three contextual planes: personal, interpersonal/social, and community/cultural. The personal plane has been the focus of most learning theory approaches in education and incorporates studying constructs such as cognition, emotion, behavior, and beliefs (Rogoff, 1995; Monkman, MacGillivray, & Leyva, 2003). The interpersonal/social plane takes into account the changing patterns of engagement with other people in collective activities and social practices, rather than concentrating on developmental changes that occur within the individual (Rogoff, 1995; Lim & Renshaw, 2001; Monkman, MacGillivray, & Leyva, 2003). The community/cultural plane includes home, family, community, sociopolitical, and socioeconomic spheres of influence (Rogoff, 1995; Monkman, MacGillivray, & Leyva, 2003).

This study utilized sociocultural theory as a lens to view how PTs make sense of life experiences at three levels of interaction-personal, interpersonal, and

community/cultural planes. This investigation focused on how self-aware PTs are of the processes on all three planes that contribute to or impede their professional trajectories of developing cultural humility. I acknowledge that this life history did not fully incorporate the principles of sociocultural theory. A future study that would be conducted over several years using an ethnographic design, in a health care setting with a team of patients and health care practitioners, using multiple sources of data collection (interviews, participation observations, and documents) would be a more holistic approach to examine the development of cultural humility in PTs' from sociocultural theoretical perspectives.

Overall, there has been a lack of research to date which has critically explored how self-aware health care providers' are of their own culture, privileges, and biases as they try to make sense of the complexities of social and culture differences within relationships in practice. In the following sections, I introduce the problem statement, purpose, major research questions, and overview of the study.

Problem Statement

There is a counterdiscourse movement in health professional education advocating that cultural humility versus cultural competence ought to be the professional and institutional goal when defining outcomes for multicultural health professional education. According to proponents of this movement, exhibiting behaviors that reflect cultural humility are advocated to be an important component of professionalism in health care disciplines. However, little is currently known about how aware health care providers are of their own culture, privileges, and biases. Furthermore, based on their awareness of their own culture, privileges, and biases,

what strategies do practitioners use to address the power imbalances in patient-clinician, clinician-clinician, and clinician-community relationships. In this study PTs' contextually-situated life histories and the meaning they derive from interactions with persons from diverse backgrounds, especially patients, provides new perspectives on understanding the complex process that underlies the development of the three prongs of cultural humility (self-assessment, addressing the power imbalances in the patient-health practitioner dynamic through relationship-centered care, and community based advocacy). It is recognized that further investigation is needed to look at the development of cultural humility from patients' and families' perspectives.

Purpose

The purpose of this life history study was to explore how life experiences, set within their social, cultural, and historical contexts, shape the development of cultural humility in physical therapists (PTs). A combination of the RCC model, sociocultural, and the insurgent multiculturalism theoretical lens were used to frame the study [Figure 1]. To date there has been a tendency to oversimplify the effect of culture on relationships and decision making in health care settings, versus encouraging deeper and more dynamic critical explorations of the effects of power and privilege in health care and the professional culture of medicine (Taylor, 2003; Wear 2003, 2006b) . In this study, life history methods were utilized to: 1) examine how PTs' discussion of culture in their life stories reveals their access to opportunity and resources and how they make sense of certain forms of power and privilege to address cultural differences and build relationships in health care settings; and 2)

demonstrate how PTs' life stories elucidate broader sociohistorical issues, and how throughout the course of their lives individuals have shifting, evolving approaches to culture in relationships with themselves (personal plane), patients or colleagues (interpersonal/social), and communities (community/cultural plane).

Research Questions

The main research questions were:

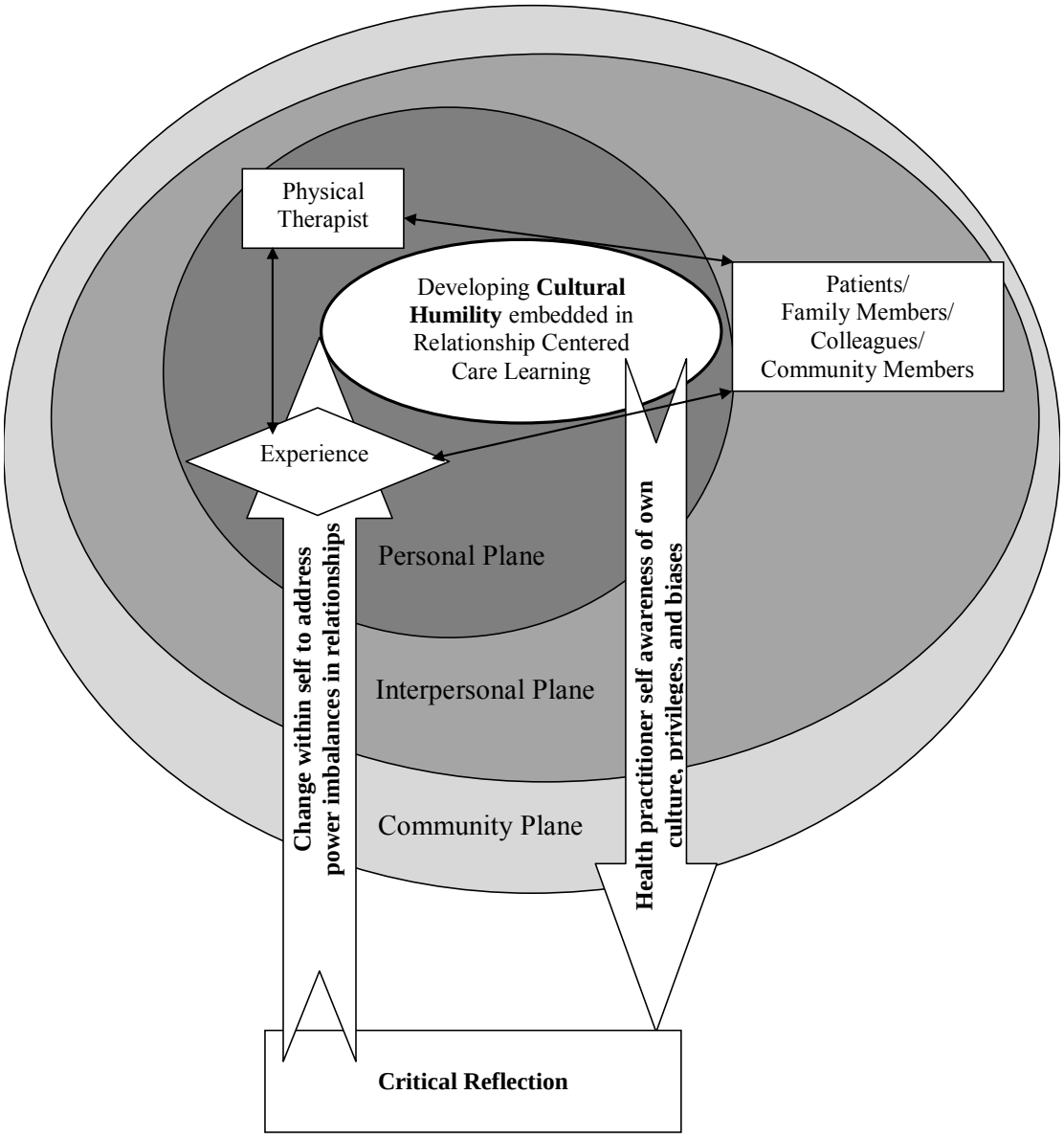
1. What types of life experiences do PTs perceive frame the way they address cultural differences and build relationships in health care settings? What meaning do PTs' ascribe to their life experiences as they strive to make sense of their approach to interacting with persons from diverse backgrounds in healthcare?

2. What contextual influences do PTs perceive have facilitated or constrained their development of cultural humility in relationships with themselves (personal plane), patients or colleagues (interpersonal/social plane), and communities (community/cultural plane)?

3. How do PTs' life histories elucidate how they attend to or resist facing issues of privilege and power in relationships with patients, colleagues, communities, and themselves?

4. What are the implications that attention to one's own culture, privileges, and biases from a life history perspective hold for health professional curricular and pedagogical choices?

Figure 1. Initial Conceptual Framework for Developing Cultural Humility



Adapted from the Relationship-centered Care (Beach, Inui, & the Relationship-Centered Care Network, 2005), Sociocultural (Rogoff, 1995), and Insurgent Multiculturalism (Wear, 2003) Theoretical Lens

Dissertation Overview

This dissertation includes six chapters. Chapter 2, the literature review, begins with an overview of health care disparities. Although the reasons for disparities are multidimensional, the review of the literature supports there is a need to further explore how cultural differences can be bridged in order to build effective relationships with patients and communities. Chapter 2 also describes the theoretical underpinnings of this research. In this study I used RCC, sociocultural, and insurgent multiculturalism theories to frame the ways that PTs' make meaning of life experiences to shape their development of cultural humility. Chapter 3 details the methodology of the investigation to answer the research questions. A qualitative, life history study design was used to collect data on how PTs learn to interact with persons from diverse cultural backgrounds. Chapters 4 and Chapter 5 report the findings of the study. Chapter 4 presents the life histories of the eight physical therapists who participated in the study, while Chapter 5 reviews the themes that were identified from the cross-case analysis. Chapter 6 provides a discussion of how each of the research questions were addressed by the data and framed by theory. Chapter 6 concludes with implications of the investigation for the practice of physical therapy, implications for education, and implications for future research. The document ends with a list of references and appendices containing the institutional review board approval form, interview guide, and the timeline for recording of significant people, events, and milestones in shaping professional development.

CHAPTER 2. LITERATURE REVIEW

> *Authentic healing relationships can only occur between persons who have some awareness of their life stories, of where they are along the trajectory of their personal narrative. When both practitioner and patient know "where they are" they can inhabit the same "space" and engage in meaningful communication. Exclusively relying on professional degrees, technical knowledge, titles, and training will only take us so far. At some point, each of us must find a deeper core strength that is rooted in our experience of being human. Once we make this connection, we can create healing relationships that not only benefit our patients (and clients and students), but also serve to help us become whole. (*Sierpina, Krietzer, MacKenzie, & Sierpina, 2007, p. 630)

The Health Care Disparity Imperative

Scope of Health Care Disparities

Health care disparities are of significant concern to health policy makers and have a substantial impact at a personal level to individuals and at a societal level to the health care system in the US. The US Congress, Department of Health and Human Services, Agency for Healthcare Research and Quality, Institute of Medicine (IOM), and the National Institutes of Health (NIH) all have initiatives to reduce health disparities (Agency for Health and Research Quality, 2004; National Institutes of Health, 2007; Smedley et al., 2003; United States Department of Health and Human Services, 2000). The NIH has defined health care disparities as "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States" (National Institute of Health, 2007, p. 1). Two key congressional initiatives early in this decade have had significant impact on health disparity policy. First, Congress passed the Minority Health and Health Disparities Research Act of 2000 (PL-106-525) that established the National Center on Minority Health and Health Disparities at

NIH. Secondly, Congress asked the IOM to evaluate health care access, prevention, intervention, and outcomes for individuals with racial and ethnic minority status in the US. The landmark IOM report released in 2002, *Unequal Treatment: Confronting Racial Ethnic Disparities in Health Care*, cited 474 references and intensively reviewed 100 studies to reach the conclusion that racial and ethnic disparities in care were consistently found across all ages, throughout all types of disease categories, in the access to best practice procedures, and in mortality rates (Smedley et al., 2003).

Although the IOM report and recent medical research literature provide numerous examples of health disparities among minority populations in the US, references specific to PT practice are lacking. Only three studies directly related to physical therapy were cited in the IOM report (Harada, Chun, Chiu, & Pakalniskis, 2000; Hoenig, Rubenstein, & Kahn, 1996; Horner, Hoenig, Sloan, Rubenstein, &Kahn, 1997). Hoenig et al. (1996) analyzed data from 2,762 Medicare patients and found that older adult African Americans were more likely to receive a lower intensity of physical therapy than non-African Americans post acute hip fracture in acute care hospital settings. Low intensity was defined in this study as less than or equal to .714 sessions per day (5 sessions/week). The authors calculated the mean number of physical therapy sessions and established that 65% of African Americans and 43% of non-Hispanic white patients receive low intensity intervention. Harada et al. (2000) also found that African Americans were less likely to receive physical therapy care in acute care hospitals or skilled nursing facilities than non-Hispanic whites post acute hip fracture; however the causes for these disparities were unclear. A few investigations have also addressed whether there are disparities in

rehabilitation of patients post being diagnosed with a stroke. Racial disparities have not been found in terms of admission to rehabilitation centers to receive physical therapy services (Horner et al., 1997; Horner, Swanson, Bosworth, & Mathchar, 2003), however African Americans have been shown to achieve significantly lower functional outcomes (Bhandari, Kushel, Price, & Schillinger, 2005; Horner et al., 2003; Stineman, Ross, Hamilton et al., 2001).

The reason for the low prevalence of studies in physical therapy addressing health disparities is likely multi-factorial including the following: 1) lack of diversity in the PT profession in terms of the proportion of therapists from minority backgrounds to heighten attention to disparities; 2) a history of minimal extramural funding for health disparity research versus biomedical research in physical therapy; 3) a health policy priority emphasis on access and quality of care provided by physicians and nurses versus other allied health care providers or health care teams; 4) and a focus on technical features of health care versus rehabilitation care which is more relationship-centered and delivered by professionals such as PTs. Minority membership statistics recently reported by the American Physical Therapy Association (2008) show that only 12.18% (0.52% American Indian or Alaskan Native, 5.20% Asian, 2.03% African American, 2.57% Hispanic/Latino, 0.28% Native Hawaiian or Pacific Islander, and 1.58% Other) of physical therapist members self-identify as being from a minority background. In comparison, the US Census Bureau reported the minority representation in the same demographic classifications in the overall population in 2000 to be 29.4 % of US citizens being from a minority background (0.9 % Native American or Alaskan native; 3.6% Asian; 12.3% Black or African American; 12.5%

Hispanic; and 0.1% Native Hawaiian or other Pacific Islander (United States Census Bureau, 2001). Certainly there needs to be efforts to recruit individuals from more diverse backgrounds into the physical therapy profession, however all PTs need to have the ability to understand and work effectively with patients whose beliefs, values, and histories are different from their own. Moreover, as part of developing cultural humility PTs ought to further investigate and be aware of where disparities may be present in access, intervention, or outcomes using a broader definition of culture than focusing on ethnicity and race. Overall, numerous studies have demonstrated racial and ethnic disparities in health care access and quality, however there is less evidence regarding disparities in care in rehabilitation fields, such as physical therapy. The literature review reveals a need to move beyond investigating the technical features of health care, to exploring how dimensions of relationships are central in supporting high quality care. It is not only important to review the present literature to understand the scope of what is known about the extent of health care disparities, it is also key to synthesize what current factors and underlying mechanisms are believed to contribute to health care disparities.

Factors and Underlying Mechanisms of Disparities in Health Care

In order to reduce disparities in health care, practitioners must have an understanding of the multiple factors and mechanisms that contribute to unequal treatment. The social environment, individual patient beliefs and behaviors, characteristics of the patient-clinician relationship, and health care institutional structural barriers, have all been implicated to be part of the cause of racial and ethnic disparities in health care (Betancourt, Green, Carrillo, & Park, 2005; Brach & Fraser,

2000; Cooper et al., 2006; Lefebvre & Lattanzi, 2007). The social environment includes socioeconomic factors such as patients' lower levels of education or lack of insurance; physical surrounding conditions like occupational exposure to toxic chemicals or air pollution; and social control parameters such as having less power to challenge bureaucratic health system processes in local health institutions (Betancourt et al., 2003; Cooper et al., 2006).

Since race, ethnicity, and level of ability/disability are thought to be socially constructed, it also follows that sociocultural differences among patients, practitioners, and the health care system are likely causes for disparities. Individual patient beliefs, values, and behaviors can influence how patients recognize and communicate symptoms, seek care at different levels of symptom severity, choose treatment options, or adhere to interventions. If patient-clinician differences in health beliefs, values, and behaviors are not reconciled in the clinical encounter then communication and trust may suffer and ultimately poorer health outcomes may result (Beach, Rosner, Cooper, Dugan, & Shatzer, 2007; Betancourt et al., 2005; Green, Betancourt, & Carillo, 2002). Furthermore, when health providers neglect to take patient values, expectations, preferences, and background into consideration, they may resort to stereotyping (Johnson, Saha, Arbelaez, Beach, & Cooper, 2004; Williams, Neighbors, & Jackson, 2003).

Recent research has provided evidence that bias (conscious and unconscious) and stereotyping exists among health care professionals and within the health care system (Johnson et al., 2004; Smedley et al., 2003; Williams et al., 2003). Ultimately bias and stereotyping may impact medical decision-making and patient perceptions.

For example, Johnson and colleagues (2004) used cross-sectional telephone survey data from the Commonwealth Fund 2001 Health Quality Survey of 6,722 adults to examine the racial and ethnic differences in patient perceptions of bias and cultural competence with health care visits. The authors using logistic regression analyses found that persons from Hispanic, Asian, and African-American backgrounds were more likely to believe than whites that: 1) they would have gotten better care if they belonged to a different race/ethnic group; and 2) medical practitioners treated them unfairly or disrespectfully based on their race or how well they speak English (Johnson et al., 2004).

In addition, relationships have been studied in health care on the basis of concordance. The term "concordance" has been used to describe shared cultural identities between patients and practitioners (Saha, Komaromy, Koepsell, & Bindman, 1999). Ethnic minority patients are commonly treated by clinicians who differ from them in racial or ethnic background, which are defined as "race-discordant" relationships (Cooper et al., 2006). Several studies have shown that ethnic minority patients, in race-discordant relationships with health practitioners, rate the quality of interpersonal care with health care providers more negatively than whites (Collins, Clark, Petersen, & Kressin, 2002; Cooper & Roter, 2003; Saha, Komaromy, Koepsell, & Bindman, 1999). Fortunately, there is one longitudinal, observational study using the Roter Interactional Analysis System that demonstrates that communication problems attributed to race discordance were decreased over time when there was continuity in the patient-clinician relationship and use of a patient-centered approach (Wissow et al., 2003). Wissow and colleagues (2007) found

African-American mothers at early visits with their infant's gave less psychosocial information to pediatric residents than did white mothers. Over a one year time period psychosocial information giving increased between African-American mothers and white female pediatric residents, so that by one year psychosocial information disclosure to inform care did not differ by ethnicity when comparing African-American versus white mothers. Overall, there continues to be a need for further studies to identify the underlying mechanisms by which race concordance and discordance influence communication and shared-decision making in patient-clinician relationships.

In addition to health care provider bias concerns, there is also evidence that persons from minority groups also face bias when interacting with the health system in general (Kagawa-Singer & Kassim-Lakha, 2003; Taylor, 2003; Wear, 2003). Barriers to care from a health care system perspective include: lack of interpreter services when needed in the clinical encounter, a paucity of health educational materials that are culturally and linguistically appropriate, limited clinical appointment hours based on community work pattern needs, cumbersome intake processes that foster distrust, and lack of diversity in the health care workforce in comparison to the racial/ethnic composition of the US population (Betancourt et al., 2003; Betancourt et al., 2005).

There is a growing body of literature documenting that health disparities are influenced by many factors. Although the reasons for disparities are multidimensional, there is a need to further explore how relationship characteristics impact interacting with persons across social and cultural diversity. Historically, the

biomedical model has traditionally been favored for making clinical decisions versus other frameworks that place greater emphasis on sociocultural factors. Since ideologies based on the biomedical model have predominated, health care practitioners and health care systems have only recently begun to confront the social, cultural, and historical contexts for differences in health care.

Critique of the Biomedical Model

Numerous authors and reports have emphasized the need for medical professionals to move away from a "Western biomedical model" and monocultural Eurocentric beliefs concerning health, disease, illness, and disability (Kachingwe, 2003; Kagawa-Singer & Kassim-Lakha, 2003; Kraemer, 2001). The Western (US) medical model views most diseases and injuries as natural mechanistic errors, with treatment interventions focused on pharmacologic and surgical repairs, such as coronary artery bypass grafts or joint replacements, with limited emphasis placed on sociocultural variables (Kagawa-Singer & Kassim-Lakha, 2003; Kraemer, 2001). However, not all cultural groups in the US share such a biomedical perspective. For example, many individuals who have migrated to the U.S. have beliefs and practices that favor use of traditional healers, medicines, and nutritional practices from their countries of origin that focus more on the emotional and spiritual aspects of wellness (Genao, Bussey-Jones, Brady, Branch, & Corbie-Smith, 2003; Koehn & Swick, 2006). Historical reliance on ethnocentric ideologies in health care have contributed to cultural dissonance and conflicting expectations between culturally diverse communities and medical institutions as well as between patients, families and health care providers (Donini-Lenhoff & Hedrick, 2000; Horner et al., 2004).

Most faculty members in the health professions have been trained under the Western-biomedical model, and as a result, there continues to be a concern that the hidden or latent curriculum does not emphasize sociocultural issues (Howe, 2002; Taylor, 2003). For example, if medical/allied health faculty members do not see culture as pertinent to medical concerns, they may not commit the time to include culturally relevant literature or knowledge in their teaching units, require students to recognize how cultural differences can affect clinical decision-making, or conduct culturally representative research (Kachingwe, 2003; Taylor, 2003; Park et al., 2005; Weissman et al., 2005). A commitment by educational leaders to fostering RCC and development of cultural humility in students or clinicians must consider the cultural attitudes and behaviors of academic and clinical faculty leaders, as well as the implicit norms and values of the school or health care organization.

Fortunately, several recent publications in medicine encourage critical analysis of power and privilege in health care to challenge practitioners and institutional leaders to think more broadly about the nature of the cultural complexities that are encountered in patient and community interactions (Aultman, 2005; Canales, 2000; Hunt & de Voogd, 2005; Kumas-Tan et al., 2007). Through critical analysis one can focus on the sources of disparities in health care in areas such as the patient-clinician relationship, hegemonic educational practices, and in health care access based on the social environment (Wear, 1997, 2003; Wear & Kuczewski, 2004; Cooper et al., 2006). The development of cultural self-awareness in providers of health care requires a system supportive of a true exploration of how dominant systems of privilege acquire, sustain, and retain power through the everyday norms or

pervasive ideology of dominant groups (Gordon, 2005; Helms, 1990, 1995). Confronting this invisible power structure is a difficult but necessary step in recognizing bias, stereotype, and prejudice (Gordon, 2005; Wear, 2003).

Liberal individualism and hegemony encourage people not to recognize how the dynamic complexities of a society so shaped by racism, sexism, classism, and homophobia have affected oneself or people from marginalized groups (Boler & Zembylas, 2003; Weiler, 1988). According to McLaren (1989),

> Hegemony refers to the maintenance of domination not by the sheer exercise of force but primarily through consensual social practices, social forms, and social structures produced in specific sites such as the church, the state, the school, the mass media, the political system and family (p. 182).

Although the health care system is not included in McLaren's definition, scholars have emphasized that hegemony has distorted the link between race or ethnicity and health status by assuming that biology underlies differential health outcomes (Cooper et al., 2006; Smedley et al., 2003). Instead, race and ethnicity are both *socially* constructed categories, not *biologically* constructed (Lefebvre & Black, 2007; Smedley et al., 2003).

Hegemony is also closely tied to liberal individualism. The dominant cultural myths often perpetuated by liberal individualism, such as equal opportunity, depend on several "acceptable" views of difference such as the celebration/tolerance model, the denial/sameness model, and the natural response/biological model (Boler & Zembylas, 2003, pp. 112-114). All three of these models of difference demonstrate a common emotional strategy to avoid responsibility for socially constructed differences by naturalizing through discourses such as "science" what are in fact

culturally constructed values. Critical approaches in culture studies are increasingly skeptical of "common sense" practices. For example, the privileging of technical medical knowledge in texts has been a focus of postmodern feminist critiques of medical patriarchy (Huntington & Gilmour, 2001; Mead & Bower, 2000). Critical and feminist theorists are encouraging the need for listening to and privileging the stories' of clinicians and patients as they are told and lived out in practice (Czarniawska, 2004; Sierpina et al., 2007; Wear & Aultman, 2007). Rather than medical experts speaking to or for clinicians, clients, and families struggling for social justice in health care using the standard Western biomedical model of health care, the goal is to work toward theory building grounded in both confrontation with and respect for the experiences of practitioners and people in their health care encounters (Frank, 2000; Hunt & de Voogd, 2005; Johnson et al., 2004; Taylor et al., 2006).

In summary, the biomedical model has traditionally been favored for making patient and community health care decisions versus other frameworks that place greater emphasis on RCC. This research study was designed to explore the development of cultural humility using the framework of RCC, since the process of understanding and respecting cultural differences needs to move away from being grounded in rationality and a belief that health providers can achieve cultural competency similar to mastering technical skills (Wear, 2006b). The next section will review the key principles of RCC.

Relationship-Center Care: A Model for Framing Approaches for Fostering Development of Cultural Humility

Based on the underlying belief that all care and therapeutic processes occur in relationships, the Pewter-Fetzer Task Force (1994) pioneered the relationship-centered care (RCC) framework for conceptualizing health care. In 2001, the Institute of Medicine again advocated that "a continuous healing relationship" as the first principle for improving quality of care. The RCC framework promotes that the explicit focus of care ought to expand beyond the biomedical model or principles of patient-centeredness to consider the relationships of patient-clinician, clinician-clinician, clinician-community, and clinician-self (Beach, Inui, & the Relationship Centered Care Network, 2005). Beach and colleagues have identified that RCC is built upon 4 principles as follows: 1) Relationships in health care ought to include dimensions of personhood of the participants, as well as roles; 2) Affect and emotion are important components of relationships; 3) Relationships in health care occur in the context of reciprocal influence with both parties having the potential for benefits in terms of personal and professional goals; and 4) The maintenance of genuine relationships is morally valuable (Beach, Inui, & the Relationship Centered Care Network, 2005, pp. 53-54). The RCC model is an approach grounded in the view that each health care participant's interaction with every other is unique and important, and considers these relationships to be central in supporting high quality care (Safran, Miller, & Beckman, 2005).

Patient-clinician relationships are viewed to be a distinct product of the mutual interaction of two participants who have their own sets of experiences, values, and perspectives (Beach et al., 2005). Whether associations are short term or long

term, patient-clinician relationships involve reciprocal tasks, duties, responsibilities, and outcomes (Dobie, 2007). In the RCC framework a goal is to equalize power between patients and health professionals through encouraging partnerships between patients and clinicians (Cooper et al., 2005). In addition to focusing on the dimension of partnership, Cooper and colleagues (2006) also encourage that communication, respect, knowing a person's unique life story, affiliation or liking, trust, and racial and ethnic concordance are key components to consider and study when trying to understand how cultural backgrounds influence patient-clinician relationships in care.

The RCC model also acknowledges that the relationships that practitioners form with each other contribute meaningfully to their own well-being, as well as the health care of patients (Safran et al., 2005). While partnerships are encouraged in patient-clinician relationships, collaboration with team members is considered critical for optimal clinician-clinician relationships. The RCC framework acknowledges that there are power inequities across health disciplines in the traditional hierarchically organized system of medical care in the US (Beach et al., 2005; Cooper et al., 2006). If the culture of health care organizations and medical education institutions do not foster communicating and respecting other members of the team, regardless of their role, the practitioner is paradoxically sometimes forced to engage with patients in a manner sometimes quite different from how he or she is treated (Beach et al, 2005).

The RCC framework in addition to valuing the interactions between clinicians and patients or peers in clinical settings, also emphasizes the importance of clinician-community relationships. Health care providers need to have a depth of understanding of the local community's social, cultural, political, and historical dynamics; health

care resources, as well as vulnerabilities. From greater understanding it is hoped that there is more public dialogue between community members and health care providers and action to promote community health (Beach et al., 2005; Pyles & Kim, 2006).

To be able to foster effective patient-clinician, clinician-clinician, and clinician-community relationships the RCC framework emphasizes that the more practitioners know about themselves, the better they will be able listen and accept another's narratives (Dobie, 2007). The clinician-self relationship is the person's capacity for self-awareness of his or her own background, attitudes, and values, and their impact upon behaviors and interactions with others in the complex and challenging circumstances of health care (Beach et al., 2005; Cooper et al., 2006). Based on the principles of RCC, health care providers ought to be introspective regarding their cultural beliefs based on their family and community backgrounds, and the biases that they don't easily see based on their cultural vantage points. Self-awareness of one's own life story and a sense of accountability are advocated to be integral for clinicians' to have genuine, effective relationships with patients, colleagues, and community members (Dobie, 2007, Wear 2006b). The following section will examine if current cultural competence models are grounded more in rationality perspectives of the biomedical model, or in sociocultural and critical perspectives of the RCC framework.

Attributes and Limitations of Previous Cultural Competence Approaches

Six-Stage Cultural Competence Continuums

There is no single commonly accepted definition of cultural competence and no single universally established model for the development of cultural competence.

Cross and colleagues (1989) established one of the earliest definitions as well as models for developing cultural competence. This group of mental health researchers defined cultural competence as a "set of congruent behaviors, attitudes, and policies that come together in a system, agency or amongst professionals and enables the system, agency or those professionals to work effectively in cross cultural situations" (Cross, Bazron, Dennis, & Issacs, 1989). Working effectively is implied to involve the ability to serve individuals of diverse backgrounds. Culture is defined by Cross, Bazron, Dennis, and Isaacs (1989) as, "the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group." The authors based on their conception of culture outlined a six-stage continuum for developing cultural competence. The six stages included cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competence, and cultural proficiency.

In health care and education many definitions and models of cultural competence acknowledge they are modifications of the model pioneered by Cross (Brach & Fraser, 2000; Shen, 2004). For example, the six-stage continuum has been adapted to educational settings and teachers (Lindsey, Robins, & Terrell, 1999). Lindsey and colleagues (1999) have utilized the same continuum; however they have described how the needs of culturally diverse students and communities can be met through improved cultural proficiency of teachers and school leaders. Leavitt (2002) encouraged PTs to become familiar with the stages of cultural competence for looking at their own professional behavior. Overall, the six- stage model positively views cultural competence as a developmental process. Although not necessarily

intended by the authors, the model with its series of stages fosters the notion that the development of cultural competence has an endpoint versus facilitating the concept that developing cultural competence is ongoing. For example, a PT may be proficient with interacting with a client in a home care setting, however may demonstrate cultural blindness in communicating with another client and family in an intensive care unit. The model also tends to focus on cultural competence of the professional or of the institution when applied to health care; however there is lack of emphasis on how provider, health system, and patient interactions may affect the provision of culturally competent care. For example, physical therapists and other health professionals work in settings with particular climates and policies. These health care settings may facilitate or inhibit individual cultural competence, and conversely the individual practitioner may foster or hinder health system cultural competence.

Component-Oriented Cultural Competence Models

A second type of approach to the development of cultural competence is component or domain oriented. Most models using this approach have advocated that knowledge, attitude, and skill domains be addressed when considering how cultural competence is learned by practitioners in disciplines such as nursing (Burchum, 2002; Campinha-Bacote & Padgett, 1995; Campinha-Bacote 1999, 2003; Kim-Godwin, Clarke, & Barton, 2001; Purnell, 2002; Purnell & Paulanka, 1998, 2003), medicine (Betancourt, 2003), social work (McPhatter, 1997; McPhatter & Ganaway, 2003), and psychology (Sue, Arredondo, & McDavis, 1992; Sue et al., 1999).

Although early cultural competence discussions from a domain oriented approach began in the late 1970s (Leininger, 1978), it was more in the 1990s and the

present decade that theorists proposed there are specific domains inherent to development of cultural competence. Understanding these domains and striving to improve one's ability within each domain are advocated to help focus health provider's efforts to improve cultural competence. For instance, Campinha-Bacote, a nursing scholar, has defined cultural competence as "the process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of a client (individual, family, or community)" (Campinha-Bacote, 1999, p. 203). Her organizing framework has evolved from four to five key dimensions (Campinha-Bacote & Padgett, 1995; Campinha-Bacote 1999, 2003). The current components of Campinha-Bacote's model are: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. Cultural desire is defined as the motivation of the practitioner to "want to" engage in the process of becoming culturally aware, knowledgeable, skillful, and seeking cultural encounters versus "having to" participate in this process (Campinha-Bacote, 1999). For example, a physical therapist may be asked to care for a patient whose religious beliefs are very different from their own. A physical therapist with strong cultural desire would listen to the patient in an unbiased manner, with an ongoing effort to understand the patient's perspectives regarding treatment preferences and goals. A strong point of Campinha-Bacote's model is the emphasis on an individual provider's desire and conviction to continually strive for ongoing development of culture competence in the different domains. A limitation of the model is that although each component represents a desirable goal for the practitioner, more emphasis needs to be placed on

how unlearning biases and prejudices requires repeated, self-critical, reflective work in examining how relationships are constructed and power shared.

Purnell and Paulanka have created a model of cultural competence which the authors espouse is a conceptualization based on multiple theories from organizational, administrative, communication, and family development theories, as well as research evidence from anthropology, sociology, the basic sciences, and the clinical sciences (Purnell, 2002; Purnell & Paulanka, 1998, 2003). The Purnell Model for Cultural Competence was developed so health care providers would have an organizing framework for providing care in a manner consistent with the culture of the patient. The Purnell Model utilizes a framework which consists of 12 domains for assessing ethnocultural attributes of an individual, family, or group. The 12 domains are as follows: overview/heritage; communication; family roles and organization; workforce issues; biocultural ecology; high-risk behaviors; nutrition; pregnancy and child-bearing practices; death rituals; spirituality; health care practices; and health care practitioners. The authors of the model advocate by identifying and understanding each domain for a patient on an ongoing basis, the practitioner will be better able to provide culturally competent care. For instance, the overview/heritage domain includes concepts related to the country of origin, reasons for immigration, current residence, economics, and politics. A physical therapist using this model to guide practice would be interested in knowing if a patient recently emigrated from another country and if the patient might have fear impacting their rehabilitation after seeking political asylum. Furthermore, these nursing scholars believe that primary (nationality, race, color, gender, and age) and secondary (educational status,

socioeconomic status, occupation, military experience, political beliefs, urban versus rural residence, enclave identity, marital status, parental status, physical characteristics, sexual orientation, gender issues, reason for migration, and immigration) characteristics of culture determine the degree to which one varies from the dominant culture. The 12 domains, along with the primary and secondary characteristics, are proposed to help determine differences in values, beliefs, and behaviors between the patient and practitioner. In addition to the nursing profession, this model has been used by physicians, occupational therapists, and physical therapists (Black & Purnell, 2002).

The Purnell model helps us envision the development of cultural competence as an ongoing process. Conversely, the model suffers from lack of clarity on how practitioners derive meaning out of the lists of domain concepts and cultural characteristics. For instance, why is sexual orientation considered a secondary characteristic and how does this classification hinder or foster providing effective care? There is also concern that the authors and proponents of this model may be encouraging stereotyping with profiling the characteristics of different cultural groups. For example, a recent text based on this model devotes numerous chapters to describing information on ethnic groups (Lattanzi & Purnell, 2006). This approach seems to foster beliefs that social-cultural group characteristics are static versus dynamic.

Burchum (2002) and Suh (2004) conducted concept analyses of cultural competence using Rodgers' (2000) evolutionary method of analyzing the literature to create models. The Rodgers' evolutionary method of concept analysis is an approach,

primarily used in nursing, to study the variable nature and context-dependent features of concepts. The approach begins with the selection of a concept and analyzing a sample of the literature on the topic. For example, in Suh's study 124 articles and 21 books on culture competence were analyzed to develop a conceptual model. The researcher then inductively identifies a set of attributes for the concept, paying careful attention to historical context. Once the attributes have been identified, the researcher finds an exemplar in real life that will help communicate the results. Both Burchum's (2002) and Suh's (2004) cultural competence models adopted concepts from Campinha-Bacote's model including envisioning cultural competence development as an ongoing process, and identified cultural awareness, cultural knowledge, and cultural skill as key dimensions. The use of concepts from Campinha-Bacote's model was incorporated because of their widespread acceptance in the nursing literature. However, Suh's (2004) cultural competence model is unique in how it envisions cultural competence as a construct with attributes, antecedents, and consequences. Suh sees developing cultural competence as a process that requires specific ability to care for diverse populations; openness to cultural attributes in terms of acceptance, respect, and being broadminded; and flexibility to adjust to those attributes, both differences and similarities. Antecedents of cultural competence are grouped according to cognitive domain (cultural awareness, cultural knowledge), affective domain (cultural sensitivity), behavioral domain (cultural skills), and environmental domain (cultural encounters). Finally, cultural competence is seen as having consequences from three standpoints: receiver-based (patient) variables like quality of life; provider-based personal and professional growth variables; and health outcome

variables such as treatment or cost effectiveness. The author advocates that the model provides a practical guide to develop strategies for culturally competent care by offering insight on the cognitive, affective, behavioral and environmental domains that are antecedents of cultural competence. Furthermore, three different domains of outcomes of culturally competent care can be examined in fields such as physical therapy. Both Burchum's (2002) and Suh's (2004) models positively describe cultural competence development as being less linear and with greater linkages between components. Like previous models discussed there is lack of emphasis on how health care professional, health system, and patient interactions may affect the provision of culturally competent care, especially when power imbalances are high in relationship dynamics.

Summary

To date the development of cultural competence has been modeled as primarily a six-stage developmental continuum, or as a component/domain oriented construct that focuses on knowledge, attitude and skill acquisition of the individual health care practitioner. There has been a tendency for models to be grounded in rationality and the belief that culture competency is something to be learned by individual practitioners and tested for evidence of its mastery (Taylor et al., 2006). Lacking in the current cultural competence models is more focused attention on how health care providers' might make sense of personal experiences and be able to narrate how their cultural lens have been shaped. Practitioners ought to be encouraged to examine how their cultural lens has been learned through families, educational experiences, religion, and social relationships in health care institution or community

settings (Wear, 2006b). Given that sociocultural theory focuses on the social and cultural factors that mediate learning in particular contexts, the theory was used for interpreting the life stories of PTs in relation to discourses about relationships and cultural humility. Past cultural competence models also have not focused on the political nature of culture and the analysis of power and privilege to a great degree. The insurgent multiculturalism theoretical lens offered a critical research perspective in the investigation for examining how PTs attend to or resist facing issues of power and privilege in relationships in healthcare settings. The following sections provide an overview of how sociocultural and insurgent multiculturalism theories contributed to the conceptual framework for the study.

Sociocultural Theory: Perspectives on Learning Relationship-Center Care, including Development of Cultural Humility

Introduction

Three key principles of sociocultural theory that have implications for learning RCC and exploring the development of cultural humility will be discussed in the following section. The core ideas include: 1. Learning to be an effective health care provider of cross-cultural care is likely heavily dependent on continuous interaction with other people in health care organizational settings and the community. 2. Cultural practices or activities are an important unit of analysis for understanding how individual engagement in activity affects development on multiple contextual planes simultaneously. In health care there is a need to explore how the sociocultural history of different key settings (educational programs, clinical education sites, and professional work environments) mediate the process of development of cultural humility by either facilitating or inhibiting the use of cultural

tools (conceptual or practical) to build and transform relationships. 3. Learning and development in a clinical encounter in a micro-environment (*e.g.,* physical therapy department) at the individual level is likely closely linked to changes in larger contexts (*e.g.*, institutional, community and global) at the historical/societal level.

Sociocultural theory can be traced to the seminal work in the early 1900s of Lev Semyonovitch Vygotsky, a soviet psychologist. Vygotsky believed that understanding children as learners must occur in a framework that analyzes social and cultural contexts to discover how higher mental functions are developed (Rogoff, 2003; Thorne, 2005). In comparison to cognitive theories of learning, such as Piaget's, which focus on individualistic development, sociocultural theory views people as cultural and historical beings (Wertsch, del Rio, & Alvarez, 1995; Renshaw, 2003). Sociocultural approaches see the learner's development, child or adult, influenced by a matrix of social relationships and processes (Renshaw, 2003). Learning is thus seen as an ongoing process where the evolving nature of social interactions and types of participation in activities shape development of different ways of thinking, feeling, and behaving.

There exists quite an extensive literature on sociocultural theory and learning, thus there is a need to outline key characteristics. Over the years a range of Vygotsky-inspired approaches have developed under labels such as sociocultural, cultural-historical, cultural-historical activity theory (CHAT), neo-Vygotskyian, and situative theories. Cole and Engeström (1995), Hatano and Wertsch (2001), and Nasir and Hand (2006) have emphasized that theories within the family of sociocultural approaches commonly share several characteristics to varying degrees. The key

characteristics or principles include: 1. Learning is heavily dependent on continuous interaction with other people and "mediational means" or "cultural tools" as individuals participate in cultural practices or activities. 2. Cultural practices or activities are an important unit of analysis for understanding how individual engagement in activity affects development on multiple contextual planes simultaneously. For example, Rogoff (1995) has focused on development within cultural practices on three social interactional levels-personal, interpersonal and community/institutional planes. 3. Learning and development in a micro-environment at the individual level is closely linked to changes in larger contexts (community and global) at the historical/societal level.

Learning as Shifts in Social Roles and Relationships within a Community of Practice or Complex Activity System

A key claim of sociocultural theory is that the learner is only one component of a more complex activity system (Engeström, 2000; McDonald, 2005; Bleakley, 2006). This principle was borrowed from the anthropological tradition. However, Alexei Leont'ev, a colleague and follower of Vygotsky, is credited with first articulating, from a psychological perspective, that activity mediates human thought and development (Engeström, 2001; Nasir & Hand, 2006). Contemporary activity theorists such as Yrjö Engeström have expanded on Leont'ev's ideas by creating models that not only focus on local activity, but also consider networks of interacting activity systems and broader macrocontexts (Engeström, 2001; Engeström, Engeström, & Kerosuo et al., 2003).

Thus from a sociocultural theory lens, research on development of cultural humility needs to be situated within interconnected activity systems. For example, a

patient's family unit, peers on a rehabilitation team (physician, physical therapist, occupational therapist, speech pathologist, social worker), and leaders in hospital administration may all be parts of interacting activity systems that influence how a PT delivers care to an individual from a background different from their own. Thus, based on activity theory, PTs' opportunities to learn how to be effective providers of cross-cultural care are context bound in the educational programs, teams, health care institutions, and communities in which they study or work. For example, one can envision how social interactions within a health care team may shape the set of tools a PT adopts for making sense of cultural differences in their professional practice. These tools may include ways of communicating or conventions for mediating conflicts. Overall, learning to provide culturally competent care from a sociocultural perspective is thought to be deeply embedded in the interactions among people (e.g. patient-physical therapist, physical therapist-physical therapist, and physical therapist-clinician from different professional fields) whose lives intersect in activity systems.

Cultural Practices and Development on Multiple Contextual Planes

Rogoff (1990, 1995, 2003) has advanced sociocultural development approaches by explaining that one can envision learning occurring on three contextual planes: personal, interpersonal/social, and community/cultural. The personal plane has been the focus of most learning theory approaches in education and incorporates studying constructs such as cognition, emotion, behavior, and beliefs (Rogoff, 1995; Monkman, MacGillivray, & Leyva, 2003). The interpersonal/social plane takes into account the changing patterns of engagement with other people in collective activities

and social practices, rather than concentrating on developmental changes that occur within the individual (Rogoff, 1995; Lim & Renshaw, 2001; Monkman, MacGillivray, & Leyva, 2003). The community/cultural plane includes home, family, community, sociopolitical, and socioeconomic spheres of influence (Rogoff, 1995; Monkman, MacGillivray, & Leyva, 2003). Although the word *community* commonly engenders thoughts of inclusion and harmony, often learning in community contexts is discomforting as cultural discourses challenge us to look at how people battle for power and prestige (Renshaw, 2003).

Appropriation: Adopting Conceptual and Practical Tools

Sociocultural theory offers the concept of *appropriation* (Grossman, Smagorinsky, & Valencia, 1999) or *participatory appropriation* (Rogoff, 1995) as a way to understand how learners adopt principles and patterns of behavior in the personal plane as a result of activity system interactions. Appropriation refers to the process through which a person, for example a PT, adopts tools for use in practice. Grossman and colleagues (1999) defined two types of pedagogical tools for teachers, conceptual and practical, which have application for professional development of PTs. Conceptual tools are ideologies, frameworks and thoughts about teaching and learning that professionals use as guides to make decisions (Grossman, Smagorinsky, & Valencia, 1999, p. 14). Practical tools are specific strategies and resources that have more specific utility (Grossman, Smagorinsky, & Valencia, 1999, p. 14).

Appropriation can take place in varying degrees (Grossman, Smagorinsky, & Valencia, 1999; McDonald, 2005). Levels of appropriation may range from lack of appropriation, to more superficial understanding of features of a tool, to grasping and

mastering the conceptual underpinnings. For instance, a PT might not always appropriate a conceptual tool such as an informed choice communication framework. Informed choice communication frameworks are valued in physical therapy for collaborative goal-setting and treatment decisions (Bainbridge & Harris, 2005). A PT might understand the concept of informed choice, yet may have a bias regarding how adherent an immigrant worker, for example, might be to an exercise program. Thus, the practitioner may not take the time to discover the patient's values and beliefs through practical tools (listening skills, use of an interpreter), to provide the patient intervention options, or to agree on a treatment action plan. The overall outcome being lack of informed shared decision-making. In contrast, a physical therapist who internalizes the informed choice communication framework would have genuine respect for the patient's values, including use of effective communication strategies to explore the patient's ideas regarding why an injury may have occurred, concerns, and expectations. The clinician would then demonstrate an ability to negotiate a treatment action plan even if the therapist's and patient's cultural worldviews are very different.

Role of Social Interactions with Others on Interpersonal Plane for Learning

Sociocultural theory has long considered more experienced members of a culture as key to facilitating learning for more novice learners (Vygotsky, 1978; Rogoff, 1990). Several concepts have been advocated to elucidate how enculturation may foster learning on the interpersonal plane. The concept of the zone of proximal development (ZPD) was applied first to learning and development in children (Vygotsky, 1978), however is also applicable to development of professionals (Lim & Renshaw, 2001; McDonald, 2005). Vygotsky originally defined the ZPD as a

dynamic space of sensitivity to learning the skills of a culture which is slightly beyond the current level of the learner (Vygotsky, 1978). In this region the "student" develops through participation in problem solving with the assistance of more capable members of the culture (Vygotsky, 1978; Rogoff, 1990). For example, more experienced members of the culture may be a parent, teacher, professional mentor, patient, or more skilled peer. Several concepts have been advanced in the literature to describe how a more proficient person in the culture can guide the process of learning including *scaffolding* (Wood & Wood, 1996; Gonzalez, Andrade, Civil, & Moll, 2001) and *guided participation* (Rogoff, 1990; 2003) of more novice participants. In this study sociocultural theory served as a lens to explore how practitioners interact with patients, mentors, other clinicians, and the communities they serve to develop relationships that promote overcoming disparities in health care.

Learning and the Community/cultural plane:

The development of cultural humility also needs to be viewed from the community or cultural plane. Analysis at this level from a health care perspective fosters exploring how the histories, values, and beliefs of medical institutions, professions, and the cultural communities of patients affect how cultural humility is learned or enacted. For example, medical education programs historically have been based on the biomedical model which has privileged technical competence over sociocultural competence (Howe, 2002; Taylor, 2003). Since ideologies based on the biomedical model have predominated in health professional education programs and health care institutions for so long, there is a need to see how this manifests in interactions and perceptions. Furthermore, there is a corresponding need to examine if

new curriculum frameworks and pedagogical strategies designed to foster the sociocultural dimensions of care are actually being put into practice and reducing health care disparities (Betancourt, 2003; Cooper et al., 2006; Price et al., 2006). For instance, are physical therapists incorporating conceptual and practical tools to understand a patient's multiple communities formed by local neighborhoods, migration affiliations, work groups, and other circumstances to offer the best care (Beach et al., 2006; Koehn & Swick, 2006)?

Although an emphasis on analyzing learning at the community plane is an attribute of sociocultural theory, a proposed limitation of the theory has been the relative lack of emphasis on the political nature of culture (McDonald, 2005; Nasir & Hand, 2006). Health care professionals may not realize how patients and communities feel inhibited from developing partnerships and trusting relationships with them when there is lack of feelings of political empowerment or community control (Cooper et al, 2006; Wear, 2003). Thus, concepts based more on critical theory perspectives, such as *cultural humility* and *insurgent multiculturalism*, provide additional perspectives on how power and privilege may contribute to health care disparities.

Linking Learning and Development at Micro- (local) and Macro- (community/global) Levels:

Although learning from a sociocultural theory lens can be understood as occurring on three contextual planes, theorists have stressed that these planes or levels influence and mediate each other (Nasir & Hand, 2006; Rogoff, 1995, 2003). Thus, sociocultural theory has the potential to fill a shortcoming of previous theoretical approaches utilized to explore the development of cultural humility that

have primarily looked at learning in the personal plane. Sociocultural theory perspectives may help elucidate how patients, practitioners, other clinicians, health system, and community interactions affect the provision of culturally sensitive care.

Summary

Overall, from a sociocultural theory perspective health care practitioners can be viewed as cultural and historical beings, and learning to address cultural issues in relationships is an ongoing social process linked to a web of shifting roles and interactions in health care and community settings. This life history study examined how PTs make sense of life experiences at three levels of interaction—personal, interpersonal, and community/cultural—in addressing cultural differences in health care. This study focused on how self-aware PTs are of their own background, attitudes, and values and whether critical reflection on their own cultural experiences reveals an ongoing willingness to address power imbalances in relationships. In a future study that would be conducted over several years I would like to use a critical ethnographic approach that would use a combination of data collections methods (interviews, participation observation, and document analysis) and include patients, health care providers, and community members to examine development of cultural humility from an activity system standpoint.

Insurgent Multiculturalism: Critical Study of Culture to Enhance Relationships

The most common critique of cultural competency is that its approaches are seldom concerned with systems of oppression (Giroux, 2000; Sleeter, 2000; Wear, 2006b). Critical theorists have emphasized that multicultural studies and cultural competency approaches consistently have emphasized individual attitudes of

practitioners and have kept the focus off the sources of inequality (Giroux, 2000; Kumas-Tan et al., 2007; Williams, 2006). Wear (2003) introduced the insurgent multiculturalism theoretical lens to medical education based on the writings of Giroux. Insurgent multiculturalism moves beyond being learning in a rational way about nondominant groups in terms of "their" characteristics, beliefs, or behaviors (Wear, 2003, p. 553). Instead, insurgent multiculturalism requires practitioners to reflect critically on how their own biases, and prejudices, as well social oppression in all its varieties lead to unequal distributions of power and disparities in care (Giroux, 2000; Wear, 2003).

Giroux (2000) argues that most multiculturalism approaches have kept the focus off race-, gender-, and class-based biases; institutional norms; and government policies by limiting discussion to individual attitudes. Giroux further emphasizes in the *insurgent multiculturalism approach* that providers of care should not limit themselves to spending time gaining knowledge about a "laundry list" of racial/ethnic/religious or other cultural differences and then be evaluated for cultural competence by matching traits to groups. Instead, there is need to promote reflection on the foundation of inequalities within health care and health professional education in the US (Wear & Kuczewski, 2004).

Insurgent Multiculturalism and the "Pedagogy of Discomfort"

For example, Delese Wear and Julie Aultman have recently adopted Megan Boler's "pedagogy of discomfort" (Boler, 1999), as a pedagogy of practice, as an alternative curricular approach to medical education curriculum that often uses a trait approach to cultural competency (Aultman, 2005; Wear & Aultman, 2005, 2007).

Boler's "pedagogy of discomfort" encourages learners to examine their values and beliefs regarding topics such as sexual identity, nontraditional family values, and racism. A central focus of this critical inquiry approach as applied to relationships in health care is to recognize how a health care provider's unspoken, unacknowledged, and often unknown race-, gender-, religious-, or class-based biases help contribute to barriers that affect the health and well-being of patients and families. Through self-reflection it is advocated that health practitioners can bring to conscious cognitive space the multiple contexts and life roles, past and current, that influence their learning and their behavior (Murray-Garcia, Harrell, Garcia, Gizzi, & Simms-Mackey, 2005, p. 694). Aultman (2005) advocates that Boler's pedagogy of discomfort may allow health professional students, educators, and practitioners to critically think about the different beliefs and values held by themselves and persons they interact within health care, especially patients. Overall, the intention of the pedagogy of discomfort, a pedagogy of practice, is to help professionals see themselves as situated individuals who have social and economic location that influences every relationship (Wear & Kuczewski, 2004, p. 8). The proponents of the pedagogy of discomfort believe the approach can be transformative if professionals' critical reflection adds meaning to experiences and they are willing to step out of their comfort zones to confront biases and privilege (Aultman, 2005; Boler & Zembylas, 2003; Wear & Aultman, 2005, 2007). In this study concepts from the pedagogy of discomfort, such as intense introspection, self-exploration, moral development, learning through emotional dialogue, and willingness to confront privilege were utilized in examining what meaning PTs' ascribe to their life experiences.

Development of Cultural Humility in Physical Therapists: Limited Research

Although there is a growing body of literature addressing the need for health practitioners, including PTs, to be able to grapple with the complexities of social and cultural differences within relationships in practice, there is a lack of understanding regarding what types of life experiences foster the development of cultural humility. Although discussion about incorporating culture into practice has been considerable, research on this topic and on PTs' experiences have been limited. Five studies have examined cultural education learning issues in physical therapist students or physical therapist educational programs (Hilliard, Rathsack, Brannigan, & Sander, 2008; Ekelman, Bello-Haas, Bazyk, & Bazyk, 2003; Kraemer, 2001; Romanello, 2007; Wong & Blissett, 2007), however no published investigations have explored the experiences of physical therapists in addressing cultural differences in clinical practice.

Kraemer (2001) used a qualitative case study design to investigate the perceptions of students during clinical experiences regarding how prepared they perceived themselves to be in providing cross-cultural care. Kraemer used a sample population of twelve students from a mid-Atlantic university. The results of the investigation demonstrated that the participants reported feeling somewhat prepared to make exercise-related modifications in cross-cultural clinical situations. However, the study findings revealed that the students felt they were a lacking in: 1) clinical preparation to interact with diverse patients in conducting initial evaluations and making treatment decisions; 2) awareness of barriers, conflicts, and resolution

methods for cultural clashes in the patient-provider relationship; and 3) available cross-cultural resources in the clinical environment.

Contemporary educational theory advocates that experiential learning promotes professional knowledge and skill acquisition through the transformation of experience, critical thinking, problem solving, and reflective interpretation of practice (Maudsley & Strivens, 2000). Using this principle, Ekelman and colleagues (2003) described cultural skill development of five physical and occupational therapy students who accompanied faculty on a 1-week immersion experience to a Mayan village in southern Belize. A qualitative analysis of data from student journals and reflections, and transcription of a videotape discussing the experience was used to develop the themes that described the students' experiences. Reflection during and following this cultural encounter was a main theme that enabled the students to understand their experience and apply new perceptions to patient care.

Romanello (2007) studied the integration of cultural competence in one physical therapist education program throughout its curriculum using an ethnographic, qualitative design. Data collection methods included document analysis, individual faculty interviews, student group interviews, classroom activity observations, and outside class activity observations. The physical therapist program studied integrated cultural competence into the curriculum by: 1) developing a strategic plan where faculty members were committed to recruiting students from multicultural backgrounds; 2) immersing faculty and students in treating patients from diverse societal groups during clinical rotations; 3) using cases, media, and teaching methods to raise diversity to a conscious level; and 4) incorporating

reflection and dialogue into activities that allowed learners to discover their own values and beliefs, as well as those of others.

In order to give students feedback on their reflections, Wong & Blissett (2007) recently reported the inter-rater reliability of an ordinal scale to assess physical therapist student behavior in cultural interactions as revealed in reflective student writing documents. To assess the reflective writing documents the investigators used a coding and ranking system based on the Continuum of Cultural Competence (CCC) described by Cross et al. (1999), which has six levels of cultural competence (destructiveness, ineffectiveness, neutrality, pre-cultural competence, cultural competence, and cultural proficiency). A weighted kappa value was calculated to assess the reliability of the two raters using the CCC to assess 152 reflective writing samples from 23 students. A weighted kappa value of 0.77 was reported, indicating substantial agreement (Wong & Blissett, 2007). Further research is needed to determine if this type of a rating approach is valid and to explore how students and practitioners derive meaning from experiences in greater depth.

In a recent study, my colleagues and I (Hilliard et al., 2008) explored the development of cultural competence in 14 physical therapist students during their final, 23 weeks of clinical education experiences. A mixed methods design was used to quantitatively measure and qualitatively describe cultural adaptability as an indicator of cultural competence. Cultural adaptability was described as having four dimensions: 1) Emotional resilience (the degree to which an individual can rebound and react positively to new experiences); 2) Flexibility/ openness (the enjoyment of different ways of thinking and behaving; 3) Perceptual acuity (the extent to which a

person pays attention to and accurately perceives various aspects of the environment); and 4) Personal Autonomy (the extent to which an individual has evolved a personal system of values and beliefs while at the same time respects others and their value systems). Subjects completed the Cross-Cultural Adaptability Inventory (CCAI ™) at the end of their didactic curriculum and again at the end of their clinical education experiences. Constant comparative methods were used to analyze written narrative summaries of how students made meaning of their cultural encounters. The students exhibited statistically significant changes in the total CCAI score (paired t-test: $p < 0.001$), and three CCAI ™ subscales: emotional resilience (paired t-test: $p < 0.002$), flexibility/openness (paired t-test: $p < 0.003$), and perceptual acuity (paired t-test: $p < 0.001$). There was not a statistically significant change in the fourth CCAI ™ subscale, personal autonomy. Qualitatively, four themes emerged that described students' cultural encounters with patients, families, and co-workers: recognizing cultural descriptors such as religious or social group affiliation (musician, war veteran, and mafia member) that could shape health beliefs or behaviors; consideration of feelings, values, attitudes and beliefs; effective communication to break down barriers; and awareness of strategies for current and future cross-cultural practice. Changes in attitude appeared to be key in effective cultural encounters as students learn to communicate and connect with anyone perceived to be different from them.

The limited physical therapy literature to date on development of cultural humility promotes use of experiential learning and incorporating reflection and discussion into educational activities to allow learners to discover their own values

and beliefs, as well as those of patients and co-workers. Further investigation is needed to look at the development of cultural humility from the perspectives of physical therapists, patients, and other community stakeholders. There is also a lack of research studies in physical therapy, as well as other health professions, that explore how health care providers accept or resist facing issues of privilege and power in relationships with patients, colleagues, communities, and themselves

Culture, Cultural Humility, and Power Meanings in Conceptual Framework

From reviewing the literature and my own experiences, conceptualizing what is culture, cultural humility, and power is an ever evolving challenge for professionals in education and medicine. Although there are many definitions of culture, culture in this study was seen as the composite of values, beliefs, and experiences that create a meaning system for persons to understand themselves, each other, and the world (Levinson, 2000, p. 4). The cultural meaning system is not static, however; it is constantly being renegotiated and constructed as persons interact with other individuals in contexts such as schools (Eisenhart, 2000; Gonzalez, 2004; Levinson, 2000; Spindler & Spindler, 1994) and health care settings (Koehn & Swick, 2006; Taylor et al., 2006).

In this study I used RCC, sociocultural, and insurgent multiculturalism perspectives to examine how PTs' life experiences shape the development of cultural humility. This study utilized Tervalon's and Murray-Garcia's (1998) definition of cultural humility which involves health professionals being actively engaged in a lifelong process with patients, colleagues, communities, and themselves to make sense of the complexities of social and culture differences within relationships in

practice. The life long process requires humility and a commitment to: self-assessment, addressing the power imbalances in the patient-health practitioner dynamic, and developing mutually beneficial partnerships with communities on behalf of individuals and defined populations (Tervalon & Murray-Garcia, 1998, p.118).

Power is a theme in the RCC model in health care, the insurgent multiculturalism theoretical lens, and qualitative research conceptual foundations. Both the RCC and insurgent multiculturalism approaches advocate that health care professionals recognize and address power imbalances in relationships (Cooper et al., 2005; Wear, 2003). Harvey's definition of relationship power was utilized in the study to consider how power is controlled or shared by PTs in interpersonal relationships and how power is organized institutionally and influences how PTs carry out their work. Harvey has described relationship power as,

> Society is not composed of individual, isolated lives and life situations, but a vast network of relationships, some consolidated into institutions big and small, some on a more intimate level, and the advantages of the socially privileged include power over other people in various relationships (Harvey, 2000, p. 181).

Power imbalances from an insurgent multiculturalism theoretical lens are explicitly linked to social privilege, as well as oppressive structures and practices (Giroux, 2000; Wear, 2003). From an insurgent multiculturalism viewpoint the influences of racism, classism, xenophobia, or any other belief system that can be linked to undesirable attitudes, beliefs, and behaviors in healthcare ought to be a focus for a critical approach to cultural competency (Wear, 2006b). In this investigation I adopted Wear's insurgent multiculturalism stance, which has been influenced by

feminist conceptualizations of culture (Wear, 2003; Wear, 2006 a, Wear, 2008). Her approach values the use of narrative inquiry to study the development of cultural humility, including willingness to critically reflect on one's own culture, privileges, and biases (Wear, 2008). Similar to the point of view of Wear, I believe that through the everyday experiences of clinicians and patients embedded in life histories and narrative accounts, personal worldviews and institutional practices that influence how power is shared can be examined. There is a lack of literature to date that explores PTs' perspectives on development of cultural humility. The life history study adds new perspectives to the literature with implications for education and medical practice on how PTs, a profession of primarily women, attend to or resist facing issues of privilege and power in relationships with patients, colleagues, communities, and themselves.

In reviewing the literature on RCC and insurgent multiculturalism, however, there is limited discussion on how power can be utilized in productive ways. Thus, I further explored the literature to understand how different conceptions of power might inform the study. From the Foucauldian perspective the complex ways that power and ideology can permeate society and social practices and create power imbalances is a major concern of discourse analysis (Foucault, 1982; Freshwater, 2007). Discourse is a term used to represent a set of values, ideologies, and taken-for-granted ways of understanding relationships, activities, and meanings about how the world works (Mortenson & Dyck, 2006; Luttrell, 2003). Foucault's theoretical perspectives have fostered the idea that the concept of discourse can be used to counter the positivist and scientific claims to truth and to identify mechanisms

whereby some versions of the "truth" come to be accepted and other versions are marginalized and discarded (Holstein & Gubrium, 2005; Freshwater, 2007). Foucault has described how the use of expert knowledge by figures of authority, such as physicians, has led to biomedical oriented options seeming to be the only possible health care choice for patient care (Holstein & Gubrium, 2005). Proponents of the Foucauldian perspective, however, also emphasize that use of power can have productive effects when persons contest dominant discourses and expert knowledge, and instead look at other possibilities for modes of action (Mortenson & Dyck, 2006; Simon, 1992). For example, Canales (2000), a nursing scholar, has advocated that power within relationships can be conceptualized as both exclusionary and inclusionary processes from her grounded theory study exploring the teaching and clinical practices of a group of Latina nurse educators. She defines a process that uses power within relationships for domination and subordination as exclusionary (Canales, 2000, p. 19). In contrast, Canales' describes a process that utilizes power within relationships for transformation, mutual empowerment, and coalition building as inclusionary (Canales, 2000, p. 25). Drawing from Foucault's view of power, attention was given in the study to the discourses guiding PTs' approaches to care, and whether their life histories provide examples for the inclusionary, productive use of power.

Summary of Literature Review

Several areas of literature provided important insights for an inquiry into the development of cultural humility in physical therapists. The initial conceptual framework based on RCC, sociocultural, and insurgent multiculturalism theories

guided the investigation. Sociocultural theory was useful in envisioning how life experiences prior to professional education, professional education, and relationship-centered learning in clinical practice mediated physical therapists' development of cultural humility. Sociocultural theory helped frame how learning in different contexts (home, educational environments, clinical practice, and community) fostered the process of meaning making (Lim & Renshaw, 2001). Sociocultural theory does not, however, provide a theoretical framework for development of cultural humility from a social justice perspective that empowers individuals to address health care disparities. Therefore, the insurgent multiculturalism theory provided an additional perspective to the study to explore whether critical reflection on their own cultural experiences, as well as the contexts of those experiences, reveals an ongoing willingness by PTs to address power imbalances in relationships.

Physical therapists (PTs) in clinical practice provided an emic or insider's perspective (Denzin & Lincoln, 2005) in this study to allow for an in-depth contextualized understanding of how physical therapists' experiences influence the development of cultural humility. A qualitative, interpretive approach provided a methodology for the intended aims of the study. Practitioners bring distinct life histories to practice environments. The meanings clinicians' derive from experiences along their life paths shapes the lens through which they view each clinical and community interaction as cultural encounters (Clandinin & Cave, 2008). To date there has been a lack of studies in health care using a life history approach to explore how practitioners' experiences and the contexts that shape those experiences contribute to the ongoing process of developing cultural humility.

CHAPTER 3. METHODOLOGY

> *A narrative approach, one that develops understandings from an experiential perspective, evolves from ongoing, negotiated constructions of understanding between researcher and participants, honors the histories of participants and the communities in which they live and work, and is philosophically compatible with multiculturalism. (*Phillion, 2002, p. 23)

Introduction to Design of Study

This study used a qualitative, narrative life history approach to explore the development of cultural humility based on the personal and professional experiences of physical therapy practitioners. At the core of qualitative research is an interest in the interpretive understanding of a topic in the complex, social world through the point of view of the individual or population being studied (Creswell, 2007; Maxwell, 1996). From this perspective all research is value bound and each participant and researcher interprets reality differently based on the context of past experiences (Denzin & Lincoln, 2005; Schram, 2003). Thus, if one is to understand actions and ideas in the social world it is essential to explore phenomena with sensitivity to context (Carpenter, 1997; Schram, 2003). In this study eight PTs in clinical practice provided an emic or insider's perspective (Denzin & Lincoln, 2005) to allow for an in-depth contextualized understanding of how physical therapists' life experiences affect the development of cultural humility.

The research questions and the theoretical perspectives framing the investigation led to choosing the life history approach as the most appropriate qualitative approach for inquiry. Narrative inquiry, although encompassing a variety of analytic lenses and diverse disciplinary approaches, focuses on a storyline and, as such, fits life history research well (Chase, 2005; Creswell, 2007). A narrative is an

oral or written story of something or someone, a series of events useful for comprehending human experiences in culture and in time (Chase, 2005; Wear & Castellani, 1999; Wicks & Whiteford, 2006). Investigators who have turned to narrative inquiry to conduct research in medicine and education have emphasized that narratives are the basic mode through which persons communicate, think, and make experience meaningful (Charon, 2006; Clandinin & Cave, 2008; Clandinin & Connelly, 2000).

A life history approach is a particular type of narrative inquiry that uses life stories to enhance understanding of the past and present contextual influences on how persons develop relationships based on their experiences at different stages of their life course (Goodson, 2003). Life history research focuses on individuals' understanding and recollection of experiences to make sense of earlier events in their lives that had a substantial influence on their development (Chase, 2005; Kouritizin, 1999). It is not the experiences themselves that are of greatest importance, but the participants' understandings of the experiences, and their later impact on how one acts (Phillion, 2002). The distinction between life history and life story is critical to this study. Exploring PTs' cultural backgrounds, privileges, and biases involves accounting for historical context (Coles & Knowles, 2000; Goodson & Sikes, 2001).

The life history moves beyond the personal life story. It instead seeks to embed the personal story within institutional contexts and struggles for power (Goodson & Sikes, 2001). The historical context is vital to life history accounts because historical events and trends are what shape the culture and social relationships with which one identifies. Rarely are PT practitioners allowed to speak

for themselves when it comes to improving health care or physical therapy education. The life history strategy in this study sought to listen to the voice of PTs in clinical practice, versus relying on outside sources of information to explore the personal nature of addressing cultural differences and building relationships in health care settings. Perhaps as PTs begin to acknowledge the interaction between their cultural backgrounds and the productive use of power in practice, educators and policymakers in health care can approach the topic of developing cultural humility more thoughtfully, instead of dismissing the topic as having negligible impact on professional development, patient outcomes, or health care disparities in communities.

Deciding to explore the development of cultural humility and analyze the life histories of PTs most likely emerged out of my own desire to understand this process in myself. I agree with qualitative researcher scholars like Lather (1992) and Luttrell (2000, 2003), that as a researcher I cannot eliminate my particular theoretical and cultural frameworks in shaping the design of the investigation or interpreting findings, but I can and ought to locate my history, values, and assumptions.

Researcher Reflexivity or Critical Subjectivity

A major issue confronting the researcher doing qualitative research is reflexivity, the process of critically reflecting on the self as researcher and how one's experience shapes the research design, data collection, analysis, and dissemination of findings (Maxwell, 1996; Luttrell, 2000; Olesen, 2005). As a physical therapist and educator, I have my own professional and personal experiences that equip me with perspectives and insights that shape the research process. I agree with feminist

scholars such as Bloom (1998) and Lather (1992) that my perspectives and subjective lenses as a researcher, as well as the perspectives of the participants will be part of the context of the findings. The following section is a brief personal biography to outline my positionality.

Personal Biography and Positionality

Early Family Life, School, and Community Experiences

I grew up on a dairy farm in a predominantly white community in the midwest, where my racial and class privileges invisibly fostered my educational experiences and social relationships. Growing up with two nurturing parents, two sisters, two brothers, and a grandmother in our household provided a rich environment for me to develop. I feel I was very blessed to grow up in an intergenerational family setting. My grandmother lived in our home through my early adulthood. Through her words and actions she was influential in instilling a sense of responsibility to help one's neighbor. For example, family friends still tell stories of her compassion and acts of kindness to neighboring families during the polio epidemic. I suspect my love for working with patients who are older adults stems to a great extent from my positive life experiences with my grandmother.

I learned about the concepts of experiential learning, teamwork, and resilience from my parents and siblings at an early age. Being the fourth of five siblings and the youngest daughter, my parents seemed comfortable letting me define my interests in such areas as science, music, and sports. Teamwork was highly valued in doing household and farm chores. Resilience was modeled and valued from examples set by my parents. My mother had to face working to support herself at a very young age

after suffering the loss of her father to death at the age of eight and her mom at the age 17. My father and our whole family persevered through a series of health challenges that he faced with seven surgeries and rehabilitation over the course of my developmental years. My parents exhibited amazing hope and were driven to provide a nurturing environment for me and my four siblings even when faced with adversity.

I attended school from K-12 grades in a rural midwest school district. All students in the district were on the same campus. The region's citizens and my classmates were primarily mono-racially white, middle-class, and Christian. I sensed difference most distinctly between myself and several of my classmates whose religion and lifestyle were affiliated with the Amish tradition. I did not perceive there were attitudes of prejudice or discriminatory behaviors occurring towards my Amish friends, however I was puzzled when in the 5th grade members of the Amish community decided to build their own school.

I was privileged to a great extent in the classroom because of an aptitude for Math and Science. I was provided opportunities to participate in Math/Science Fairs and College Preparatory State Retreats. Historically, the passage of Title IX legislation in 1972 gave me opportunities in academics and athletics that were not available to my older sisters.

In my view, a positive sense of community has major educational consequences. In addition to being involved in numerous school activities, I was also involved as an active member of 4-H and church youth organizations. These youth organizations had community service programs to reach out to older adults in the community and persons with mental health problems. In these community

experiences and in interacting with an uncle who was cognitively disabled, I started to grapple with the stigma placed on individuals in our society who cognitively and behaviorally don't fit the idealized norm.

Current Family Life Influences

My interest in cultural humility became more marked as my now husband and I dated for several years and got married in 2005. My husband's racial and ethnic background is multiracial, and he identifies himself as a Black man. When we started to date I was awakened to my White privilege and the hurt that racism can cause. My husband is passionate for social justice as a lawyer in the Illinois court system. As our relationship has grown, I too believe I have become more committed to being a social justice oriented health care provider, educator, and researcher.

Early Professional Education and Career Developmental Experiences

At 18 years old, I began my undergraduate college experience at a large, public midwestern University. Although I grew up in a fairly homogeneous cultural climate in terms of race, ethnicity, religion, and class, when arriving on campus I was interacting on a daily basis with individuals from different cultural backgrounds. During my entry-level physical therapist education from 1979-1981 I feel I learned to consider a patient's cultural background primarily from clinical education experiences with patients, versus having cultural issues addressed in the classroom curriculum. Overall, my perception is that I learned more about multiculturalism and diversity from informal interactions with friends versus formal learning during my undergraduate years.

In my first professional position I served as a PT at a Rehabilitation Center in a mid-sized city in the midwest. I provided treatment services primarily to persons who had neurological dysfunction from strokes, head injuries, spinal cord injuries, and cancer. This period of life was characterized by patient-centered learning and informal learning from peers/friends. There were definitely many experiences which caused cognitive and emotional dissonance as I realized my values and belief systems were sometimes different from my patients or colleagues. I became more aware of the need to respect different lifestyle choices. At this stage in my professional development I was beginning to develop cultural humility by understanding my own cultural background. I was not very attuned to sexism or racism.

After about four years in practice I decided to pursue a Master's degree. I was challenged to develop my critical thinking regarding scientific and psychosocial issues in graduate school. I became engrossed in trying to better understand the nervous system and movement control based on the questions that continued to arise as I treated patients in a university hospital setting. During this time I also served as a teaching assistant for physical therapist students in neuroanatomy and clinical courses. Unfortunately, during graduate school I witnessed discriminatory acts based on sexual orientation in faculty-administration relations that were discomforting, yet critical for me to become more attuned to sexism.

Mid Life and Mid Career Professional Developmental Experiences

After completing my Master's Degree I next ventured professionally to serve as a research physical therapist and supervisor of a biomechanics laboratory in a large, not for profit health care institution which cares for persons from the midwest

region, as well as national and international locales. My leadership philosophies started to develop during this phase of my career, including valuing the benefit of having a staff from diverse backgrounds. My teaching responsibilities in this setting included instruction of physical therapy and medical students, as well as training post-doctoral fellows from a number of countries from fields such as Orthopedics, Bioengineering, and Physical Medicine and Rehabilitation. Definitely there were challenges at times in being a female in the male dominated field of biomechanics research, while previously I had worked primarily in settings where there was more opportunity for mentorship by women.

My current professional role is teaching in an entry-level professional doctorate program in a private, urban, midwest university. I consider it a personal passion to encourage faculty members and students in physical therapy to develop cultural humility. I have been involved in three research studies exploring cultural competence/humility development in the last five years in collaboration with faculty members and students. The results of the first study were described in the literature review (Hilliard et al., 2008), while the two other studies are ongoing. The preliminary findings from a qualitative study with 15 early career PTs (no more than three years of experience) describes four themes regarding transforming experiences that assisted in developing cultural humility: 1) importance of "out of comfort zone" cultural experiences throughout the lifespan; 2) value of local or international service learning experiences; 3) value of patient-centered learning experiences; and 4) significance of reflection in learning and leading to conviction for change (Hilliard et al., 2007; Salzman et al., 2007). The third qualitative study with experienced PTs is in

an earlier stage with 15 PTs interviewed and data analysis in process. My previous research collaborations shaped this investigation by stimulating a desire to better understand how the meanings PTs derive from experiences along their life paths shape the lens through which they view each clinical and community relationship. I feel my own journey to develop cultural humility has led me to be more open to explore how health professionals, including myself, struggle with issues of power, privilege, and dismantling oppression.

As I have examined my own positionality I have come to realize that I have a three-fold allegiance to the biomedical, RCC, and insurgent multiculturalism philosophical frameworks as a clinician, educator, and researcher. I believe effective clinical practice and health professional education pedagogy requires a combination of biomedical, RCC, and insurgent multiculturalism approaches. I have evolved to embrace insurgent multiculturalism as more of a lens with professional and personal experience. I definitely believe my early family life, my present family background, and my Christian spiritual beliefs influence how I address cultural differences and build relationships. Thus, I tried to be especially vigilant in this investigation to capture meanings when individuals shared stories that were not parallel with my family–oriented values and religious beliefs. I found that two of the eight participants did not feel early family life values and beliefs were influential in how they attend to cultural differences and form relationships in clinical practice. There seemed to be a varying range of dialogue between the participants and myself regarding how religious beliefs or spirituality affects their care giving approach. I tried to be

mindful only to ask more probing questions regarding religious beliefs or spirituality if the participant's responses guided our conversation in exploring more deeply.

Methods

The research strategy chosen for this investigation on how PTs' life experiences influence their development of cultural humility was a life history methodology as illustrated through eight cases. This qualitative approach sought to make meaning out of the participants' individual construction of their cultural meaning systems within the context of social and cultural relationships (Chase, 2005; Goodson & Sikes, 2001; Kouritizin, 1999). Life history methods encourage an approach to inquiry in which personal and professional lives are seen in relationship to each other. Life history methods also attempt to situate the life history of participants not only within their personal contextual plane, however also within interpersonal and community contextual planes. Because a defining feature of life history research is establishing a dynamic relationship between researcher and participant in order to produce data that represents the details and complexities of the participant's life, special attention needs to be given to reciprocity and ethical concerns (Wicks & Whiteford, 2006; Johnson, 2007).

Participants and Selection

I utilized theoretical sampling to recruit licensed PTs who by intent have elected to practice in one or more settings that serve patients from diverse backgrounds and are interested in how culture influences how they build relationships. Other inclusion criteria consisted of requiring participants to have three or more years of clinical experience as a PT and be involved in direct patient care at

least 50% of the time in their professional role. Selection of persons with three years of clinical experience or greater was based on desiring the participants to have enough depth in their occupational experiences to be able to look over-time at the influences that have shaped how they address cultural differences in developing relationships. Since I was interested in how patient-therapist and clinician-clinician relationships help foster the development of cultural humility, I also set a criterion of participants being involved in direct patient care at least 50% of the time. The participants selected also were chosen to provide insight along a continuum of professional experience including: 1) number of years in practice; 2) type of health care institutional settings where they have practiced in terms of ownership category (private practice, nonprofit health care organization, and government/public health organization); and 3) type of environment for providing care (home care, acute care/inpatient hospital, rehabilitation center/ inpatient, and ambulatory care/outpatient). Snowball sampling (Bogdan & Bilken, 1998) was utilized as an additional recruitment technique, which is a process whereby initial participants are asked to recommend others whom they believe fit the inclusion criteria. One participant in this study was recruited through this sampling process.

Participants were recruited through sending recruitment materials to twelve Center Coordinators of Clinical Education of physical therapists in the Chicagoland area. CCCEs were asked to share informational letters with PTs at their facility who met the inclusion criteria. Physical therapists who responded to recruitment information were contacted by phone or E-mail and provided basic information about the study including its purpose, confidentiality, informed consent and the

methodological procedures involved. Participation was voluntary and participants were informed that they could withdraw from the study at any point in time. All participants signed an informed consent approved by DePaul University's Institutional Review Board (See Appendix A).

Data Collection Overview

Three methods of data collection were utilized: interviews, timelines, and artifacts (documents). Data collection instruments were pilot tested prior to implementation. As a result of the pilot study clarifications were added to the potential probes in the interview guide; the wording and format of the professional development timeline was modified; and the time needed to administer questions in Interviews 1 and 2 led to the decision to give participants the option to answer both sets of question in one session versus two sessions. The life history interviews were the focal point for data collection. The interview data were supported by collecting timelines and artifacts such as résumés, publicly available health care organization mission statements, and community demographics. The purpose of collecting résumés and creating timelines of important life events, career stages, and critical incidents was to help participants recall important events (Goodson & Sikes, 2001) and allowed me to ask follow-up questions regarding these experiences. Gathering documents such as publicly available health care setting mission statements and community demographics was utilized to more fully understand the contextual features of the participant's past and current work and community settings. Interviewing participants two to three times and using triangulation of methods (Maxwell, 2006) enabled gathering detailed and varied enough data to answer the research questions.

Interviews

The primary research method used in this study was one-on-one, semi-structured, in-depth, life history interviews. All other data collection methods were used to enhance information provided in the interviews or to substantiate the information given in the interviews. The semi-structured interview format allowed me to conduct the interviews with a set of questions, but also to explore particular ideas or themes as they emerged in purposeful conversations (Bogdan & Biklen, 1998). Semi-structured, life history interviews have been advocated as an optimal data collection method when trying to identify the personal, social, economic, and historical influences that shape professional action (Goodson, 2003; Wicks & Whiteford, 2006).

A series of two (7 participants) to three (1 participant) interview sessions were conducted in a location of the participants' choice that afforded visual and audio privacy. The settings where interviews took place were the participants' homes, one participant's workplace, my home, and the conference room in my workplace. The total interview audio recording time was 1008 minutes (16 hours, and 48 minutes). The average Interview 1 and Interview 2 recording time, whether done separately or combined was 83.5 minutes/participant. While, the average Interview 3 recording time was 42.5 minutes/participant. To facilitate interviews, I utilized an interview guide (see Appendix B). The interview guide provided some organization to the interview sessions, while still allowing the participants to diverge to pursue an idea, and as the interviewer, allowed me to probe a topic more in depth. The interview guide included topical areas that related to the research questions or provided insight

into social context on the topical areas. To develop this interview guide I drew on qualitative interview techniques elaborated by Seidman (1998) and oral history interview guidelines outlined by Thompson (2000).

Seidman's three-interview structure (1998) was used as a strategy to allow participants to reconstruct and reflect on their experiences. Interview one focused on the participant's life history to explore what experiences in their background led them to become a PT; what was the educational route they followed to become a PT; descriptions of the settings in which they have worked to evoke how they name or don't name culture or culture related issues; and what are the significant events or milestones in their career to date. Interview two aimed to probe in greater detail what experiences and contextual influences in their personal and professional lives (early, mid, or recent career) have shaped how participants address culture differences in building relationships (patient-clinician, clinician-clinician, clinician-community). Jackie, the participant with 25 years of experience as a health professional, answered Interview 1 and Interview 2 questions on separate dates. When conducting the first interview session with the other seven participants it seemed natural based on the flow of the conversation to continue answering Interview 2 questions on the same date. Interview three was designed to develop a conversation with the participant to encourage them to engage at a deeper level on their meaning of experiences in regards to facing and acting on issues of privilege and power in relationships on all three contextual planes: personal, interpersonal/social, and community/cultural (Rogoff, 1995). In Interviews 2 and 3, I explicitly defined community for the participants to include home and neighborhood contexts; as well as economic,

political, cultural, and social contexts that foster people to connect as they live in families, work, worship, and socialize in leisure activities. At the first interview, I asked each participant to select a name as their pseudonym, as a strategy to preserve confidentiality.

All interviews were audiotaped on a digital voice recorder and transcribed verbatim from the audio recordings. The transcriptions were saved in both audio and digital format. After initial transcription was complete I relistened to each tape to check for wording and punctuation accuracy. The transcripts formed the main 'data' for the study.

Timelines, Resumes, and Other Artifacts

Résumés were collected at the first interview if a current version was available, following informed consent. Reviewing the résumés of the therapists allowed me to have an initial snapshot of the participants' past and present experiences that revealed influences to their cultural meaning systems such as work roles, educational background, service learning experiences (domestic and international), and advocacy activities. Goodson & Sikes (2001) also advocate timelines as a way to start a life history research study. During the first interview I had the participants fill out a timeline to record what personal experiences, educational experiences, professional experiences, or people have shaped the ways they think or feel about the work of physical therapy in developing relationships (Appendix C). It took participants approximately 15 minutes to fill out the timelines prior to starting to ask interview questions. The timeline was frequently referred to during the asking and answering of questions in Interviews 1 and 2.

The gathering of other artifacts in the data collection process promoted gaining more perspective on the participants' work environments and community contexts. The artifacts included: 1) mission and policy statements (e.g. access to language services, commitment to community partnerships) accessed online from websites of health care organizations where the participants worked; 2) newspaper articles regarding health care reform and health care disparities that discussed the role of healthcare organizations in this 'urban area' in providing care to underserved populations; and 3) community demographics for the towns and cities where participants have lived and currently live.

Data Analysis

Data analysis for this study was ongoing and involved both inductive and deductive processes to foster critical thinking about the contextual influences that have facilitated or constrained physical therapists' development of cultural humility in relationships with themselves (personal plane), patients or colleagues (interpersonal/social plane), and communities (community/cultural plane). The interview data were analyzed throughout the research process using the constant comparative method (Merriam, 1998). The constant comparative method involves the investigator taking a particular incident or concept from an interview transcript, field notes, or a document and comparing it with another incident or concept in the same set of data or in another set (Merriam, 1998, p. 159). Comparisons continue to be made within and between levels of conceptualization until themes or a theory can be formulated from the data. Utilization of the constant comparative method as

interviews were being conducted was important so I could note what themes ought to be explored in greater depth before finishing the data collection process.

The coding process is a key, early part of the qualitative analysis process, requiring the researcher to define and categorize the data (Charmaz, 2003, 2005; Strauss & Corbin, 1990). I used open or first phase coding as a way to focus and reduce the data and to begin to generate a working list of codes with which to frame the data (Charmaz, 2003). Code categories are the words and phrases that are assigned to topics, patterns of behavior, processes, and participants' ways of thinking that stand out in the data as units of meaning (Bogdan & Biklen, 1998). After open coding of the interview and documents, I went through the data again; using focused or patterned coding (Charmaz, 2005). This second phase of coding, allowed for the honing of the major themes and discourses and the identification across data sets (such as between interviews and documents). During the focused phase of coding, I wrote analytic memos (Bogdan & Biklen, 1998; Maxwell, 1996) as a way of elaborating on the connections and themes that were emerging and to examine the interview data from RCC, sociocultural theory, and insurgent multiculturalism theoretical lens. Once defined, the codes were used to create concept maps for each participant and an overall conceptual map for the investigation. Cross-case analysis, done by comparing and contrasting cases, used the concept maps and written cases. Constructing concepts maps has been advocated as a positive analysis strategy to elaborate codes and memos spatially and visually, so major themes can be identified and clusters of ideas can be explored (Miles & Huberman, 1994). Data collection and coding continued until data saturation was reached, meaning the conceptual

framework being developed from the findings became an increasingly tighter mesh that encompassed the data (Merriam, 1998).

Quality Considerations

The issue of maintaining the integrity and rigor of qualitative research is an ongoing and important one. Guba and Lincoln's (1989) notion of trustworthiness and its four components which include credibility, transferability, dependability, and confirmability were utilized as a framework for quality considerations. Concerns about credibility and confirmability, or the parallel criteria in quantitative research, internal validity and objectivity, surface in life history research as they do in any research method. Although one can argue that all research has subjective components, life history research has tended to receive more critique in terms of credibility and confirmability because of its dependence on the stories told by people and research interpretation of the meanings people attach to their experiences (Goodson & Sikes, 2001). A number of steps were taken to maximize credibility including: exposing the researcher's background and potential biases; utilizing multiple data sources; conducting in-depth interviews; using multi-layered analytic strategies to represent the thoughts, feelings, and actions of the participants; using peer review; and using participant checks (Coles & Knowles, 2001; Guba & Lincoln, 1989; Patton, 2002). Also, during data collection and analysis I kept an audit trail of my movement through the data to document my decision making process for interpreting the data. This strategy served to reinforce the dependability and confirmability of the findings and the recommendations that emerged.

I tried to be mindful of my own assumptions throughout the data analysis process, so that although the results are my interpretation, I would still be telling the participants' stories. After completing coding and establishing my initial themes, I had two peers with experience in qualitative analysis check my coding and my first draft framework for potential biases to enhance the credibility, as well as dependability of my analysis. The peer reviewers provided feedback that validated my coding schema was accurate, challenged some of my tendency to use technical jargon in presenting the life histories, and supplied recommendations where more clarity or depth was needed in the cross-case analysis of themes. The participants were also contacted via E-mail and presented with their life histories and an abstract of findings. They were invited to confirm or refute the accuracy of the life histories and themes as representations of their statements, clarify points with which they did not agree, or to provide additional insights. The participants provided a few corrections to the demographic descriptions. None of the participants expressed concern for how their life history was told or refuted findings. One PT asked for a family story to be omitted from her life history for privacy reasons.

Transferability is achieved through in-depth description of the time, the place, the context, the culture of a person or group in data analysis and interpretation, so the reader as receiver of the findings can choose to decide to apply the results of a study to their own situations when they deem there are sufficient commonalities (Guba & Lincoln, 1989). Thick description strengthened the transferability and overall trustworthiness of the data.

Ethical Considerations

In order to produce data that represents the complexities of the participant's life, life historians cultivate relationships with their participants which support the discussion of the details of their life. Studying cultural humility and discussing issues such as bias and privilege is an area of potential sensitivity. Asking people about experiences where there they had to navigate the cultural terrain of difference may elicit a variety of emotional responses. As a researcher I wanted to honor the participants' willingness to share their stories and perspectives, while at the same time respecting their privacy. The participating PTs completed written consent forms so they could understand the purpose of the research and were also aware that they could withdraw from the study at any time.

Another area of concern is what I or the research can give back to the participants. Reciprocity is used to indicate a relationship in which both parties receive benefits for their work together (Bogdan & Bilken, 1998; Luttrell, 2000). I view the research as collaborative in nature, where control was shared between me and the PTs who became my informants. I felt that it was important to share with them how I told their stories and the themes that were discovered in the cross-case analysis. The sharing process has included informal discussions at professional events and when I have seen the participants in the community. Also, I have received E-mail messages after the interviews where participants wanted to share additional information or relay how being involved in the investigation had stimulated reflection on how they can better practice. Ultimately, the true gauge of ethical consideration is

the degree to which the participants feel they, their time, and their information was respected and delivered to the public (White, 2007).

CHAPTER 4. PHYSICAL THERAPIST LIFE HISTORIES

Introduction

This chapter shifts to reporting the findings of the study. Chapter 4 will present the life histories of the eight physical therapists who participated in the study. The organization of each life history case follows a similar pattern. Each life history case is divided into four parts: 1) early foundational experiences; *2)* professional journey; 3) philosophy of care; and 4) life experiences and contextual influences on development of cultural humility. Each case purposely ends with a discussion of contextual influences to extend each personal story into a life history. Chapter 5 will follow with presenting the themes that were identified from the cross-case analysis.

Before introducing each of the eight participants, an overview is provided of how participants were found, what kinds of settings they have worked in, and their demographic characteristics. Jackie was recommended by several of my peers as likely to provide valuable insights because of her many years of working in an urban public hospital and in homecare. I connected with Christina through having sent her recruitment materials in her position as clinical coordinator of clinical education (CCCE) at an urban rehabilitation hospital with a history of community initiatives to reduce health disparities. Sarah replied to my recruitment materials as a CCCE of a private physical practice with several urban and suburban locations known for providing personalized care. I connected with Aliza as a CCCE of an urban public medical center and I also knew that she might provide valuable perspectives from her Orthodox Jewish cultural background. Hazel and April were referred by a CCCE from a nonprofit rehabilitation center that provides multiple levels of care including

inpatient care, day rehabilitation, and outpatient rehabilitation care. Art was recommended by Sarah. Lastly, Sven was referred by a CCCE from a nonprofit academic medical center that serves community members from both urban and suburban neighborhoods. For a summary of the demographics of the eight participants and the types of settings in which they are employed refer to Table 1.

Table 1. Demographic Profiles and Clinical Settings of the Participants

Pseudonym	***Gender***	***Age***	***Race***	***#Years of Clinical Experience***	***Most recent clinical setting***
Jackie	Female	51	Caucasian	25	Homecare
Christina	Female	32	Caucasian	8	Rehabilitation Hospital
Sarah	Female	34	Caucasian	10	Outpatient/Private Practice
Aliza	Female	32	Caucasian	8	Outpatient/Public Academic Medical Center
Hazel	Female	30	Caucasian	6	Outpatient/ Nonprofit Rehabilitation center
Art	Male	29	Caucasian	5	Private Practice
April	Female	30	Caucasian	7	Outpatient/ Nonprofit Rehabilitation center
Sven	Male	35	Caucasian	10	Outpatient/ Nonprofit Academic Medical Center

Jackie

Early Foundational Experiences

Jackie was born in the late 1950's and grew up in a rural community in the upper midwest. She described her home town and her classmates from elementary school through college as being "vanilla". Jackie reported little exposure to health care issues while growing up, although her family was committed to keeping fit through exercise.

Professional Journey

Jackie has been a physical therapist for twenty five years. She initially completed an undergraduate degree in physical education with a minor in biology and worked as an instructor at a health club. Many of her clients suggested she pursue a career in physical therapy, and after the health club went bankrupt she followed their recommendations. Jackie received her B.S. in Physical Therapy in 1985 from a public university and went to work at an urban public hospital. At the hospital she assumed more and more responsibility over her 11 years of service. She served as a senior therapist and provided leadership for physical therapy care in five specialty intensive care units. She also became the coordinator of the clinical education program. She described the patient population as follows:

> I would say low socio-economic. I would say either Black or Hispanic, so I would say minority. So minority, lower socio-economic…or you could say indigent or you could say illegal alien. It seemed like it was pretty mixed (in terms of gender), but if we had men, it was more they were younger. The trauma victims, the gang bangers…we know that in the burn unit, more men are burned than women, but you know I would say it was pretty much half and half…The working poor.

Jackie developed a holistic view of her patients very early in her career. She attributed the learning environment and leadership style in the physical therapy department as being influential in shaping her approach to care. Jackie appreciated that there was a lot of autonomy in the setting to allow professionals to deliver the best care possible, however with a concomitant underlying commitment to mentoring less experienced therapists. Jackie stated,

> I think the nice thing was that we were…we did a lot of different rotations. So when you do a lot of rotations, I can look at a patient from a whole perspective, not from just their orthopedic diagnosis or I can look at them as a whole person from all aspects. I think the fact that because there was professional freedom it actually forced you to take a leadership role to really assume care for the patients. So, because they've allowed you that freedom …you took that freedom to care for the patients to the best of your knowledge. They [department leaders] had it set up that you would start as a junior PT and then you would move up to being a senior PT when a position opened. That would mean that you would be responsible for training the junior PT's that came in. That was a nice thing—because there was always that [mindset] we helped one another no matter what. Again it was understood that the Senior PTs or someone who was more experienced would help the younger PT's, so there was always that fostering of development. Then when you became a Senior PT and you accepted responsibility for specialty units, that [opportunity] was kind of nice. Administration had a hands-off approach that you could run specialty units any way you wanted as long as you got the job done. So I think that really fostered you developing a leadership style, but your own leadership style. You didn't have to follow a set pattern. You developed your own.

Administrative changes eventually created a more bureaucratic environment and Jackie decided to transition to a different area of practice. She recounted,

> I knew after leaving the public hospital that I didn't do well in structured environments, that I needed to go to an environment where I made my own structure…I figured the home care setting would allow me professional freedom, too… I didn't have someone dictating to me what I was supposed to do. I was in the home. I saw what the problem was and I treated it appropriately.

For the last 14 years she has worked for four different homecare agencies with a focus in geriatric care. Most of her patients are now middle to upper class in terms of socioeconomic status, and in her present position she also serves as the education coordinator for clinical staff.

During the 1990s she was involved in global health volunteer experiences in Bali and the Philippines. Outside of the work environment Jackie maintains the home she owns, enjoys adventurous trips around the world during her vacations, and participates in ongoing educational opportunities. She recently completed a Master's of Health Sciences degree, which she expressed has refreshed her professionally. She is planning to participate in international health care volunteer efforts in the future.

Philosophy of Care

Jackie refuses to categorize her patients according to cultural or ethnic characteristics. She prefers to take time to develop a relationship and become aware of the stories patients bring with them to their encounter. Getting to know patients in their home environment is an opportunity she appreciates, and she strives to be compassionate and nonjudgmental with regard to their situations and preferences. As she stated,

> You learn that everybody has a story. You don't know where people come from until you know their story. To be [able] to show more compassion. If someone wants to spend the rest of their life in a wheelchair that's their choice and you know there's no sense in getting upset about it. But again, show them compassion. Everybody is on their own path and their own stage of development. Who am I to judge?

Jackie is conscious of how her philosophy of care has evolved over time. Clinical competence allows her to devote more time to building relationships with patients and she now feels more comfortable taking time to find out about the

patient's preferences, expectations, and background. Reflecting on her change in style from early to mid career, she stated,

> Early in my career I came in there [initial session with patient] gangbusters and now it's like…I kind of walk in and see…and get the feel of the land… I'll come in [to home setting] and say what do we need to work on? How can I help you? I know what I can do for them, but do they want it? What is it that's important to you [the client]? It gets them to participate more in the therapy.

Jackie believes that the home care setting allows her professional autonomy and increased opportunities for developing connections with patients and families. She described how interactions with older adults in the home care setting have fostered her approach to relationship-based care. She recounted the following story to illustrate how she negotiates a plan of care while considering psychosocial and cultural issues, and establishing a trusting relationship:

> Okay, my Romania lady. She was missing her son who was out of town, but also she's 94. She's feeling that what's her life worth living? Again, is she valued? So, again just treating her and it was funny because I would take a million of these ladies because she was willing to try and willing to do the exercises, but it was on her terms and that's fine. … I told her what I wanted the outcome to be and I don't care how we get there as long as we get there. Again I started to get the feeling that this was… somebody plopped me in the middle of a soap opera and didn't tell me and didn't give me the lines. [Laughter]. It would have been nice, but I figured it out. So, when I saw her Monday she started to get better when she knew her son was going to come back into town...The first thing I did was I just sat down on the couch with her and we talked for a half hour. She told me about her life story of what happened in Romania, because I asked. I was curious. This is my friend…So, she eventually did [participate in her plan of care] and obviously she's doing a lot better, which is what I wanted. But also I understand there's a cultural thing with her that she is the mother. She has all this wisdom that she wanted to share. Again it was about respect that yes, I honor what you have, but you also honor what I have. Again we worked out an agreement that we had some disagreement about [how to approach her rehabilitation]--this is what I needed her to do, this is how she operated. Okay, let's negotiate so we can move on.

Jackie reflected frequently during the interviews on providing care that is relationally and contextually dependent. She is attuned to the ongoing worth of learning from her interactions with patients in the interpersonal or social plane. Jackie described how she often establishes a bond with a patient that feels akin to friendship. She talked about how there are moments when you "both are in the flow", and feel the partnership is working. She also noted how necessary it is for the clinician to understand the cultural context of a patient's life. For plans of care cannot be negotiated effectively without close and careful attention to intricacies of history and family structure.

Important life experiences and contextual influences

Jackie's clinical education, ongoing clinical experiences, and personal "ups and downs" have been critical in the ways she approaches building relationships in healthcare. When filling out her professional development timeline in the influential people category she wrote, "Too many to mention", indicative of her belief that her learning has been significantly impacted by interpersonal interactions. She also recognized how "out of comfort zone" experiences shaped her own learning and may have merit for professional education. She remarked:

> Work in a different culture. I came from my idea of a minority as being Polish and everyone else being Finnish; and from a small community, like I went to the same school K-12. So, then I come to Chicago and I work in a public health system where it's lower socioeconomic, and let's face it Black and Hispanic, which is totally [different]…and then to go to other countries where it's totally out of my culture where it's like what planet did I land on and what was I thinking? It's quite liberating to know that you can function.… So, I would say, like anybody get out of your comfort zone. That's the biggest advice. Get out of your comfort zone.

Jackie also expressed her philosophy of care has been shaped by her own temporary disability after an ankle fracture. She stated,

> I was a fully functioning person and all of a sudden I was no longer able to function in my role. …I think in some regards it's good because you know our patients a lot of times they lose a level of function and they may regain it, which is great, but then they need to be able to function in that temporary impaired state. But some patients they will always be impaired. They need to learn and open up to new avenues on how they're going to function. How that's going to look like…and being able to have gone through that I have something to say about that.

Jackie acknowledged that challenging personal and professional life experiences have stimulated reflection and increased self-awareness. She described how self-development has impacted her ability to act with more compassion to others:

> The biggest thing that helped me was reading a lot of psychology and just also development as a person…Who am I? If I know myself then I can see aspects of other people, because I mean they come roaring at you. [Laughter]. So, I think that helps too because I think also in that comes compassion because we all have strengths and we all have weaknesses. If you accept your strengths and you accept your weaknesses, therefore you can be more compassionate to someone else because they're going to have their strengths and they're going to have their weaknesses too. People are mixed bags.

In summary, Jackie has developed a holistic view of her patients. She refuses to categorize her patients according to cultural characteristics. She prefers taking time to develop a relationship with patients through understanding their stories and needs. Reflecting on her own strengths and weaknesses has fostered her ability to develop bonds and trust with others.

Christina

Early Foundational Experiences

Christina was born in the mid 1970's and grew up in a small midwest city of 12,000 people. Christina expressed that thanks to her parents she was raised with an

open-minded, respectful, broad view of people of different cultures:

> We were exposed to a lot of cultures growing up. We had foreign exchange students at our house from the time I was in sixth grade, pretty much through junior high where we had …two girls from Panama, one from Honduras and Spain, and then a girl from Japan even for a month. So I think even though we grew up in a really small town my parents did a great job of just exposing us to a lot and they let us travel over there [to countries of foreign exchange students]. I think that exposed us to cultures and showed us flexibility and how to let people in [our lives].

Professional Journey

Christina has been a PT for eight years. Her father, who has a nursing background, was influential in encouraging Christina to explore physical therapy as a career. She completed her undergraduate degree in exercise science at a large public university, where she also was a scholarship athlete. After completing a doctorate of physical therapy (DPT) in Physical Therapy in 2002 from a private university, Christina began working at a suburban teaching hospital serving a primarily middle to upper class community. During her three years working at the hospital, she rotated through several clinical services. She described the supportive learning environment, the value of peer mentoring, and the importance of learning from patient interactions:

> I look back on it as a great experience. I mean I felt like I learned a ton from the therapy aspect from the other clinicians. It was a young group of people but it was a group of people that stayed around for probably 2 ½ years. So, we all kind of grew together and learned from each other and there were enough older people to really help with the mentoring. The mentoring system is set up really well there. You're not thrown in, you kind of are brought along slowly and you really learn the system. It was always a good group that I never felt awkward to go ask a question, or if I needed help somebody would come over and offer some guidance. The patients again were a good group, just respectful. In your first experience working you realize when people are angry that it's not personal. All those life experiences you kind of realize so those definitely happened. But, I look back on it more…thinking like everybody was very respectful and just…I feel like I learned a lot from them as well just from sitting down for five minutes and hearing their story and that was a great experience.

For the past five years she has worked as a lead therapist at an urban rehabilitation hospital and in her present position she also serves as the clinical coordinator of clinical education. Christina explained the cultural backgrounds and health insurance status of the patient population:

> The patient population is…I would say on average 90% African American maybe 5% Hispanic, and 5% White. Definitely, [the patient population is] from a lower socioeconomic standpoint. Most of the patients we see are public aid, maybe 10% Medicare on the inpatient side.

Christina further described the communities that this health care setting serves and how her learning has been shaped by mutually respectful interactions with patients and families:

> It's definitely the poor areas and more violent areas….. A lot of patients are on public aid; don't have jobs; and multiple families, or multiple families living in homes. So you ask somebody who they live with, and it's grandmother, aunt, uncle, two kids, everybody in the one house. So it's a neat environment, it's something I've never been exposed to. So every day you learn a little more. But at the same time even though they're poor, they've been in these accidents where you're like how did that happen? What were you doing that you were shot? You know it's they're actually very respectful and very thankful for what they're being provided.

Christina expressed that in her second work setting she had to struggle more to understand social class differences, as well as cultural differences in providing quality care. Several times during the interviews she reflected on how riding the bus to work has caused her to wrestle with issues of privilege, socioeconomic status, and the underlying violence that may lead to the injuries she commonly treats in the hospital:

> [The urban rehabilitation hospital] is just a whole other ball game in that…it was weird just to ride the bus down for the first three months that I was there because I was the only white person on the bus and it was a…it was a great…it still is a great experience. I'm so thankful that I've had it because you never know what it is like to be the only African American or only

> Hispanic person because of the population. But that was kind of eye opening and nerve wracking for a while. But, I think the population—what I realize a lot and struggle with still is some of the reasons people are admitted from multiple gunshot wounds or from these traumatic beatings or things that you read. You're just like, "I don't know how much longer I can do this". But you kind of look at them and you realize kind of just the whole socioeconomic thing of it and that plays into it. Why did they choose a gang? What was their history that led them to this point?

Christina values social responsibility and it is important for her to work for an institution that is committed to reducing health care disparities for persons with lower incomes and less access to optimal material conditions:

> I think that where I work has a good influence on health disparities because the population that we serve is underserved; and they don't have good health practices from the time that they are born. So I think that creates a division between people that are educated more or have increased financial resources that can buy healthy food. So I think that they are at a disadvantage coming into it [rehabilitation]. The setting that I work in and what I am able to provide is quality care for them; by rehabbing them after these events that they have had due to poor health, or poor economic status, or poor environments that they live in; trying to better their lives in some way.

Outside of her work environment Christina spends time with her fiancée, holds a leadership position at the district level of the American Physical Therapy Association, and she recently completed the certification process for being credentialed as a geriatric clinical specialist. Over the last four years Christina has also been committed to global volunteerism with a health care service group that set up a self-sustaining clinic that provides rehabilitation care to an underserved community in Guatemala. Much of the work in the clinic is focused on individuals with disabilities who could benefit from orthotics and prosthetics to improve their mobility. She recounted how her volunteer experiences have been influential in her professional development:

> The other influential experience was recently volunteering in Guatemala. I was able to group up with two prosthetists that developed a service group in Guatemala. They've now built a prosthetic center down there so patients have come from all over the country and Honduras. The patients come to this facility which is now sustainable by the Guatemalans that actually run it. So, we go down for one week in October and the prosthetists make the casts the first couple days. Then I get to do gait training with patients for three or four days. It's just a great experience to again learn more about cultures. I see people that are underserved similar to the people that I see that are underserved [in U.S.] but in Guatemala they don't have the government agencies supporting them. The patients in Guatemala now have amputations and their only way of surviving is to work, so they are extremely motivated to get the prosthesis. They usually walk out of there [the clinic] after like an hour of training just fine. So…it's been really good to go down and see that. I think that's carried over well here.

Philosophy of Care

Christina's philosophy of care is focused on her desire to empower her patients and to be an effective teacher:

> I like to think of myself as patient, [attentive to] listening, and letting the patient dictate what they want to do; run the show in a sense. I'm just there to foster them getting better. I really do try and sit down and be like, How are you doing? What do you feel like doing today? What can we do to get you home? Those type of things so that they have a little…I like for them to have ownership of their care and feel like they're getting better. I think also just teaching...You understand "neuro" and you understand science and you get all this stuff in school, but really you're just a teacher in a different form. I love that part of it. I…it makes me shudder a little when I see other therapists not doing that [teaching and empowering patients]. In that it's more just [their approach] to [interact by] this is how you should do it, this is what you do, you only do it this way. I don't believe in that. I don't feel people have to do it one way as long as they are getting the end result and its safe; then, that's just fine. So…I try and promote them kind of figuring things out and I really do like to teach and make sure they understand why we are doing it [performing exercise or practicing task], or what's going on, or why they feel that way. Then adjusting it to what they understand is kind of the fun part or trying to say it in Spanish is even more fun.

Christina described how important it is for her to develop trusting relationships. For example, she recounted a story regarding a teenager she established a long term relationship with:

> There was one guy who had multiple gunshot wounds and ended up having to have a hip disarticulation and went from being like 280 down to 170 when we saw him because he had been in the hospital a month and all... His battle was hard for me because I needed to separate what were you doing when this happened; to I need to treat you right now and not remember that. He was just such a great kid, but he again had like just multiple injuries. He had paresthesias in his hands; he had all this weakness from just being in bed for a month. So, he went from laying in bed, to we got him up to a platform walker, to hopping, to moving around. Again, it was the whole trust issue I think. I was pretty scared honestly to go in because I'd worked with a patient with a hip disarticulation in Guatemala, but that person had [lived with] hip disarticulation for five years and was healed. This guy had a sore from where the incision was, had multiple surgeries, and was just super weak. You just never know how the person is going to react.

Christina made sense of this experience by realizing that she was able to set aside her biases and fears in interacting with this young man; and instead focus on her responsibility to build a trusting relationship and striving to provide him the best care. While many would see this young man's community as a barrier to recovery, Christina appreciated that his family and community likely had a positive influence on his resiliency. She remarked,

> Like most of the people there they surprise me in that it's not…I think the general population that I grew up in if that happened they would just be like my life is over, I'm distraught, like I…how am I supposed to deal with this. I think just from experiences that population has, or the other people in their family maybe had, or the experiences they've been through they cope so well. Where I feel like they cope better for themselves than I do for them. Because it's just a lot that this kid had gone through. He…and again with him it was working to build his confidence I think, just letting him know that this is going to…you're going to get out of this, and this is going to be fine. This is going to work, but at the same time being honest, like it's going to take this long for you to get there. You need to do this, this, and this. Now he comes back and he's almost too big for his prosthesis because he's so strong and like ripped [muscular physique]; and incredibly big. He's walking fine with crutches and getting around.

This story is an example of the types of stories Christina told about challenging patients. Challenging patients have facilitated her learning on how to

build trusting relationships and have strengthened her commitment to social responsibility. She expressed that all the pieces have come together over time to shape her core values around issues of social responsibility:

> I feel like it is a social responsibility [to address health care needs]. I kind of look at it sometimes and it's weird that you feel that so strongly based on where you grew up, because I know the people in my community don't. I think it's just all the little pieces that have come kind of come together over time and with this last piece of just being at [the urban rehabilitation hospital] and it's just stuff that people in the city of Chicago don't even know exists, I think. I feel it is that kind of responsibility though that I have this ability to be a physical therapist. I am sure I won't be there forever and I can do it other places. For right now I enjoy the responsibility of going in providing care for the people that don't…they have access to good health care because they have public aid and even if they don't they're accepted there; and they get good health care. So, that's kind of taken care of by the government. But, it's my job just to provide them with the best care I can so that hopefully they'll go back and be in a better place or like they'll go back and the family will know how to take care of them safely. Just to better them in some way than they were before they came into [urban rehabilitation hospital]. Whether it's kind of helping, we're not going to solve like a drug problem or we're not going to do that; but, just showing them that there's other ways to repair their bodies. There's other ways to gain health in a sense and just educating them on other…educating them on what's out there as far as ways to improve their life in some ways. I think the biggest thing is though just that they're there because they're sick or they've been injured in some form and it's my responsibility to help them and the social part of it just becomes…is because they are a diverse population and I get the opportunity to kind of deal with that and see what works and what doesn't and how best to go about it.

Important life experiences and contextual influences

During the interviews Christina talked about many life experiences and people who have been influential in learning the process of relationship building. Christina described how reflection during some course activities during her entry-level physical therapist professional education, and especially situated learning in clinical education experiences have shaped how she addresses cultural differences:

> Probably some of the projects and things we had to do were beneficial in just making you sit down and think about culture. Then, I think the clinical

> experiences. ..There's a culture of PT, so just going from being a student to being thrown into even like a day observation [integrated clinical experience during more didactic phase of curriculum]…So it's good to…it was good just to see that real world kind of what we were shooting for. Also, I think just the longer clinical education experiences were good. Mine weren't extremely diverse or in a really unique setting, but it was the real world and it was cities. It was Pittsburgh, Seattle, and St. Louis. Those [longer clinical education experiences] I think again taught me a lot just from the people I had interacted with to do my job, but then otherwise the patients as well.

Christina recounted an experience at a skilled nursing facility near the end of her full-time clinical education experiences where she felt she learned several lessons from a patient who was a Jewish rabbi and his wife:

> So, the one experience was with an Orthodox Jewish couple and the gentleman had a stroke. I walked in and his wife was in the traditional like skirt and the wig; very traditional, but very nice. He was a rabbi, a very well-known rabbi I guess in the area. I was a little nervous …half nervous because I was still in my clinical and trying to do what I need to do with this person, and also nervous just for traditions of their background. Because I'd treated a couple patients prior and realized there were traditions and were cultural things that needed to be observed. I remember the wife being very helpful and very open in telling me why they do this [cultural practices] or telling me kind of trying to educate me a little bit too. I appreciated that and also telling me when I needed to step out because she needed to help him or…just…I don't remember the exact details right now. But, I remember looking back on it [the experience] that it was an educational encounter more for me, I think, in just learning about their faith and about… just that he was a rabbi and he was well-respected…I was kind of like taken aback like okay wow, this is somebody very important to a lot of people and just figuring out how best to help him.

In her reflection Christina attended to the ways she learned from her interactions with the couple about how cultural practices and expectations shape a plan of care. She realized that she needed to be sensitive to the role of the wife and the traditions related to physical contact; as well as being mindful of the rabbi's role in his faith community because of the wife's willingness to explain cultural differences.

When asked if peers, friends, or faculty members opened her eyes to culture or thinking about culture during professional education, she remarked:

> I think…it's kind of hard to say…I feel like it's something I've been more aware of after…from being a therapist than I was like in school. It was just being around the class…you know you're with those same 45 people [fellow students] day in and day out. It wasn't the most diverse group of people, but just different backgrounds. I mean my closest friend in PT school was from a city on the west coast and so therefore that was a whole different culture than I had ever been around. He was influential in a lot of ways in just saying well, "Why do you think that? What about this? Well that's what you were told, but what do you think?" I was like…I don't know what I think. This is what I do-A, B, C, D. I think that was probably again coming from a very structured upbringing as far as sports, wanting to do well in school and kind of having things go this is the next step, this is the next step. To meeting somebody and being around that person all day; and then going to work out, to study, and doing all these things [to explore our differences]. This person didn't take that traditional path. He went to school, changed schools, worked for two or three years, then came to PT school. I took a week off between undergraduate and graduate school; so just that right there was totally different. Then, just his upbringing of growing up in an environment, a culture of northern California; especially that he was always asking and always questioning, always diving in or trying to prove something is wrong. I from a very Catholic, structured upbringing was pretty eye opening and frustrating at times too. Where I'd be like, "No, that's just how it is, just let it be". But it was…looking back on it very good, because it did make me think along with… I think just being in the curriculum [name of university] forces you to think when it's not what you want to do. When you want to be told do this, do this, do this, but it's…it's probably the most important thing I got out of PT school, I think.

Christina made clear academic experiences and interactions with one of her classmates were influential in helping her become more questioning and open-minded.

Christina is also conscious of the privilege she enjoys as a middle class, white woman, and how that privilege may impact her perceptions about disparities in health care:

> I think that I have always felt by no means spoiled, but pretty lucky in where and how I grew up. Through college I realized how lucky I was to have [interactions with] all the foreign exchange students; to have my parents say, "OK yes, go play volleyball", and to travel here and there with the team. To allow me to do all that stuff and to be around different cultures and environments; and also people of our same culture in a sense. That evolved in

> college, but the whole thing has grown with physical therapy too, just from a health care standpoint. Looking at the culture I grew up in where nobody was really sick. My mom is one of fifteen, everyone is healthy. No one had problems growing up. Everything was there that we needed, we didn't live in excess, but we were comfortable throughout our lives. I think with Guatemala and working where I do now, you are thankful and appreciate the environment based on what you see and how people can struggle in the states and overseas.

Christina, both in her timeline and during her life history interview, also stressed how a fellow colleague and friend transformed her approach to being a professional. Christina stated,

> My friend who was a physical therapist and passed away 3 years ago, taught me how lucky we are to be therapists, how to have passion for what we do, and how important it is to maintain balance in life. (Christina Timeline, Influential People)

> She was the first person…of my friend circle who wasn't afraid to express an opinion. Who wasn't afraid to say no, you will not treat me that way. Like as far as patient care even, just the way she held herself in the therapy world; and the professional world, her professionalism was pretty amazing. She wanted to get her PhD and she had all these goals. I was still kind of stuck like I go to work every day, this is what I do, I'm learning, I'm here. I think she moved the blinders back. It was like, "No, you can do all these things or you can be involved in this way, but it doesn't have to be over the top". So it was pretty impressive to see somebody of my age, we were born two weeks apart, doing all these great things and I was still kind of like timid in wanting to do those [professional activities], so she was kind of influential in that way.

As an emergent leader in clinical practice, Christina consistently seems to approach relationships in clinical practice with what Epstein (1999) has described as mindfulness. She enters into an encounter with a focus on the relationship at hand, attends to both the patient needs and to her own, and has a critical curiosity that includes courage to wrestle with her biases and to confront complex patient cases.

Sarah

Early Foundational Experiences

Sarah was born in the mid 1970s in a suburban community near Chicago. She described the background of her group of classmates during elementary and high school as follows:

> Probably not too diverse, I went to public grade school; it was mostly Caucasian, Christian. My high school was an all girls' Catholic school. It was in the city, so there were some African Americans, but not too many, predominantly Caucasian, Catholic. One of my good friends was Greek.

She explained that her family's commitment to caring for her grandfather and great uncle were influential in her choice of a profession:

> Probably, when I was growing up my mom's father, the last ten years of his life or so, lived between my aunt's house and my parent's house…From the time I was a young child we cared for him and he had Alzheimer's…or some form of dementia that he couldn't be left alone. I think it was good because it taught me to care for your family members and the elderly and not to just take care of yourself, worrying about your family as well... Caring for our grandfather and after he passed, we started caring for my great uncle. That was probably a lot of it, just taking care of people; I guess it just became a natural role for me. I liked doing it [care giving] and wanted to continue doing it. I remember thinking when I was in high school that I wanted to go into a profession where I could have that role.

Professional Journey

Sarah has been a PT for 10 years. She completed her undergraduate work in biomedical science with a psychology minor at a Catholic and Jesuit university. Sarah related how service learning during her undergraduate experience may have shaped her professional choices. She remarked,

> I was also thinking when we had talked a little bit about my undergraduate university, my involvement with some of the service activities there; that I think it probably was more influential than I thought at the time, because I was involved in a fair amount of volunteer activities. When I was entering my undergraduate experience, I really wasn't sure which direction I was going [in

> choosing a career]. The public university I had applied to, I had applied to their business program. So, I was thinking business at some point. I was thinking education, or business, or healthcare...My first couple of years I did do a lot of service activities and I'm thinking that it probably may have been more influential in my decision to go into a service career than I was thinking.

After completing a MPT in Physical Therapy in 2000 from a private university Sarah began working at a suburban outpatient clinic. The outpatient clinic provided care for persons with musculoskeletal diagnoses from mostly "blue collar" backgrounds. She recounted that economic conditions influenced her decision of where to begin working as a PT:

> The job market was not very good. I had student loan payments starting; I commuted to [suburb one hour from home] for a year. It was spine based patients which were fine; I still enjoy working on spine patients. It was largely patients with neck and back problems…A lot of post surgical cases, fifty percent. We worked with a neurosurgeon and another doctor, it was autonomous, but not the most autonomous setting.

Economic conditions improved a year later and Sarah decided to seek employment at an outpatient clinic which was part of an urban public medical center. Sarah expressed the rationale for her decision:

> I wanted a better commute. I liked the idea of the teaching aspect and being involved with the physical therapy school there. The director of the PT program is very involved in the American Physical Therapy Association and PTs being autonomous. I thought that would be a good place to be.

Sarah described the patient populations that she served in the following way:

> It was mostly a fair amount of Public aid and Medicaid, maybe a third of Public Aid, a third of Medicaid, a third HMO…I am going to guess ten or twenty percent Spanish speaking. Half of my patients were African American and twenty five percent Hispanic, and twenty five percent Caucasian. The youngest were students; we had a decent amount of college students that we would see; then after students, persons probably thirty to sixty years old.

Budgetary concerns and high patient case loads precipitated a job change three years later to her current employer. Sarah explained,

> [Public medical center] was a great place, however affected by the state budget. I remember having a large patient caseload and needing to hire more therapists and there was a freeze. [The problem was] just more the difficulties of a state institution and the budget, affecting how you are practicing. Then I was out to brunch with a friend and she worked for [private clinic] and she said that it was great. That was how it happened, I gave her my resume and I got a job with them pretty quickly.

For the last five years she has worked at two suburban, outpatient clinics under the same private company ownership. Sarah moved to the new clinic setting between the first set of interviews and our last interview together. In the new setting she has a short commute to work from her home. For the last three years she has also served as the coordinator of clinical education for the company. Sarah reflected on how she perceived the different settings have influenced her ability to reduce health care disparities:

> When I was at [public medical center], I think treating patients of various ethnic backgrounds and providing what I thought to be was good care, I would think to be helping with the disparities. When I was in [affluent suburban private practice setting], I probably wasn't doing a whole lot to be helping with health disparities. Where I am now, seeing more variety with ethnic and financial backgrounds, hopefully I'll be doing a little bit more for addressing that.

Sarah expressed a desire to get more involved with community volunteerism. She described the activities she has been involved in and her aspirations for greater community volunteerism as follows:

> So, my husband and I have done some community service. When we had lived in the city there was a retirement center that he had gone to for years and he would cook Saturday breakfasts. … He prepared breakfasts for a longtime and then for a couple of years, while we were dating and then newly married, I would go with him once a month or so...Anyways I did some of that work and then I did some other work with [local service agency] as well working with schools. So, I think I've done some community work, but not necessarily connected with physical therapy…I definitely have had that feeling as well that I feel I'd like to do more, but there's just not enough time. Now I almost feel like I'll have more time since I don't have a commute at all. The things in

> our house are more situated. On and off over the years my mom had been a religious education teacher. I've been thinking that would be nice to start getting involved in that maybe initially helping someone teach a class then more taking over a class. So, I think now that I'm more settled, I think I'll have more time to do some of those things.

Philosophy of Care

Sarah's philosophy of care is centered on her desire to build trusting relationships. She described that trust can grow in relationships through providing comfortable environments for interpersonal interactions, listening attentively, and designing plans of care that focus on patient goals. Sarah shared a story to illustrate the importance of creating a comfortable, calm environment for communication:

> A patient right now who is a very nice lady, she has been in PT for three or four weeks, who has a back problem, somewhat getting better. But her mom is going into surgery in the beginning of August. She took a week off for the surgery; I had seen her the following week. [Before treatment session had started] I had gotten a phone call, other things happened, I was late getting started with her, she was very upset. I was trying to listen to her, apologize for being late, get the session started without saying too much. She was so stressed out with her mom, ten minutes into it when I was doing some manual therapy work with her, she started saying that her mom was having complications from the surgery, she was in the hospital. I think it was stress that was affecting our session, her back, I remember trying to keep it calm. She will say what she wants to say, [reveal] what is bothering her.

Sarah elaborated on her communication style and the importance of listening:

> I think that I always try to make sure that I'm listening to a patient. So, talking with them in the beginning of the session; seeing how they're doing, listening to their concerns that they have, trying to answer some of those concerns before you get started on the session. So, we're all on the same page and know what's going on. Yes, I think kind of keeping things calm and comfortable so that patients can voice their problems.

Sarah also emphasized it is important to gain a deeper understanding of patient goals and preferences. She explained:

> I think knowing someone's background, knowing their belief system is helpful in how you can communicate something, knowing what is important

> in their life or their goals of what they want to get back to, I think that [knowing a person's goals and preferences], that is involved in cultural understanding. If you know what is important to them and what they want to get back to doing, you can shape your plan of care and goal setting around that.

In reflecting on how her philosophy has developed with increased experience,

> I think it has probably grown, when I was a newer therapist, it was what I thought that patients should be able to get back to doing. I think the longer I have been a physical therapist, you have a better understanding that if it is not important to them to do XYZ, then you don't really need to work towards that.

Important life experiences and contextual influences

Sarah's family, entry-level PT professional education, ongoing clinical encounters with patients, and interactions with respected clinicians all have influenced the ways she approaches forming relationships in healthcare. Sarah described how her family has shaped her communication style:

> My great uncle interacted with people really well, he had a way of making people feel comfortable in any situation, finding out about their history. I think he was a great "people" person. My parents were very social and welcoming and good at communicating with people as well. We grew up with a lot of family get-togethers. We were an easy going, welcoming family.

Sarah commented on how communications skill training through role playing and practical exams with simulated patients impacted how she approaches clinician-patient interactions:

> I am trying to think who influenced my communication style. That was probably more during entry-level PT curriculum, in our role playing and practical exams. I can remember a practical that I had with a faculty member, I remember getting nice feedback on what I did well, "Being calm, communicating with patients, they really appreciate it". I think that that stuck with me…I think it was more those things that more influenced my style and motivation style with patients.

Sarah also reported that she finds learning from patients as critical to her professional growth. She recounted a case where she learned the importance of understanding the community environment when establishing a plan of care:

> I remember certain patients and trying to have them become more active and saying go outside and walk around the block. I remember a patient telling me that if they did that they would get shot. That was probably more where it was the first time that I had to change my treatment plan and modify things to what they were able to do. I think just understanding the difficult situations.

In the final interview Sarah went back to thinking about this woman's circumstances when asked whether her ability to reflect on her own privilege has evolved. She explained,

> I think so…I think back to how I was when I was a student, I think it's pretty different now just from my years of interacting with all different types of people. Yes, it's probably hard to really put it into words…I think some of it might be just more understanding of all the different types of people that I've worked with over the years. Kind of being able to interact one-on-one with all different types of people and understand their background. I know I mentioned it earlier that when I said, "Okay, why don't you go outside and walk around the block to get some exercise," and she said, "I can't. I'll get shot." Then she was going into more details about her home situation. That I wouldn't have thought of unless I was talking with this person and she explained, "Look, here's the story. There are shootings several times a day and it's all around this neighborhood." So, I think when you think about childhood obesity and all these problems that we have understanding what patients are able to do and what they're not able to do. I remember just seeing some of the eating habits or nutrition habits that people would have and it was a lot of times foods that were probably easy to buy…I think interacting with individuals and understanding kind of where they're coming from has been really helpful for me to understand different cultures.

In addition, clinician-clinician interactions that are characterized by mutual respect have impacted how she provides care. Sarah talked about an influential, long-term collaboration with a physician:

> I think I have known him and worked with him for quite a few years, back at urban public medical center, just talking through a lot of patient cases over the years. I have learned that he is an excellent physician and really cares for his

> patients and is very thorough. Hopefully he has learned and can feel similarly in the way that I treat patients.

Sarah described how she has learned from this colleague the importance of being both technically competent along with focusing on patient stories:

> I think he is very thorough with patients, if there is a doubt or he is wondering about this problem, but let's do some diagnostics and rule it out. He is fairly conservative in how he treats patients. I have learned that from him and being thorough…I think he does a very good job in getting to know their story and what they want to get back to, whether they might be an athlete or someone who is primarily a desk worker.

Sarah is guided by an ethic of care in building relationships in clinical practice. She is attuned to the importance of effective communication and the affective domain in her interactions with patients and other practitioners. Professional experience has strengthened her belief that an individual's background and community context matters in her compassionate philosophy of care.

Aliza

Early Foundational Experiences

Aliza was born in the late 1970s in a suburban community near Chicago. She disclosed that her early family and school years were highly influenced by being part of a Jewish community culture. Aliza recounted,

> I grew up going to Jewish private schools all of my life and only had Jewish friends and I did not have a non Jewish friend until I went to college. So that is pretty different as it relates to culture. A lot of the experiences at the time were on the reverse end because there often is discrimination against Jews. So a lot of the education that we got was how to change other people's perspective on us, versus us about other people. That was very different and then really there wasn't much cultural diversity in high school. I went to an Orthodox high school which was fairly stringent, so beliefs and views are somewhat limited. We did have an exchange program with a school on the South side, which was predominantly African American. It was night and day from the Orthodox Jewish high school where you have to have lot of money to go there type of thing, even though not everybody was of high socioeconomic

> status, it was just a different environment there. It was only two days, so you are not getting much [interaction]. College was a "welcome to the world" type of experience. Where everybody is different and you are for sure going to meet other people from different cultures, backgrounds, histories, and things like that.

Professional Journey

Aliza has been a PT for 8 years. She completed her undergraduate work in Movement Science and Kinesiology at a large public university. After completing a DPT in Physical Therapy in 2002 from a private university she has worked the past eight years at an urban public medical center. She also recently became the coordinator of the clinical education program in the outpatient physical therapy clinic. She described the patient population she serves as follows:

> Very diverse. A lot of patients come from the south side; lower economic status; diverse ethnic backgrounds; sometimes less education. You also get university students; a younger, college level population. But you also get hospital employees, so in that respect it is diverse age wise, pediatrics and geriatrics. You get different patient populations in terms of needs also. Cardiac, ortho, neuro, prosthetic training and care; it [patient population mix] is a mish mosh of almost everything.

Aliza emphasized that positive professional relationships and collaboration characterize the clinical environment:

> On the inpatient side of things, there are [patient] rounds for each floor and there is now always a PT involved with rounds. In outpatient, the departments that have strong referral basis, like orthopedics, is right next door. It is actually really nice because we will cover physician clinics, so we know who the attending physician is, we can communicate informally, formally as needed. If there is a patient who needs PT, they can walk over and seek our advice and if we have a patient that we are concerned about from a medical vantage point, we know that we can go over and a resident will come and check the patient out on the spot. I think that that is a nice working relationship.

She described teamwork and adaptability as being critical in meeting patient needs in a setting with heavy caseloads.

> I think we [PTs] help each other tremendously, I still think that there are too many patients to go around. For example, a therapist today, his wife had a baby; we all take on the responsibility to absorb more patients into our own caseloads. I got an E-mail with eight patients today to take care of them and figure out what to do…We will also in order to cover the volume, we have unassigned patient slots where everybody schedules are completely booked, but we have a patient on top of that who we tell to come in at eight thirty and we guarantee that they will be seen by noon, because we know that people fail to keep their appointments. To accommodate the patient who is waiting to be seen by noon, we will have to shuffle around other patients in order to get the time to evaluate the patient, everybody sort of pitches in. I think it is a matter of communicating what needs to get done and people stepping up to the plate and accepting more or different responsibility.

Aliza noted how her viewpoint regarding social responsibility has evolved with experience such that she thinks more broadly about how economic and political factors affect healthcare provision.

> I think that I am more aware, especially now with all the talk about changing the healthcare plan and I definitely know a lot more. As a student, you don't necessarily pay attention to all the economic factors and legal things that are involved in healthcare. Now you just have a much greater understanding of what is involved with healthcare and obtaining good healthcare and limitations of insurance coverage or preventative health. Now there are more insurance companies that cover health screens, so we [physical therapists] will do sub maximum stress tests and body fat composition testing. So more the patient walks in for a once over to see what their health is like and their general fitness is like. In that respect, we do that a little bit, but it is more of my awareness of what is going on around me. That definitely has an impact on how you perceive things or deal with patients and their insurances, how to get around it, things like that.

Aliza's approach to impacting health disparities is to meet individual patient needs and to act as a clinical instructor to physical therapy students from a number of universities. She explained,

> I think only to the extent [impacting health disparities] of kind of a branch out affect in terms of I have a lot of students. So, if I can set the example for students and then students will take that into their practices and set the example for others, so only from that perspective.

Outside of the work environment, Aliza maintains the condominium she

owns; teaches religious education courses for children; participates in a variety of worship and fellowship opportunities in the Orthodox Jewish community; exercises to keep fit; and enjoys traveling.

Philosophy of Care

Even though Aliza works in a hectic clinical environment, she talked about the importance of taking time to explore in depth a patient's needs, problems, and history. Aliza articulated her philosophy on providing care to patients with diverse cultural backgrounds as follows:

> I would say my philosophy would be to treat everybody as an individual and address whatever the individual persons needs are, in a manner that suits them and yourself at the same time to provide the best quality of care. I think that I have always had that approach and [university she attended for PT school] does a good job of helping you into that philosophy and to focus on what patient's individual needs are.

Aliza recounted an incident with a student to illustrate her approach:

> The biggest thing [to understand a patient's story] is to get a good subjective history to begin with, to understand a patient's needs, problems, and history. It is interesting in that respect because I just have had recent discussions with a student who perhaps disagrees with that approach and their response to not gathering [a more in depth history]…I will spend twenty to thirty minutes just talking to a patient when I first meet them, in order to get a good history.

Aliza described a case demonstrating how central it is for her to develop partnerships with patients and take into account sociocultural factors.

> One sticks out in my mind…This is a patient who had some unknown infectious process, more presenting as a transverse myelitis, and he went completely from a 40 year old very active person, father, to not being able to sit on his own independently, wheel chair bound, from a Hispanic family and didn't speak any English at all. I didn't speak any Spanish, now I speak a little more, so we can communicate better than we did. It was 2004, five years ago when this happened. I think he was very depressed, maybe going through a divorce due to his disability. Getting social work involved, getting on disability and getting him to the point of being ambulatory; it took a bit [of

> time]… He going from I am not going to smile at all, be happy, laugh; to emotionally, mentally better. That was influential. Culturally things were different, in terms of his family and how they deal with illness and his approach to, "I need to get better and I can't be this way"… Now he is back in PT, he went to Mexico and ate a lot of pork rinds, so he gained thirty to forty pounds and now has lost a lot of his mobility. He used to walk on the treadmill fifteen minutes, twice a day, now he can't walk a half a block, lots of change. He only wanted to come back and see me; it is nice in that respect. So we will see how things go.

Aliza elaborated on how setting and achieving short term goals based on this individual's needs were critical for patient engagement:

> He was somebody that you just got the sense that he was ready to give in right from the beginning. Because he was just so depressed, and not smiling and just making sure that the goals we set were very realistic and obtainable to a point where you could just point out, "Well, two weeks ago you weren't able to do this and now you're able to do this." So, for somebody who is going to be in therapy for a year like trying to not look at the big picture when you're just starting out your rehab and looking at the smaller gains I think is a big deal. So, I think that building on the little successes…I think once he saw the little gains he ended up deciding to come in more times per week based on that, like making the effort because it wasn't easy. Somebody who has neurological problems and it's a hassle just to get in and out of a car and out of the house to come more frequently is difficult. Once you see the little results then you're like, "Okay, now I want more."

Important life experiences and contextual influences

The above story is an example of the types of stories Aliza told about experiential learning through navigating complex patient situations. In addition to experiential learning in clinical encounters, Aliza explained that her college roommate awakened her to the concept of her own privilege:

> I also grew up in a very rich perhaps community, like from multiple perspectives, not only money… I think the most impactful time was when I got to college and my freshman roommate had to pay her own way through college. I'm like, "You have no money coming out of high school?" [Roommate replied] We have nothing. I didn't really work like any kind of fulltime job in high school. Granted I went to a school that basically met from 8:00 o'clock in the morning to 6:00 o'clock in the evening. But, I think that

> was like one of the biggest times where I was like, "Okay, I'm lucky. I don't have to worry about this. This is something that my parents are providing me with."

Aliza stressed that she is continually learning from her mentors and colleagues. She described the key influence mentoring has played in how she approaches patient interactions:

> As long as you have that positive mentoring and role modeling then I think at least to me that's more of an influence than anything. If I can see the rudest and most aggressive of patients and a therapist who is a senior to me or not a senior to me deal with that really nicely then I can say, "Oh wow that was really a great way of dealing with a patient like that. Maybe I'll try doing that in the future."

When asked about if there are institutional policies that promote her providing individualized care, Aliza talked forthrightly about how the overall mission of the public medical center sets the tone for her being able to provide culturally holistic, patient-centered care.

> Everything about it [institution]…I don't think that there is one thing. To give you the authority to do what you know is best for a patient. Someone can write PT evaluation and treatment and they [referring practitioners] will have the trust that you are going to give the best quality of care, just that in general. There is always a different end, such as charity care, trying to provide patients with the care that they need. I don't know if I have a better answer.

Aliza finds the positive attributes of the public teaching hospital to outweigh the barriers of the system. The public teaching hospital's commitment to patient-centered care, high performing patient-centered teams, and the organization's teaching mission buffers the challenges of high case loads and lower than optimal resources.

Overall, Aliza is focused on exploring in depth what are a patient's concerns, problems, and history to provide quality care. She envisions impacting health disparities by providing personalized, evidence based care; and acting as a clinical

instructor to physical therapy students from a number of universities. Increased professional experience has strengthened her commitment to meeting fundamental human needs of persons who are often underserved in the current health care system.

Hazel

Early Foundational Experiences

Hazel was born in the early 80's and grew up in a rural area on the East coast. Hazel described her early community and family life in the following way:

> I grew up in a pretty rural area outside of a town of about 40,000. Predominantly where I went to school, I would say it was 95% white, maybe 80% protestant, it was run of the mill working class, middle class to upper middle class. I'm lucky enough to be part of a family who there's no pre-judgment [of people]. It took me going to college to learn what some of the stereotypes were about people. People would say something like maybe a not very nice comment. I wouldn't even know what it meant because I had never heard it before. Not that I was sheltered, but it just wasn't part of my daily vocabulary or things that were talked about at my house.

Hazel expressed that her family has been influential in every stage of her personal and professional development.

> Family is across the board. I can't put them on a timeline because they occupy every spot. I feel lucky I have my mom and dad and then two half brothers that are 15 and 16 years older than me and then they have their own families. So, that's my little nuclear family there. Every one of them from my dad all the way down to my youngest niece, I feel some healthy obligation to always do my best and try my best because I want to represent who they are to me and what I am to them…My dad held the same job from when he was 19 until 63 and he was a machinist. He got up every day and went to work, came home every day and I loved it. I always respected that he left his work at work. Nothing ever trickled in, so that's something I'm still working on. My mom went to Business College and she was always an office worker and just has this way about her. She's always…always polite, always on, and always thoughtful. Puts everyone ahead of herself, but still manages to take care of herself on top of that. I respect her too because when she married my dad, my brothers I think were 12 and 13 and I couldn't imagine myself entering into a situation like that and I can't believe that she did it successfully with my brothers.

Professional Journey

Hazel has been a PT for five years. She completed an undergraduate degree in Biology at a small Catholic university with a strong liberal arts curriculum. Hazel received her DPT in Physical Therapy from a private university. She has practiced since graduation at three different outpatient settings owned by the same non-profit institution. The first two settings primarily were oriented to day rehabilitation of persons with neurological dysfunction. Hazel described her first work setting as follows:

> Since it was like my first real job and my first time actually practicing on my own license I was lucky enough to have great peer support. Through physical therapy, as well as the other two disciplines with speech and OT. Because we all work together and there's a really great Physiatrist there, and nursing staff as well. So I learned the value of teamwork there. How much you need your co-workers... I learned that I loved the "neuro" population, but it wasn't as rewarding to work for me to work with that particular group and that particular class of people [persons from more affluent suburban areas]. I found that I got a little bit more excited when I was working with someone who didn't have as many resources as other people. I don't feel like it ever influenced how I approached a patient or treated a patient, but I knew that I was…I felt more rewarded at the end of the day if I made a difference in this person's life versus this other person's life. So, that was one of the reasons that prompted me besides the commute to switch locations is to get more of the population that I enjoyed working with.

Hazel appreciated the professional growth she attained from positive clinician-clinician interactions in her first work setting. Yet, she self assessed that her personal preference was to interact with patients and families with less privilege.

Hazel reported she was able to transfer to a day rehabilitation setting where she served a more diverse, less financially advantaged population.

> The patient mix was more of a minority, lower socio-economic class. It just amazed me that…these people would come in with whatever deficits and just know that this was just one part of their life. Maybe they had this brain aneurysm and now they're a left hemi [person with left hemiplegia post

> stroke] and they still have three or four kids that they're the primary care giver for at home. How is this going to work and just it was much more challenging to try and figure everything out; because they couldn't have a 24 hour care giver paid care giver. We had to help figure out what resources were available, or what can you still do, or what can your family members do? So it was more rewarding in that sense, feeling that you actually make a difference. I fell in love with that urban patient population, and it's an opposite [environment] compared to where I grew up. I grew up pretty rural and it's exciting just to see people that are different than you and you can learn from them and they can learn from you.

Hazel emphasized she learned the value of focusing on activities to help individuals transition back to their communities in the day rehabilitation setting.

> The rehabilitation team did community outings and community re-entry which is incredibly valuable. If it's your goal as a patient to be able to go to the grocery store and you never try it while you're still in therapy I think that we missed the boat. So, once a week there would be an out trip to either the grocery store, pet store, or to a museum, that type of community outing. The outing would be staffed across the disciplines. Speech would help with the planning and deciding who was handling the money. Everyone would have a role. Then OT and PT would decide who is going and we would operate in our realm. I would be concerned with their (patients') safety with community mobility, crossing the streets...OT would see how they're doing if they have to use the bathroom there [community site], can they? So, I think the community re-entry piece especially for the urban population. Because that's how you get around you have to walk you have to take the bus, so I felt like we did a good job there.

Hazel moved to her most recent employment setting to give day rehabilitation a break and to work with persons who have more musculoskeletal diagnoses. She described the patient population as follows:

> Well there's a lot of geriatric care where I am, I mean I would say 80% of my case load is probably over 75 years old. But these are mobile people. These are the people that still drive, that are still out in the community; so, there's a big increase in my geriatric population. I've seen pediatrics at both previous work settings. Children probably made up 10% of my case load and now it's probably 1%… I still feel it's more of that urban feel and people that want to do for themselves, want to get better, and just may not have the resources that others do.

Hazel believes in patient empowerment. She is self-aware and mindful of the ongoing importance in her professional journey of not allowing her biases and stress levels to be barriers to patient-centered care:

> It's always my goal to be objective, but just like anyone else you're subject to prejudices or quick thoughts that pop in your head that you didn't even know how it got there. You're like oh, where did that even come from? ... I sometimes rather than empathy, I feel a little sympathy when I see situations where wow, I'm the same age as this person and look at the path they've gone down and look where they came from. So, I might have a tendency to be more of a fixer in that case, rather than trying to empower. It's like well they've already had it really rough let me see if I can kind of do that. So, I know I have to sometimes step back from that and say do you know what? It doesn't matter. They still need to learn how to do this. So sometimes I think I will go more sympathetic then empathetic on certain cases. Depending on levels of stress for the week and if I'm seeing 12 patients that day and this is patient number ten and it's the fourth evaluation and I see someone come in and they just look like they're not…they look like a mess physically or whatever reason you know I can…that's when I'm at my weakest point. When I'm like, "Oh, can't I just have someone straightforward whose knee hurts"; so, being careful of that and not to let my personal [sense of being] overwhelmed with job and all the paperwork and everything [impact care]. I know that if I have a lot of the evaluations and it's towards the end of the week and someone rolls in like a wheelchair and they are 26 with cerebral palsy and they haven't had therapy since they were 10 and now they want to walk. Just not being overwhelmed and just being able to step back and say, " Why couldn't this be a 35 year old with a mild ACL [knee ligament] strain?"; something straightforward, something clean, something neat and stepping back. That's where I feel like I need to do a better job of not letting my frustration or being overwhelmed with work influence my view. I'm pretty good…I sometimes get that initial wave of like oh…but then as soon as I sit down and talk with the person I'm like this is fine. It doesn't matter what it is. But I have to be careful not to let the stress part creep into that.

Outside of the work environment Hazel exercises to keep fit, enjoys camping and traveling, and participates in ongoing continuing education opportunities.

Philosophy of Care

Hazel's philosophy of care is grounded in her desire to form trusting relationships:

> I think regardless of anyone's background, everyone should be approached as an individual. You got to get in there and figure out what they're all about and that it's dangerous to come in with any assumptions. You can come in with…if you see someone and they're dressed in traditional Orthodox Jewish clothing, you can make the assumption that they're Jewish. But beyond that I would review or…make sure you understand any intricacies or cultural views that they have that are important. Establishing that trust and relationship from the start.

Hazel conveyed she believes listening attentively and dialoguing with patients is crucial to building a trusting relationship. She explained,

> I think the subjective part (interview portion) of the evaluation is so important and can go either way. You can get way too much detail and you can lose 30 of your 45 minute session just trying to figure out why they're here today or you can just get too little so you know two weeks down the road you realize you just missed this huge piece. So being able to get a good history of not only what they were doing before and why they're here now and understanding like a brief like snapshot of their cultural picture is crucial. It is an art to be able to reel the talkers in and also be able to make the non-talkers talk and get to the core...I think it's making sure the patient is comfortable. Some people get curious why I'm asking some questions… "I'm here because my shoulder hurts. Why are you asking all these things?" Just establishing that you're there to help them and that this is the background stuff we need to know to help guide us through your course of therapy. I think it's the questions and your ability to step back and let them talk not override them and then prompt them…because they're going to lead you to the right way and if you don't get the information out, it's not that they didn't tell you, you just didn't…in my mind you didn't ask the right question or pick up the right string of thought. I think it's a combination of questions and listening and seeing how you can help guide where you're going.

She described how her philosophy has evolved with experience:

> I think I've been lucky. I don't think of myself as…everyone has prejudices and maybe if I'm in a bad mood I might roll my eyes at something, but I try to catch myself. Far from perfect, always trying to improve on things and not judge. But I feel like 95% of the time I'll give everyone a fair shake. I feel like I've always been that way and I'm continuing to be that way. Always trying to improve, but haven't had any huge change in philosophy or…you get better with doing the interviews, you get better with teasing things out. I think I've always pretty much come to the table with a pretty open mind with things and not letting other clutter get in the way. Or roll your eyes when you see…you know sometimes it's not the patient's fault, sometimes you see a doctor's name on the prescription and you roll your eyes…you're like, "oh, it's one of

> so and so's". Really trying to catch myself and be like, "You know that's not fair, because now you're letting your view of this physician influence how you're going to treat this person." So…just letting the conversation be open, just viewing the situation for what it is, and you let the patient fill in the blanks.

Although her own core values are focused on autonomy, Hazel has learned to negotiate family preferences for more collective-oriented care. As Hazel noted,

> I think a lot of my core values are [centered around] where if you're able to take care of yourself and if you can do it by yourself then you should be able to do it and you should want to be able to do it. So, I've learned in certain cultures it doesn't matter that if the son is injured if the son is four or the son is 45 often there's a really strong bond between the mother and the son, or the mother and the child, to keep providing and doing more for them when the patient himself, he could be doing more. I've learned a lot with showing, not forcing it down their throat and being like, "please stop wheeling him around in his wheelchair, he can do it". But making a statement like, "Look what he did. See how he did that? It benefits him when he does this every time. You can certainly help him." Making more of a melding of things. So not saying, "Don't you ever help him again, he's fine." To stating, "Why doesn't he do his stuff at breakfast, you go ahead and do lunch, and then together you guys do dinner." So, that everyone feels a sense of themselves in there. I think with that dynamic I sometimes struggle…this person can do so much more than they are and darn it I wish mom would stop it. But, it's part of their culture and history. I think I've had good success with trying to find a compromise with those types of situations. I've seen that more in a lot of the Hispanic families, where there's such a strong family bond. I was like," Wow, I don't even think my mom did that for me when I was a baby". You know that sort of thing. So that's been nice just to find the compromise.

Important life experiences and contextual influences

Hazel described her family, educational experiences, patients and their families, and clinical mentors as being influential in learning the process of relationship building. She stated that her family provided her foundational values:

> I feel really lucky that I grew up knowing that you don't judge a person based on anything except how they treat you or treat others around them…I think it was mainly my family's influence in just always have an open mind and not to judge someone.

Hazel explained the process of developing cultural humility to bridge differences in order to build an effective relationship continued to occur through educational experiences and learning from patients in clinical practice.

> In my physical therapy school we had a cultural sensitivity class which was interesting and at the time it was…it was one of those classes you didn't appreciate until you were done and you were actually able to apply some of it. But we took one of the assignments was to take a cultural group different than your own and just talk about how it would be different or just things you would be aware of treating them. A group of my classmates picked the Amish which no one else picked and it was just interesting. Other student groups picked the Arab or Muslim culture or…and other people picked the Orthodox Jewish culture and just different things to be aware of so that was a neat lesson. That's really the only thing I remember from that class, other than just the take home message of making sure you know what you're walking into. If you have a doubt of how someone should be addressed, or if they have views and beliefs--that if they're a female and can't work with a male, or if they're male and can't work with a female. It's to know that preferences might exist and to never assume was the biggest lesson I took from that [entry-level PT education]. Is never assuming anything and ask. Is it okay if I do this? Are you comfortable with this? Figure that out first because if you don't establish that trust at the forefront then you're going to get nowhere. So that was in PT school and then I think just on the job training and individual experience is the best way to learn. You meet different people and you can categorize it and file it away and be like, "Oh, I didn't know that", or "Oh I didn't realize that family was so important in this culture" or "Wow, here I am trying to…working so hard with so and so in therapy, but when he goes home his mom does everything for him. That doesn't happen at my house. So, I just assumed that was the way it was at home. Just learning those different little nuances but knowing never to assume anything. That was my biggest lesson.

Finally, Hazel made clear that clinical instructors and mentors in the institutions she has worked have shaped her approach to practice.

> I was really lucky during my last clinical education (CE) experience to work with a clinical education instructor who was just one of those out of the box thinkers. She was a dancer, a ballerina, not that she would ever be a professional, but that was a huge part of her life. Interacting with her was one of the first times I saw somebody take something that was so important to them and managed to incorporate it into something else. I was like, "I would have never have thought to do that." Whenever I can find someone who does things a little bit different, I get excited or it sparks my interest, like I could do that. At [rehabilitation institution] there's a whole host of therapists that are

> just…just so dynamic and so excited that you still know that they go home at night and do their regular thing. I just think it's nice to have a balance, which is good. I was lucky to have good clinical instructors throughout the mix [of CE experiences]; enough to show me different ways of approaching care. There was never one that I met that I thought to myself, what this experience is teaching me is what I don't want to do. I always learn and I was like this was good. So I was lucky to have good experiences.

Hazel's philosophy of care is grounded in her desire to form trusting relationships. She is firmly open-minded and nonjudgmental in forming relationships. She is committed to ongoing learning and serving patients with compassion and vigor.

Art

Early Foundational Experiences

Art was born in the early 80s in a suburban community near Chicago. Art values being open-minded and discussed how his parents and college experiences impacted his development:

> I think one thing going back to values my parents helped instill, is understanding that you treat other people like you'd want to be treated and you don't judge people. So, I think growing up with that value and understanding that it's always been in the back of my mind, like if I don't know that person I can't judge them by something until I get to know them. I think growing up I went to a pretty much all white, Catholic grade school and high school. So, not being exposed to very many things outside of that was interesting. So, I grew up in that kind of world and then going to college my first roommate was Jewish. So, I learned a lot about his background. I had roommates and people in the fraternity that were from different…you know some people from the middle of Illinois and they took off every hunting season from school and that was different to me. We had people from St. Louis, people from different parts of the country, New York, California that I got to know. So, I definitely got to see how people are different depending on where they come from just geographically and then different aspects of life whether their religion, or their family structure. You appreciate the differences that people have. So, I think college is a big eye opening experience just from the different people that you meet and the different backgrounds everybody has. So, I think that was probably a big learning experience for me was college.

Professional Journey

Art has been a PT for five years. He completed an undergraduate degree at a private university in Health Sciences. Art received his DPT in Physical Therapy from a private university in 2005. He has practiced since graduation at an urban, outpatient private practice clinic. Art was promoted to being the Assistant Facility Manager in 2007. Art described the outpatient clinic atmosphere and the patient populations served in the following way:

> Our clinic I think is unique in that it was, when I started, only like eight months old. It was a newer clinic and it's in a unique area. We're in Chicago like by a major street and we have a very high population of workmens' compensation firefighters, Chicago policeman that are in our area, so we have a lot of blue collar patient populations. But, we also draw patients from three nearby suburbs where it's a little more affluent. So we have a very diverse mix. We have a lot of high schools in our area. So a lot of younger athletes and even people who have been in the community for a while. So we have a lot of Medicare patients. So, we have a little bit of everything.

Art talked about the company he works for having policies that enable him to provide care that is aimed at the well-being of patient populations served.

> I think that access to care is a policy that they have where it really promotes people getting the best care possible. I think it's not…I wouldn't say it's policy but it's encouraged to be involved with relationship development.

Art has evolved to using an adaptable communication style in interactions with patients, as well as colleagues he supervises. Art stated,

> As part of the management role it's obviously my responsibility to do a lot of the just tedious tasks, but also have a pulse on what's going on in the clinic. I think that's been a large influence on me because I have thirty some people in the clinic [to supervise]. Everybody's different. I would say physical therapists tend to be in the same mold a little bit, you know very Type A. Then we have…we have a couple message therapists that are very kind of different. They move at a different pace, they operate completely differently. I've had to change how I interact with them. Our office coordinators again are in a very different position and you have to change how you interact with them. I've learned sometimes the hard way you've got to be different in how

> you approach and communicate; delegate and handle issues when it comes to some people that are I guess different in terms of your profession or your…sometimes even backgrounds their educational level, or their role in the clinic.

Outside of the work environment Art enjoys training for marathons and triathlons, spending time with his wife getting their new home settled, and traveling. He recently started an orthopedic physical therapy clinical residency.

Philosophy of Care

Art's philosophy of care is centered on providing patients of different cultural backgrounds the best care possible and on appreciating the mutual benefit of cultivating relationships.

> I think my philosophy is that it's my job to give persons the best care possible, regardless of who they are, what they are, where they come from or anything like that. So, I would say from day one it's been my philosophy to give everybody the best possible care. That philosophy hasn't changed at all to try my best with every patient and I think it's been…I try to approach it as a unique opportunity, because I really like my job because you meet so many different people and you meet so many different professions. I mean I've asked people questions about buying our house…like hey you work in finance, or hey you know what you work in construction… So it's like okay, you cultivate those relationships. I definitely think it's something I focus on.

Art also repeatedly discussed the importance of effective communication and confronting biases to negotiate the cultural terrain.

> I mean we have a lot of patients that are from different cultures that speak English, but not well. They don't get what you're trying to say or they have a hard time articulating what they're trying to say. So, I think if you can get a translator for them it helps out a lot…Then I think just being aware of their background, where they come from and what's going on and I think it goes back to not being biased. Obviously every culture has a bias of what that culture is like or their stereotypes; not…using that in terms of any rationale or decision making or thought process. Treating everybody completely separate and if it takes further explanation or further effort to get something across to them, or interact with them, I think you have to do that.

Art and I talked about the process of learning how to address cultural differences and whether competence or humility is more descriptive of his approach. Art responded,

> I think you have to recognize and appreciate the differences of all the cultures and all the backgrounds; not think you know well this person's has this background and that's why they're not getting better. I can't imagine anybody thinking that. Just knowing there's a difference in how this patient interacts and how they perceive things based on their background and that's fine. Just being aware of it and doing the best you can to either work around it, or try something different, or try to accommodate them; whatever it takes. Just being aware of it [cultural difference], you know being humble about it is definitely a good term.

Important life experiences and contextual influences

Art talked about his parents, educational experiences, and positive and negative attitudes of clinical instructors as being influential in learning the process of relationship building. As previously noted he acknowledged his parents for instilling values of being open-minded and respectful of people of different cultures. Art also described how field trips to clinical sites early in his entry-level PT curriculum, a course focusing on psychosocial aspects of care, professional development seminars sponsored by his employer, and especially learning in clinical education experiences have shaped the way he addresses cultural differences:

> I think being at a university that was located in the city, going on field trips to a ton of different areas. You could be up in the affluent suburbs for a field trip; you could be at public hospital for a field trip, in two totally different worlds… After we did those field trips there was like a debriefing in a small group…I had to go to a public hospital setting and it was not what I was expecting. It was totally eye-opening and it changed how I look at health care.

> I definitely remember things from psychosocial course. I'll still think about things like, how do you when someone has a concern, how do you rephrase that in terms of letting them know I understand what you're saying. I've learned like at any physical therapy clinic, any job you have the customer or patient that you want to try to satisfy. So, there's going to be times when there

> is a problem. As a company, like our company tries to help people with strategies of how do you communicate this to somebody? How do you talk to him about if they don't show up you're going to cancel their appointments. Like…how do you talk to them about their co-pay if it's really, really high when they don't understand why they have to pay it [co-pay]. So, and being in the management role we have quarterly meetings where they've [owners have] had a consultant come into talk about communication, delegation, things like interacting and how to be present with…your patients and your co-workers for that matter. So I've gotten a little bit of it in my professional life. But, definitely I still take things away from school. There's probably no substitute for experience. So, some of the clinical education experiences were definitely were helpful, particularly I think like I said the last two. Because those experiences were with very diverse populations; the one in the south we had a lot of very poor patients at [teaching hospital in Appalachia area]. Then at the [urban Midwest private, nonprofit teaching hospital] there was a lot of diversity there, too with the student population as well as the local area where there were some affluent people in community and then some people that were…one kid was there because he broke his leg running from the police. So, I think the clinical education experiences helped with my understanding of different cultures.

Art further elaborated on how both positive and negative attitudes and behaviors of clinical instructors shaped how he approaches care:

> I think what's probably opened my eyes the most is seeing what it's like when it's bad. I was going to mention this that I think in the clinical education process that's where people probably pick up any bias or negative attitude about something because if you have a clinical instructor who has maybe been out in the work force for several years and is maybe a little out of touch with things or has formed their own opinions about things based on where they work or what they've seen that can rub off on a student. So I think seeing what it looks like when it's gone bad makes you focus on okay I don't want to be like that, I don't want to act like that, I want to have a better mind set when approaching these different issues. So, I think you can just kind of do the opposite of what you see when it's bad. So I think that's helped me or opened my eyes the most.

When asked to clarify how he transformed positive and negative experiences into his current approach to care, Art responded:

> I think you have to…you know how you're supposed to approach every interaction. I think everybody should know that when they come out of school. I think when you see it done well and when you see it done poorly; then it's up to you to say-how do I want to approach. I think for me, that's

> probably what influenced me the most is seeing it done well, seeing it done poorly and knowing okay how do I want to be? How do I want to be interpreted by other people when they look at how I treat my patients? So I think that's probably been the biggest influence is just seeing kind of the two different dichotomies.

Art is guided by an underlying belief that it is important to be open-minded in building relationships in clinical practice. He is also motivated to adapt his communication style and use language services to meet the communication needs of patients, other practitioners, and support staff. Professional experience has strengthened his resolve to recognize biases and to appreciate cultural differences.

April

Early Foundational Experiences

April was born in the late 70s in a suburban community near Chicago. She discussed that her exposure to persons of different cultural backgrounds was limited early in life. When asked if there were early family or school experiences that influenced how she learned about culture and building relationships, April replied:

> Interestingly, almost no. I feel like when I look at my parents, my parents have never traveled anywhere. My sister really hasn't traveled anywhere...I don't know how I was exposed. Maybe that was college. I'm not even sure because my family really had no influence there. I have a very small family too. So, I don't have a big background. My dad was an only child. So, largely I know my mom's family and her influences. But, I don't know, perhaps college meeting different people from different locales, being a liberal arts college and having to take different criteria.

Professional Journey

April has been a PT for seven years. She completed an undergraduate degree at a private liberal arts university in Biology with a Psychology minor. April received her DPT in Physical Therapy from a private university in 2003 and began working at

a suburban academic medical center. She described the setting and patient populations served as follows:

> My first PT job I took with an academic medical center working in an outpatient clinic in the suburbs and a very diverse group of patients. I was seeing patients who were post-op; I was seeing patients that had a lot of different types of neurologic brain surgery, brain tumors, and stroke. Actually, the reason I think I took that job initially was because it had such a diverse background and they were willing to do some pediatric training with me, since I hadn't had that with a clinical. So, I started doing some pediatrics with infants taking over a couple of kids from one of the therapists that who going on maternity leave. I saw kids that she had been seeing for years with CP [cerebral palsy] and I probably got a little bit of everything, age, population, everything…I could get patients, most of them were local, but I could get patients traveling a pretty good distance because that was the closest or most convenient clinic...I had a couple patients that we had a little bit of a language barrier. I have a little bit of Spanish, not a lot, but what I remember from high school. So a lot of times I would be able to get by with a little bit of communicating simple commands and counting numbers and things like that for patients. I had a couple; actually I had a little girl that tried to teach me Polish. She was cute. She was about thirteen and she was in Polish school and learning Polish herself. I think culturally it was a fairly different type of clinic. I could get a very blue-collar worker, or I could get somebody who actually I think I had one of medical center's own doctors once as a patient. So, I had a good range.

April reported when staffing changes started to make the setting less desirable three years later, she decided to seek a new position with more opportunities for professional growth.

> I found that at my first job I really wasn't growing. I was trying to do too many things. I was doing neuro. I was doing orthopedic, pediatrics. I could get somebody with vertigo or a BPPV [a type of vestibular dysfunction] issue or an amputee. I was never feeling good with any one thing. I was feeling okay. The staffing was going through a lot of changes and it felt like it was the right time to move. So, I explored a lot of different ideas. I explored going into pediatrics fulltime and I explored the outpatient orthopedic end of things. The rehabilitation center had an opportunity. I remembered my great experience with my clinical with them. So, I sought out after that and I actually ended up initially at the clinic that I had my five-week clinical education experience at and the commute actually ended up being better for me. I had to take a small pay cut, but I was so happy to be happy in my normal everyday life that the cut was worth it in the end to me. I saw a huge

> opportunity for growth because I was going to be concentrating more on an orthopedic population. I just knew so many great things about the clinicians and what the rehabilitation center's mission and goals are.

April has practiced the last four years at two different outpatient settings owned by the same non-profit institution. She talked about the supportive learning environment and the value of peer mentoring in the organization:

> Mentoring I would say is probably the one huge thing I saw right away. I wasn't really assigned a mentor. They now do have a mentorship program where they try to help train their staff to mentor new employees. I would say generally everybody kind of took me under their wing a little bit. I could tell they had a little bit of a different practice style from what I had come from. But, I did not feel judged in that I wasn't really doing things the way they did them. By sharing a few patients and allowing me to block out some time to watch seasoned clinicians with a really challenging patients gave me a huge opportunity to learn and grow. I still go back and tell everybody I think I grew more in three months there than I did in three years at my first job…So, I think there's a great collaboration there and so we all challenge each other and I love that aspect about our clinic.

April discussed the cultural and social class backgrounds of the patient population in her second work setting as follows:

> Mostly, it's very much the affluent of urban region and on the whole I think all of our patients had a high expectation. I was very surprised from my first experience. People just seem to demand things and that was a new type of challenge for me…Largely I had a lot of people that lived in the area or worked in the city. So, I would have sometimes some young 20 or 30 year olds who took the train in or maybe lived in other areas of the city. But, I had a pretty good sort of middle-aged population. It was my first chance where I really had a high population really of people that made millions of dollars of money more than I did. I was shocked within my first couple of weeks when they told me I had a VP of this company who was flying in only for the day…So, a different type of culture and very stressful type of culture.

April moved to her most recent employment setting to work for the same health care organization in an outpatient clinic nearer her home. She commented,

> It was actually really hard to make the decision to leave there [after a year] and the only reason I left there was to stay in the organization and be closer to home. So, I'm basically at what you would probably consider at a sister site

> now. I still work with a lot of the same doctors because they travel, but I just don't work with the same therapists. That didn't feel like I was taking a new job or a new position at all because it was all the same sort of treatment style. Like I said previously, I work with the same doctors that I already collaborated with; just a different clinic in that it's trying to grow. It had only been open I think about eight months maybe or just shy of a year when I first went out there…I still say it's a very high maintenance type of population…On the level of expectation we do have some people traveling from some further out suburbs.

April has increasingly become more involved in systems and procedures oriented responsibilities within the health organization as she has gained more experience. She remarked,

> I've taken a huge role in that we went to a computerized documentation system. Because I was the youngest at our site I kind of picked it up quicker. So, I became labeled what we call one of our "super users" and being the point person for questions. I was growing openly frustrated with our system and they started to look at members for a small team to try to make improvements...I stepped up to be the chair [of the committee]. I'm going to be involved in two different educational courses this year, assisting with the labs…Now they [institutional leaders] have started an outcome measures committee. I don't fully know what I'm getting myself into yet [being a member], because it's kind of a new committee. But, from a PT perspective looking at valid tests and measures and performing those tests appropriately in the clinic and the teaching.

Outside of the work environment April enjoys yoga, knitting, and international travel with her husband. She participates in ongoing continuing education opportunities and recently has started to explore involvement in global health care initiatives.

Philosophy of Care

April's philosophy of care is focused on being open-minded and focusing on how she can provide the best care possible to patients. She stated,

> I think my big main goal is that I always want to just provide the best care that I can to everybody. I try not to let things shape my opinion when somebody comes in the door whether it be age or occupation…So, I don't know if I've

> changed a lot over my practice in that regard. I think I just have always tried to stay more open. I think I'm better at doing that now then I was when I was a new graduate. I think it probably just comes from those personal experiences and learning from them and growing.

April's approach to care includes sharing power in her interpersonal relationships with patients. As she noted,

> I like to really show the patients they have the power. Because they always tell me thank you and you know you're doing such a good job. But, I always kind of take that and put it right back on them and say, "Thank you because you're doing the hard work. I'm just telling you what to do. You're taking advice and you're learning." So I try to show them that they have a lot of power for change, whether that be to get stronger, to be able to get out of a chair without their hands, or to have the power to decrease their pain if they've been sitting with back pain for 30 minutes, that they can do a simple movement or exercise to abolish it. From the family level encouraging the patients that may need reminders and empowering the rest of our staff to share that same kind of knowledge.

She recounted one of her favorite stories about patient empowerment:

> Well I had a really good, crabby, old lady. [Laughter] Who I loved…I think I loved to hate and hate to love who constantly tells me how much she hates exercise. She came in asking this week if she was going to have pain for the rest of her life. I said, "You have a choice". She looked at me. I said, "You have a choice…you can do exercise, you feel better after you see me and you can do exercises and feel better". She says, "I hate exercise. I don't want to do it". I said, "That is your choice. Your choices consequences could mean that you are likely to hurt for more time". So I structured her visit a little differently that day and we got really down to very functional tasks and how to change some of her body mechanics. I think she saw the light about how she felt better doing some of the things we did that day and we'll see how she turns out next week. [Laughter] But she, for the moment she had this light in her eyes that was like yes, I can do this and I will so we'll see if she sticks with it.

April is self aware of the ongoing need to assess her own biases as she develops relationships in clinical practice. When questioned on how aware she is of her own culture, privileges and biases, she stated,

> I think I'm pretty good. You know I think I'm always growing there. Something will inevitably always challenge me to step back and reflect. I see

> some of that even as a generational change in how I see my parents viewing the world and people in the city. I see generations…of new graduates coming out and having even a different work ethic and things like that. So, that's where I'm realizing some of those blind spots. I guess I'm always trying to change. I don't always want to accept the things that I think are like oh, that's not so great. So I'm trying to be open to embracing change.

Important life experiences and contextual influences

April described her educational experiences and clinical mentors as being influential in learning the process of relationship building. When questioned how she learned about understanding another person's values, beliefs, and experiences in physical therapy school, April responded:

> I think actually the Physical Therapy school I attended does a phenomenal job about incorporating that aspect into their program. I was very focused on wanting to learn the physical side of things; anatomy class and dissection is really where I first gravitated towards in terms of classes. But, I think some of the certainly communication kind of classes, where as much as I hated role-playing, in retrospect I think that was a really good thing and really helped my communication skills; trying to plan for different scenarios. Then the clinical education experiences and being encouraged to be in different sites. Again, if everybody had their pick they'd pick what they first thought they loved and they'd pick all outpatient sites. I'd never have found wound care had I not have taken the clinical I had. You meet different people when you're spread out.

April talked extensively about how clinical instructors and mentors in the institutions she has worked have shaped her approach to practice.

> The second clinical, which was five weeks I did with a Spine and Sport Center and I had a fantastic clinical instructor. She was just so influential in a lot of my learning and my experience there. She really shaped even now what I look for in a job and a clinic. The first day she had us (April and peer) fill out this huge questionnaire, which I thought this is really strange. What is with this? But it allowed her to learn and understand our learning styles and the differences between the two of us. I watched her shape her entire experience with us that way. She did just have an interesting and unique way of connecting with patients. She was unlike anybody I'd ever met that really challenged the patient's thoughts. Sometimes we'd come in and the patient would have a certain belief about something. We'd spend 20 minutes getting to the bottom of that belief, so that we could actually make some progress.

> Which I saw that when we did that [exploring a patient's beliefs] the patient was much more successful to implement the type of therapy we wanted. Versus, if we would have not made that understanding and then would have asked somebody to do something that they would have then gone home and said, "I'm not doing this." It was cool. It was a great, different view and approach.

April described how her current clinical mentor promotes her development on multiple levels—technical, communication, sociocultural, leadership—to provide relationship-centered care to the privileged and less privileged.

> A good example [of how mentor has influenced practice], I just had a patient yesterday who really was overwhelmed by pain and she's had chronic pain for a significantly long period of time and just broke down crying. I think early on in my experience I would have been really nervous in not knowing how to handle that type of situation. I probably sat her down for a good 20 minutes and even in my lunch, not knowing how much time we'd used up, just exploring ways for her to have an outlet. She doesn't have a lot of friends. We explored things, book clubs and interests. I don't think I would have ever have gone there had I not already watched and listened to my mentor and her skills of talking to people. There's a pain classification course that she helped develop at rehabilitation center. Her own instruction, as well as going through that course has helped me identify different influences. Whether something [pain] is truly an acute just inflammatory issue or are there a lot of psychosocial influences. So she's influenced me in that way as well. I think then too just to stick to your guns. Patients that come in and start demanding three times/week that really don't need it; come in and challenging them. I don't think I would have been as good, had not my mentor have given me the courage and the expertise to do that.

April's care approach is centered on being open-minded and empowering patients. She is conscious of the need to wrestle with her own biases as she works with privileged and underserved populations.

Sven

Early Foundational Experiences

Sven was born in the mid 1970s in a midwest city of 70,000 people. He remarked on how different his exposure to diversity is today versus where he was raised:

> Well I think especially from where I grew up to where…especially where I work now there's a huge difference. Because my hometown is very conservative, mostly white, not a whole lot of diversity except for I think for the big minority population is Laotian, that's the major one. So that's about the only thing really at a more than one percent of the population level that I was exposed to growing up. So just moving to Chicago just increases your thinking and your level of thinking about more of a diverse population.

He also related that his Mom's disability influenced his decision to specialize more in treating persons with neurological dysfunction.

> My mom has multiple sclerosis. So, she had been through some of the therapy process, not as much at that point. But, as I was progressing on in my schooling she went through a little bit more and then a little bit more. So, her experiences with rehabilitation actually kind of got me more interested in the neurological side of the therapy.

Professional Journey

Sven has been a PT for ten years. He completed an undergraduate degree at a private liberal arts university in Biology with a Psychology minor. After completing a MPT in Physical Therapy in 2000 from a private university, Sven began working at an urban community hospital. Similar to Sarah, he recounted that economic conditions influenced his decision of where to begin working as a PT:

> I interviewed a few places and just took the first job that somebody offered to me, because there wasn't all that much out there at that point and the job interested me. Maybe it wasn't the perfect setting that I had envisioned when I started PT school. It ended up being a rotating position where I got to learn all aspects of physical therapy in acute care, sub-acute rehabilitation in a skilled nursing facility (SNF), an extended care SNF, and then the outpatient

> portion too. So, you got to learn the continuum of care, which was good I think even at this point in my career only working in an outpatient setting; because at least you know where patients are coming from a little bit better…It was a community hospital, so it was a little bit more of your general injuries and basic surgeries; then, just the medical issues that people have that put them in the hospital. It wasn't anything like I could say real complicated or "out there". It was more of the common stuff that you would see at a community based hospital.

Sven further described the patient populations that he served in the following way:

> It was blue collar and it was actually a younger Hispanic population and an older Polish population, because it was kind of a neighborhood in transition at that point. Then we saw other people of other ethnic backgrounds, but those were the two different I think main backgrounds. I actually had to pick up a little bit of Spanish and Polish to be able to make sure you get the patients to do what you want them to do…I would say low to middle class.

When the job market improved Sven decided to seek employment at an outpatient clinic which was part of an urban academic medical center. Sven expressed the reason for his decision:

> Luckily the market did improve a couple of years after that, so it kind of opened up a little bit. I decided at that point that outpatient was what I liked doing the best because I like the detail of putting the puzzle together part of outpatient. Whereas inpatient and rehab is not as…obviously you have to think while you're doing it too, but it's not as much of…I think with outpatient you get more complex issues to deal with at a certain point because you're seeing patients for longer time periods. You're trying to figure out what's going on. You're not just seeing them for a week and then trying to get them home, because that's only about what the insurance will pay for. So, that's why I decided what I liked best was outpatient…I get to see a little bit of everything since it's a level one trauma hospital… You see everything there from your general surgeries and injuries to some crazy neurological stuff; that I have to Google when the patient comes in because I remember reading about that in the school, but I haven't thought about it for eight or nine years and more complex orthopedic issues. I get to see vestibular patients and conduct functional capacity evaluations. A little bit of everything and then also since it's a big clinic, there are a lot of therapists. There are a lot of people to learn from and bounce ideas off of, which was something that appealed to me.

Sven talked about the wide range of backgrounds of the patients served in this setting:

> I think the youngest that we see is about seven or eight years old because we're not the main pediatric site…Anywhere up to the 90's…In terms of their socioeconomic background it's kind of a mixture because of the surrounding areas around the hospital…We get a mixture of different backgrounds in terms of socioeconomic and also racial backgrounds; because there's a different mixture in communities [neighboring the medical center]. Because of that we see a broad range of insurance issues. We get to see a lot of private insurance through the hospital, but we do a lot of the public aid, Medicaid patients as well.

Sven emphasized that positive collegial relationships and collaboration characterize the outpatient setting he works in:

> I would say the teamwork and the collaboration is pretty strong within our site. That's one of the reasons I like working there, as well as the diverse population and diagnoses. Also, just the staff there because we all get along really well and are very comfortable with bouncing ideas off of each other and helping out as a team; especially since the recession. Now, we've had to do more within our clinic, because they laid-off our technicians. So, we all pitch in together to help out and do what we need to do to get through the day. Also clinically there are some people there with a lot of experience too, which helps in terms of helping out the other staff. One person may have more experience in orthopedics or neurological background; so we'll definitely even tradeoff patients if somebody, like a newer graduate, doesn't feel comfortable treating a more complicated patient. We'll help them out or co-treat or something of that nature to facilitate their learning process.

He has had the opportunity with increased experience and education in geriatric care to be more involved in community educational opportunities:

> I've done some educational outreach in some of the senior centers. I've talked about balance and falls and that type of thing at different senior centers around the surrounding area. There is also the stroke support group.

Outside of the work environment Sven enjoys participating in and being a spectator at sporting events; maintaining strong relationships with friends and family; and traveling with his wife. He participates regularly in continuing education opportunities.

Philosophy of Care

Sven's philosophy of care is focused on establishing trust relationships. He stated,

> I think it's important to gain a level of trust with the patient, even though you may be from different backgrounds or have different situations; it's the whole empathizing with the patient and trying to get them holistically the best plan of care that you can to reach whatever their goals are.

Sven was conscious of how his philosophy of care has to be carried out throughout the process of treatment to create a level of comfort that will engender trust:

> I think in their whole treatment process you're sharing power in some respects by just finding out their comfort level in anything you do with them for the most part…In terms of if patients want the [treatment area] curtain open or closed? Are they comfortable doing an exercise out in the middle of the gym or do they want to do their exercises in a more private area. So, everything like that I think is somewhat you're giving power to the patient because they…it's feeding into their comfort level with you and with the clinic. They're going to be more readily wanting to work with you in getting the plan of care that you've developed together going and kind of listen to you a little bit more readily and kind of trust you as an expert to help them through the whole process.

Sven described a challenging situation where he tried to create a comfortable environment for a person with a brain injury and his wife:

> I can remember one specific couple, which was actually kind of sad. It was a gentleman I was completing a functional capacity evaluation (FCE) on. His wife was there for the FCE and he had some type of brain injury at work and had some physical disabilities because of that. They were just there to see the doctor to determine what he could do and what he couldn't do to go on disability. There was some type of brain injury with a neurological injury where he had a lot of pain on one side of his body. I worked both with him and his wife during the FCE because to physically do some of the things he had to do on the FCE caused him pain. Since he had some cognitive issues as part of the injury, he kept asking me, "Why are you making me do this? It's causing me pain?" So, I had to work with him and his wife and luckily his wife was there as a social support network to understand that we needed to do the testing to figure out what he could do. At the same time adjust it [FCE] as

> much as possible within the confines of the testing to not cause excessive amounts of pain, since cognitively he couldn't understand why I was making him do all these things.

Sven further elaborated the emotional nature of dealing with pain and loss on a personal and interpersonal level:

> Actually, it was kind of sad because during the evaluation he actually started crying because he had some cognitive deficits, but he was still aware enough to understand why he was doing the tests. He was upset with me, that I was causing him pain, but also I think upset with just the situation in general. He was worried about the fact that he couldn't work and provide for his family. So, it was kind of heart wrenching situation to be involved in, knowing you had to do the test, but trying to make him feel comfortable and get through it as much as possible.

Important life experiences and contextual influences

Sven discussed how his personal experiences with his mother's disability and his own learning style challenges help him in interacting with patients:

> I guess…second hand living through my mom's experiences through the health care system helps me realize that how much you need to gear your treatment towards the patient's preferences or what they want to get back to doing. Because just knowing the things that she likes to do and her limitations and seeing what the therapist would work on with her in therapy. Then, things that I could do to advise her on a little bit as well, without seeming too intrusive. Also, I guess with my learning style just knowing that other patients probably learn differently than I do, so since mine's a little different than most people. But, just kind of learning then what best suits them [patients].

Sven credited both his parents for instilling values of being open-minded and respectful of people of different cultures:

> I think the first thing was just growing up with my parents both being very religious. I was brought up with a pretty strong Lutheran background with my dad being a Lutheran school principal. I just learned the values of a Christian education; being accepting and open to all different types of racial backgrounds or religious backgrounds. I think my parents lived that creed, and not only taught it.

Sven's explained how his holistic approach also evolved through educational experiences and learning from patients in clinical practice. He stated,

> Then that approach just continued through to the rest of my education going to a liberal arts college. Obviously, they teach that as well because it was a Lutheran liberal arts college. Then PT school and talking about how to work with patients; learning about different cultures and different backgrounds that you may encounter in your practice. Just learning about how persons deal with medical issues; or how the differences between their family structures or dependency on other people; or what kind of help they will accept or can get from other people within their community or families. Then also just through experiences while practicing and encountering different cultures and people. Feeling comfortable if there's something that you don't exactly know, either looking it up or reading about it or just asking the patient, "Are you comfortable with me asking about your culture or some differences just so I can learn and be able to best help you reach your goals in terms of your medical progress or your therapy progress," but also holistically within their cultural beliefs and practices as well.

Sven voiced he has been fortunate to have mentors in the clinic to help foster development of technical and communication skills. He described his mentor when he transitioned to working in the outpatient clinic:

> Definitely I had some patient populations or diagnoses that I hadn't seen before. So, he was specifically a person that I think myself and then a lot of people go to if there are issues that arise that are unfamiliar situations that you're not comfortable with. He's very good at teaching and helping out with those situations and helping you learn how to best treat patients and not just telling you what to do, but helping you work through the issues and learn from those situations…I think he communicates very well with patients. He's very honest about where they're at, where they need to get to in terms of setting goals for patients, and being realistic but in a nice way…Technically he's very good explaining what's going on with the patients, what the process will be, and what the goals are; which I think it's not always the case sometimes when you see other PT's practicing. So, it's a good learning model and then also you basically develop your skills too to match those.

Sven values continuing to be able to develop cultural humility, and see it as important to work for an institution that is committed to reducing health disparities.

> Then working in the setting that I am it just…it makes you realize that I guess that there are a lot of different cultures, different backgrounds, different

> family structures, different obviously levels of socio-economic background, and accessibility to equipment to insurance. Just things within the community that you really have to work at finding out those things and not just assume that the person has the same resources that you had or you have now. Because not everybody has those things which you know makes you feel number one…lucky to have those things. But, also makes you want to help other people I guess that don't have the same background or things that are accessible to you reach their goals. You know you can help them do that to the best of your ability.

In summary, Sven has developed a holistic view of his patients. He is conscious of the privilege he enjoys. Sven is motivated in patient interactions to build trusting relationships and to have persons reach goals that may have fewer resources.

CHAPTER 5. CROSS-CASE ANALYSIS

> *Culture (often unconsciously) identifies crucial ruptures, rifts, gaps and shifts in society. It is indispensible for understanding the mechanics of the world in that respect, pointing us toward those things around us that are unstable, changing, that shape how we live and how we treat one another. If we are alert to it, it helps reveal who we are to ourselves, often in ways we didn't realize in places we didn't necessarily think to look.*
> *(*Kimmelman, 2010, p. 19)

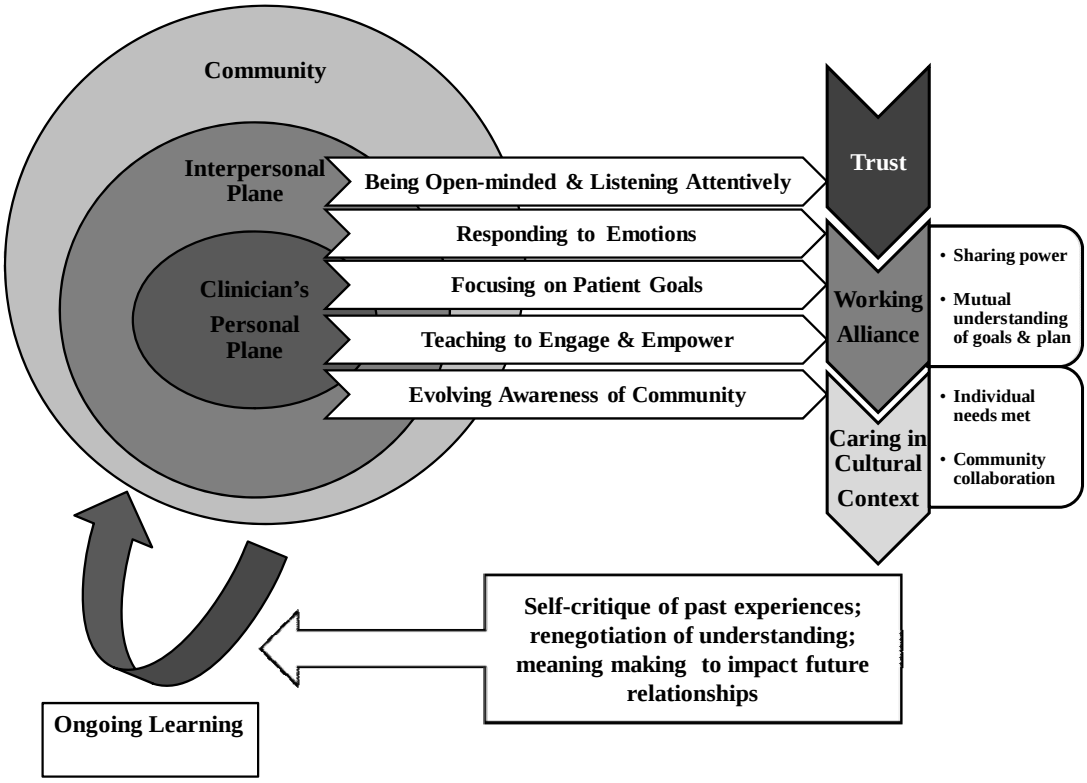
Introduction

The semi-structured interview process offered participants an opportunity to share their stories from their vantage points. Cross-case analysis of their narratives revealed five recurrent themes that centered on trusting relationships with persons of diverse backgrounds. First, the participants described developing cultural humility as an ongoing process that requires one to be open-minded and to listen attentively to patient stories. The second theme is related to PTs being attuned to emotions in their highly relational work as healers. The participants discussed creating comfortable and calm environments to promote working alliances with patients and colleagues. The third theme is focused on attending to a patient's goals to achieve a common ground to establish and implement a plan of care. The fourth theme that emerged from the study was developing increased skill in teaching to engage and empower patient and family involvement in decision-making, adhering to exercise/activity recommendations, and ongoing health promotion. The fifth theme is grounded in an evolving awareness of community needs and assets.

These five themes are presented in the subsections below in more detail, with examples and quotations from the participants to demonstrate how these clinicians have learned to build trusting relationships with persons of diverse backgrounds.

Figure 2 provides a pictorial display of the revised conceptual framework that emerged from this study.

Figure 2. How Physical Therapists Learn to Address Cultural Differences and Build relationships



Theme 1: Remain Open-Minded and Listen Attentively

All the participants described the development of cultural humility as a process. The first step the PTs expressed is vigilance to remain open-minded as patients tell their stories and communicate their desires, versus making assumptions. Every one of the therapists conveyed the importance of listening attentively to a person's history, circumstances, values, and preferences. They also talked about how important it is to avoid being biased by stereotypes or negative clinician-clinician

communication. Hazel explained her philosophy of providing care to patients from diverse cultural backgrounds in this respect:

> I think regardless of anyone's background, everyone should be approached as an individual. You got to get in there and figure out what they're all about and that it's dangerous to come in with any assumptions. You can come in with…if you see someone and they're dressed in traditional Orthodox Jewish clothing, you can make the assumption that they're Jewish. But beyond that I would review or…make sure you understand any intricacies or cultural views that they have that are important. Establishing that trust and relationship from the start. But not to fall into the stereotype, just viewing people for what it is [that brings them to need care]. So if you see a kid come in and he's young and he's got tattoos everywhere and he's got bandanas not to assume, that this kid is bad. This kid's probably a drug user, I'm sure he's in a gang. But just, well I've got a 25 year old African American male in a wheelchair. That's objective, that's what I see and then I talk to him and let him fill in the subjective. It's not your job to be subjective, it's their job to be subjective, and you are to be objective. So just getting…taking the snapshot, you can know where you're going to go with things, but… no assumptions. Let them tell you who they are.

Art was self-aware that he needs to be vigilant in not letting assumptions or negative talk between professionals affect the care he provides. He expressed how he has to wrestle with not being biased when fellow professionals share judgmental viewpoints about persons whose insurance coverage is through workers' compensation benefits.

> Yeah, I think and it happens a lot with the "work comp" cases. Especially if you have a patient, like if a therapist is…I'm working with one of their patient's that was here before. Like oh, I don't know about this. They make their comments and it's like well, I almost don't want to hear that, like okay I'll listen to it, but I'll just kind of put it out of my mind. I'm going to take a look at this person from my standpoint. Or even if the doctor is…you know calls up on the phone and says, "Hey you're going to see this guy; man, he's a piece of work." You know that's again setting a bad tone so you kind of just listen to it and say, "All right, well thank you" and have your own…you kind of have to shift from that and have your own thought process and interact with that person and not take that into account.

Art and the other seven participants described the concept of open-mindedness as guiding how they engage in dialogue with patients and build relationships. The concept of open-mindedness based on these physical therapist experiences implies a need to bring to self-awareness and hold in check cultural biases. April emphasized one strategy to encourage health care providers to be open-minded is to teach students to have an in-depth conversation with a patient versus relying on information recorded in medical documents:

> I think it's important to teach students to not always assume and to not always draw their immediate conclusions just from things that might be either written down from say a doctor's prescription, if they have access to the doctor's note; or even a lot of times patient's fill out an intake form. Instead, to really dig deeper and to ask a lot of questions from the patient and to have them speak first.

Hazel pointed out how the teaching and learning of attentive listening ought to be an explicit focus of the health professional curriculums:

> I think so often especially in schooling you're so focused on the clinical assessment, the techniques you're going to use, range of motion, how you're going to do this, that you forget the listening piece and it's I think overlooked to teach or help people learn to be active listeners and empathetic listening. It's not always as engrained in some people as one might hope. Going beyond where you already have the little voice in your head and you're just saying agree, agree; or you're listening to the person, but you're not taking it in; or you're distracted. Just getting the basics and kind of going into two levels. Maybe being able to take what they told you and spit it back to them, not word for word, but just a summary. Then taking it that second level and acknowledging their feelings about it and what's going on just to get a better sense. Because if you pigeon hole someone as they walk in the door…you already know they're "worker's comp", this is their third case they've had in two years. They have a neck brace on and they're walking with a cane, if you let that cloud your interview and assessment you've already set them up for failure, because you put your impression on it. So wiping that [impression] clean. Just reading the facts. Taking only objective findings and then going there and letting them tell their story and validate it. You don't have to agree with them, but just acknowledge that you've heard it and let it come out. So, I think that active listening skill is lost. I've been lucky to have mentors to help foster that in me. So, I know to not just breeze through these things and kind

> of get it down. I think a lot of PT schools now I think are doing more of like cultural sensitivity and diversity courses; and even education courses within their curriculum and that that's something that could be part of it; and make that as important as your clinical assessment and evaluation skills.

Each of the participants believed that classroom and clinical education learning ought to be integrated in fostering the development of attentive listening and relationship development skills. Experiential learning in the context of interacting with clinical instructors and patients within healthcare institutions during clinical education was consistently described as impacting how these PTs developed their philosophy of care. Art expressed the significance of having a clinical instructor who was an exemplar for being open-minded, non-judgmental, and compassionate.

> My clinical instructor was really good. Because the setting was a big regional hospital for the whole southeast, we had people from Mississippi, from Georgia, and from Kentucky. We had a large variety of patients and he was very good at making them feel important, making them feel that he was there for them no matter what their background was, no matter what their story was. Whether the one guy was playing with a gun drunk and gave himself a…C7 spinal cord injury, he treated him the same as the guy who got hit by a drunk driver. So, I think…I learned a lot from him just in terms of making sure that you're giving them the care that they deserve no matter what their background or story is.

He further described the qualities of his clinical instructor:

> I think I guess he would definitely be considered a good listener and very compassionate. We were on a "neuro" floor, so we had a lot of tough cases. A lot of bad spinal cord injuries, brain tumors; so bad neurological issues that cause huge life changes for people and their families. I think he's…to be successful and to have that job be fulfilling you need to be compassionate and understanding and supportive for people no matter what, so…I think he did that well.

Like Art, Christina was reflective about how her clinical education experiences facilitated her approach to developing relationships. Christina recounted

learning the value of attentive listening through a relationship with an older man and his son during one of her clinical education experiences.

> [I interacted with] an older gentleman in a skilled nursing facility and he did not want to do anything. He was extremely like just probably depressed and frustrated; tired and sick; and his family was super motivated to help him. [I remember] just kind of getting in there and talking with him and like figuring out what was important to him in his history. It turns out he knew like the old…mob guys that had been involved in like…he knew Al Capone or he knew all these people. I'm sitting there, like oh my goodness, okay. Just the culture of that and bringing stories out of him and it was more from his son's doing. We got to talking about things and kind of reliving some of his past history. What was his culture growing up? It kind of allowed him then to gain a little more confidence and just…he was able to do more. He was able to walk some and able to go home and return with his family. But…just I think getting in there and listening and kind of making that first move to let him open up was beneficial.

Christiana noted how her listening skills have evolved with experience. For her, listening and exploring patient stories drives her approach to care and gives her personal satisfaction. She noted,

> I think I probably get more out of what I listen to. I feel like I've always kind of gone in and sat down and said how are you? What's going on today? Did you sleep well? What did you have for breakfast? Like that's just me. Because I want to know how the person is doing and that's why I love my job and just the personal part of it. But I think what I've developed in a way is just the ability to get things out of it and to lead the next question. That's been very helpful mainly in this facility in discharge planning. Because that happens from the very beginning and they'll say they have a daughter and it's like well do you live with that daughter, what kind of place do you live in? Is your daughter going to come in? Not being over consuming with that [probing questions], but just kind of having that lead the conversation to things I need to know. Also, just listening to these great stories these people have. There are so many still that are from Mississippi and Georgia and all these places and have been through more than I can imagine. Yeah, it's really fun to just get some of their history out of it and what they enjoy talking about.

Christina also expressed she is committed to serving as a clinical instructor not only of technical skills, but also of relationship development skills. In the final interview Christina talked about how she might approach interacting with a mentee

who was struggling with developing trusting relationships with a patient of a different cultural background. She explained,

> I think in that situation it might be difficult, because everybody is an individual, so it might not work best to say, "This is how I do it, or watch me treat this patient". What I have found myself saying sometimes, like if there are differences, or the student and patient just don't get along well, or the patient is more aggressive and not cooperating… I find myself saying, "More to listen to what the patient is saying and communicate on what you need them to do and with the reinforcement that this is helping you get better so that you can go home and get back to your normal life, rather than this frustrated state you are in". I encourage people to just listen to what people are saying, rather than how they are saying it. I think that philosophy goes a long way in confrontational type interactions. I think that it is a natural type thing and a hard learned skill to have. But, if you can encourage people to slow down a little bit and listen. When you ask a question to actually listen to the response rather than saying, "What did you have for breakfast, ok, let's get up and walk". It is important to genuinely ask a question and wait for a response and respond to that question appropriately.

Summary and Analysis

All the participants in this study shared, as a care philosophy, a strong desire to listen to patients in an unbiased manner in order to understand their stories and perspectives. The PTs in this investigation voiced that really listening to a person and trying to understand that person's needs is a habit of attention that requires continual effort. Similar to advocates of the RCC framework (Beach et al., 2006; Dobie, 2007), these practitioners stressed entering into any positive relationship with patients and families first requires self-awareness and integrity to foster being open to knowing others on their cultural terms. The results demonstrate that trust is foundational to interpersonal interactions and that being open-minded, listening attentively, and challenging one's own assumptions are critical components for formation of caring, effective relationships. According to participants, PTs must learn to listen across difference and develop empathetic listening skills to practice with cultural humility.

Theme 2: Responding to a Person's Emotions Matters

The ability to engender trust when cultural differences might impact the process of building relationships was also central in the second theme. The second common theme focused on creating comfortable and calm environments for patients to express their stories and concerns. All participants, regardless of the health care institutional setting in which they deliver care, described listening and responding to emotions as critical to care. Sarah explained her approach to interacting with persons from diverse cultural backgrounds in this way:

> I think if you try to create an environment where they are comfortable, then it'll be easier for them to develop trust in you. So, the outpatient clinic that I'm at now, which I've only been there for like a week and a half, I'm going to be seeing patients of more varied ethnic backgrounds. I think that approach where making sure that someone is comfortable and letting them talk first a little bit and figuring out a little bit of where they're coming from, what their viewpoint is on things. Then I'll alter what I'm going to be talking about or things like that from what I'm finding from them.

During academic training, physical therapy students are trained to make rational, objective decisions about patient care, but they are also expected to learn how to build relationships. Hazel and I talked at length about the complex process of combining objective clinical goals with compassionate, relationship-based care.

> M: In the first interview I interpreted that even though you emphasized being objective in your patient clinician interactions, yet it seemed you also follow the principle that affect and emotion are important components of relationships in health care. Is this a correct interpretation that you balance being objective with being able to respond to patients emotions or did you mean something different?
>
> H: No, that's actually a great summary... I think it's the matter of…it goes back to just treat people how you want to be treated and I wouldn't want anyone to assume anything about me if I sit in front of them to do a patient interview. As a patient I want to be able to tell my story and a lot of times especially when dealing with pain, which is why we see a lot of the people, understanding where they're coming from and just taking that emotional piece

> and helping them understand where it came from or help remove any fears, worries, concerns that they just may not understand what pain can be and how to interpret it.

Hazel acknowledged that she sees it as part of her role as a physical therapist to help patients explore the interrelationship between pain and emotions. She stated,

> So, it really is trying to find that balance of taking the objective findings and then listening to what the emotional pieces are. On the first level just making sure you understand it and then on the second level saying, "It seems to me that you might feel overwhelmed, or that this pain may be scary to you, or you're unsure of your prognosis because of this medical condition", so not naming the emotion for them, but giving them an opportunity of this is how you're presenting to me, is this really how you feel? So, then you have the total package because you have your objective findings and then now you know what fears, worries and concerns they may have attached to it. Then you can know where to go from there.

Hazel recounted a therapy session with a woman with severe low back pain where understanding how pain and fear were interconnected was central in providing care:

> So, recently I had a young woman in her late 20's …worked part-time, four daughters at home, with a supportive husband. She came in with low back pain, with radicular symptoms past the knee, constant, changed the way she walked, couldn't sleep, all these things. She also came in with her MRI report in hand that was pretty much a huge bulging disc. So she came in obviously in a lot of pain and a lot of despair because her role as mother and partial provider for her family had been significantly altered. She had all this pain and had this MRI report that says apparently things look really, really bad in there and no explanation about what to do. So tearful, hard to keep on track, was very concerned how this was going to affect her in the future…does this mean she's never going to walk again? So, just finding that being able to talk to her and say you know you serve…you're very important to a lot of different people in your life. You've got your family, you've got your job, you've got your kids, and you've got all these things. Then taking what she understood her pain to be and just helping to educate her a little bit and saying, "Well we know you have this leg pain, but it's really coming from your back". Just trying to get her to understand how the pain process works and that pain is a warning system that something's going on. So, we know something's wrong, but we have to find out what tissues are affected and just helping to "de-scarify" the pain and help her to understand it.

Through telling the story of this young woman Hazel made clear that she sees value in understanding the family and economic conditions of this individual. She is willing to explore the concerns of the young woman, and then incorporate those concerns and fears into how she approaches designing a plan of care. She proceeded to explain how more time was needed to understand the sociocultural and emotional aspects of this person's pain, than collecting objective findings.

> Then kind of go from there… how, even though it says it [the MRI report] looks really bad it doesn't mean that you can't recover from this [problem]. Going through that…just it was…the actual clinical evaluation part where I had her do like movement assessment was probably the last ten minutes. It was the first thirty five minutes where it was just trying to wade through these pieces. Even though I didn't put hands on her at all and we'd only done a few active movement assessments, at the end she walked away feeling better and walked away with less pain, even though we hadn't even done anything [treatment wise] yet. So that was just a nice…and I…the only thing that I saw in front of me was a woman with a lot of responsibility and a lot of fear. I didn't view her as anything else, didn't look into it in any other way, didn't say how can you have four kids and only be this old or how do you have a job and still do this? Didn't go down that path at all and just said okay here's a young woman who has a lot of responsibilities and can't fulfill them right now. Then here are her misconceptions about pain and what she has attached to it. How can we deal with it?

The physical therapists interviewed all felt responsibility to be teachers in the profession, including fostering the development of effective relationship building skills. Aliza discussed an example of mentoring a physical therapist intern to navigate an emotional situation:

> I mean definitely like this morning my student has a patient who was diagnosed with breast cancer and is having a mastectomy tomorrow. She came in and she was even crying in the waiting area before my student even got to her. Apparently she doesn't have a very perhaps supportive daughter. She didn't even want to come to therapy and her daughter made her come. Then, the patient's like, "I'm in so much pain I don't want to do anything, like let's just go home"; and the daughter's like, "No way, I just drove you here so you're going to stay because I brought you here"; as opposed to, "Oh God, you're in pain. Let's let you go home." So, talking to the student about

> perhaps having the daughter wait in the waiting area, closing the lights, just doing things to relieve the patient's pain as opposed to focusing on, "So, after surgery you have to do this, this and this," and change the focus of the session based on that patient's response of knowing that she was already upset, irritated, and stressed. You're not going to get anywhere with a patient who is in that situation. Then once they're calm then you can talk about the things you need to talk about.

Jackie described how homecare physical therapy inherently lends itself to emotional engagement with people's lives. She expressed how she has learned the importance of dealing with patient, family, and her own emotions:

> One of the things I learned is that when you go into someone's home you see all the dirt. You see all…you have to deal with them; you may have to deal with their family. They may have all these emotions--anxiety, anger, and fear…you get blasted with that the first moment you walk in. The other thing is, after you build a rapport, you get their life stories. I like to call it emotional vomit on you. You have to learn how to A) protect yourself from it; but, B) learn how to deal with it. I mean the first few times I'd walk in the family is panicking and they are anxious and all of a sudden I'm feeling anxious and I was fine when I walked in there. You know so I had to learn how to deal with all that. So it's like in some regards I'm confronted with dealing with my own emotions because I'm confronted with theirs. You know and it's right in your face and so I had to learn a lot of psychology to deal with…well to deal with them, but it ultimately helped me deal with just…life has ups and downs. You lose a job. You…get a divorce; you get in a car accident. Life happens.

Jackie talked about how providing care to patients in their own homes makes the sociocultural contexts of their lives real to her. She sees mutual benefit to the persons she treats and herself from learning how to be resilient in response to the emotional challenges and unpredictability of life.

Christiana expressed the ongoing emotional challenges of implementing care, even as an experienced therapist, when the psychosocial and economic realities of care are complex:

> There was one girl a year ago that had been hit by a car and dragged for a while, had just massive like road rash. She was in the hospital for a while with like multiple organ problems as well and then came to us [rehab hospital]. She

> was just insanely anxious that first day and would not let go of me. She was like, "Do not leave me, do not leave me". It was pretty interesting just to see her go from that to her coming back a year later walking in and saying, "Hi" and being okay. Because you're sitting there reading the history like one, how is somebody still alive after this. Two, what kind of shape is she going to be in; how motivated and cognitively aware and all this. To see her go from doing nothing to pretty much being independent at a wheelchair level by the time she left after six weeks was pretty impressive. But the battles that would go on daily were very draining on both of us. I think it was learning that I needed to be a little more assertive in that culture. I look at some of the stuff that comes out of my mouth now based on three years ago and I'm like oh, Christina…it's the population and it's the culture it's a more assertive culture. It's to the point. There's no rosy story around it and I think that's been helpful in life, too. But with her it was daily battles because she I think had dropped out of school right before this happened, was pretty defiant with her mom and the personality…it was a battle between balancing…she's been through this traumatic event and how do I have empathy and deal with that versus no, she's being disrespectful and this is…I need to redirect this or I need to focus on this. She would be screaming as we would be walking and you're pushing her to keep going and she was only able to bend her knee like 30 degrees and we're like is it h.o. (heterotopic ossificans) or what is it? Then they ordered a CPM (continuous passive motion) machine and trying to be calming…trying to get her to put that on and working her through that.

Christina has grown into a PT who is able to critically reflect on her practice and consistently be engaged in actions required to build trusting relationships across a variety of social and cultural boundaries. She has learned how to wrestle with discomfort in order to form relationships and provide quality care. She goes on to state:

> The whole time her mom maybe came in like twice a week. She had three other kids at home and it's your heart goes out to her because it's not just her story it's like all of the population. It's…hard to explain that to other people. But it…I think it's a big spiral going on because it's low economic status, it's poor nutrition, it's poor education and then people have strokes at 50 and rather than 70 or 80 and it's kind of daily event that's pretty eye opening I think.

Christina seems to be disposed to struggle with the impact less privilege has on the family and community, yet is unsure if others share her conviction to try to

understand and act. Christina spoke about some of the strategies that helped her negotiate the difficult emotional and cultural terrain with the young woman in this story, she stated:

> The biggest thing I think was getting the trust, gaining her trust and kind of putting her at ease and that did happen a lot in the first day. She went from being really anxious and not even wanting to get out of bed and being scared of doing that to getting in a wheelchair and kind of working through it. Then it [her anxiety] would just kind of come back with each new thing we did and so the biggest thing for her was well fear. So, I think with a lot of patients just educating them on like what you want to do and how it's going to work. Let me show you what this is going to feel like or let me show you what we're going to do here. That approach just helps bring that anxiety level down. But I think the big thing with her was just the trust and fear and it was…they were huge things until the day she left because her discharge kept getting put back. She was still kind of sick when she went home and so it's…I just give her a big hug every time she comes in because she's doing so well. But yeah those two things I think work the best.

Christina's narrative exemplifies that developing patient-clinician relationships requires emotional labor, yet can produce favorable results including positive patient outcomes, self discovery, and hope.

Summary and Analysis

The participants in this study expressed the importance of emotional responsiveness for effective relationships in healthcare. These health care providers believed that understanding how someone feels and being an empathetic provider is crucial to providing care, especially when cultural differences between the provider and patient might tend to make a person less comfortable in expressing their concerns. The PTs emphasized that it is not enough to be technically competent in patient assessment or intervention skills; instead practitioners also need to be emotionally engaged with patients and their families. The findings support the central worth of developing emotional understanding, respect, and empathy in building

relationships in health care encounters. The data suggest that greater time and self-reflection may be required to build emotional responsiveness and understanding when practitioners are more socioculturally distanced from patients based on dissimilar levels of privilege or community backgrounds.

The participants also candidly discussed how the effort involved in emotional responsiveness and demonstrating empathy can contribute either to feelings of burnout or to deep personal satisfaction. Participants such as Jackie, Hazel, and Christina talked about protecting themselves from burnout; conversely, they also discussed the positive fulfillment received from clinical relationships with patients and families embedded in complex medical and sociocultural situations. The results suggest that health professionals need to be attentive to their own emotional well-being and personal integration as they strive to practice with cultural humility.

Emotional responsiveness in health care communication, defined as responding to patients' emotions by establishing rapport and demonstrating empathy, has long been an area of interest of clinicians and researchers (Mast, Hall, & Roter, 2008). Although empathy is widely accepted and expected to be a central component of patient-clinician interactions (Larson & Yao, 2005; Pedersen, 2009, 2010), research has raised the considerable concern that empathy is reduced during medical training (Bellini & Shea, 2005; Stratton, Saunders, & Elam, 2008; West et al., 2007). There is a lack of research on empathy development in physical therapy practice, yet literature from teaching, medicine, nursing, and counseling provides a backdrop for interpreting findings. Research into empathy development is complicated by a variety of differing conceptualizations. Empathy has been described as a multi-dimensional

construct (Stepien & Baernstein, 2006) and a process (Benbassat & Baumal, 2004; Larson & Yao, 2005; Stepien & Baernstein, 2006). The participants' descriptions of emotional understanding and empathy are consistent with previous literature that advocates that learning to be empathetic is a process that occurs both in the personal plane and interpersonal planes (Larsson & Yao, 2005) with the social and historical context of both the patient and clinician affecting how emotional understanding is reached (Pedersen, 2010).

The findings demonstrate that although empathy is a complex concept to understand, experience, practice, and teach; its relevance to practice promotes the need for further exploration of how health professionals' emotions are shaped by the variable conditions of their education and work. More contextualized understandings of emotions are evident in the studies of the emotional experiences of nurses (Chambliss, 1996) and teachers (Blase & Anderson, 1995; Hargreaves, 2001). The emotional geographies framework of Hargaeves (2001) may potentially to be applied to study fields like physical therapy to elucidate the supports for and threats to emotional understanding that arise from distance or closeness in interactions occurring in sociocultural, moral, professional, political, and physical domains. For example, the political distance or closeness domain acknowledges emotions are not just personal matters; they are linked to people's experiences of power and powerlessness in communities, health care organizations, and the workplace.

In summary, the results support the notion that in a culturally diverse clinical environment building strong patient-clinician relationships depends on emotional

responsiveness and understanding to bridge sociocultural differences, create trust, and encourage patient and job satisfaction.

Theme 3: Focusing Care around a Patient's Goals and Needs

Participants reported that listening to stories of patients and having an empathetic understanding of the emotional nature of patient or family situations motivated them to incorporate these concerns into personalized goals. All the participants in this study spoke about focusing on a patient's goals and needs to achieve a common ground. Once common ground is established it is easier for the patient-clinician relationship to be a partnership. Sarah described why she thinks learning about a patient's beliefs, lifestyle, and goals are central to shaping a plan of care:

> I think knowing someone's background, knowing their belief system is helpful in how you can communicate something, knowing what is important in their life or their goals of what they want to get back to, I think that, that is involved in the cultural understanding. If you know what is important to them and what they want to get back to doing, you can shape your plan of care and goal setting around that.

In reflecting on how her philosophy has developed with increased experience, she said,

> I think it has probably grown, when I was a newer therapist, it was what I thought that they should be able to get back to doing. I think the longer I have been a physical therapist, you have a better understanding that if it is not important to them to do XYZ, then you don't really need to work towards that.

The physical therapists interviewed expressed a need to find some type of connection on which to develop a relationship with patients, so patients feel an openness to share concerns. For example, April commented:

> I try to look to some way to relate to them (patients). You know we might have very different backgrounds and we're still both human beings on that level. So … I look for some way to have them identify with me as not being

> this person of authority, that I'm just another human being and we can relate about the weather or we can relate about a [shared interest in a] sports team or something. That sometimes just helps to gain…just on a personal level a trust and kind of an openness level.

April than described a situation where she had to work more intensely at building trust:

> Actually, a woman who I saw today…I had seen her in the past and she's back for a different type of issue. But even for her new issue I see the same type of posturing in her and she tends to be a very guarded person, which I think is actually what's relating to a lot of her problems with her headaches right now. She's extremely quiet and you can tell she's not overly open to talk about herself. I think our first experience we got to know each other well and talked about some positive things in her family. So I draw upon some of those positive experiences in her life and finding out about her daughter who is overseas and bringing that out of her.

Once a connection or rapport is established, all the participants discussed that to provide culturally sensitive, relationship-centered care an understanding of the patient's goals is imperative. Jackie described how her attitude has changed regarding prioritizing the patients' goals the more experience she has gained in clinical practice:

> I do know that as time has progressed that my attitude has changed. Meaning that if I think a patient say for example, has a stroke but has the ability to walk again, when I was a younger therapist and if that wasn't the patient's interest I would have bumped heads and fought with them and blah, blah, blah. Now working in the field if that's not the patient's goal, that's not the patient's goal. It's not my place to judge. What are their goals? What do they want from me? What do they expect from me? It is their session. There's not a bloody thing wrong with me. This is their session. What can I do to help you? Their goal may be totally different from what my goal might be.

She talked about two instances where the patient's goals were surprising or different from goals she would have set:

> Well, there was the one who wanted to be able to walk so he could go from the SRO to the liquor store next door. Now, I can get patients moving again. It's not my position to say what they do with it…There is another recent case.

> A gentleman, he was I think 90 and they brought me in to provide therapy because he was a fall risk. Well, he'd have to be more mobile to be a fall risk. So we talked to him and we talked to the caregivers and the caregivers were concerned because he was such a dead lift for them. So, yes it made sense to get him more mobile but he wasn't interested. It was like, "Well, I'm paying good money for these caregivers. Why should I do stuff when I'm paying good money for them?" So, yes I can understand your point but we would explain to him, "Well, we want to keep you in your home and you do need to do a little bit of something so they can care for you better in the home." Sometimes he would cooperate and sometimes he wouldn't. I guess the credit to the occupational therapist and I was, I came one day and the caregiver told me, "My God, he tried to get out of bed by himself and fell," and I thought, "Well, I'll be doggone." I didn't think he was that motivated to get up by himself. So, we were kind of surprised. I mean treatment works. There you have it. Be careful what you wish for.

Jackie's tone switched and was more serious tone as she continued,

> Then again we talked with the patient and it finally worked out that he just wanted to go to hospice and so that's fine. So, maybe in some regards we helped him make that decision. What is it that you want? We're not forcing anything on you. What is it that we can do for you?

In another patient narrative, Jackie expressed the professional reward associated with effective patient-clinician partnerships. Jackie recounted a therapy session with a woman with a recent total hip replacement:

> I had a great day today with a patient. She has the most crooked spine I've ever seen in my life and I don't have a clue. I don't think I'm going to do anything. She had a hip replacement and so there's a lot happening. She's got a leg length discrepancy. So, she started to ask me today, "Well, should we walk with a cane? What should I do with this?"…So, we just started with the simple; put her in front of a mirror, get her to shift her weight, get her to put a shoe on, and then have her look because it was a body awareness issue. Then, it's like okay, "What do you want from therapy? What should we do? What are we looking at?" Then what became very apparent is what she wants. Then it's like okay, I know what you want. This is one approach we can try. So, when it gets to that point, then it gets much more fun because it becomes a creative process between two people and two heads are better than one, that's what I say. I find that very enjoyable because then I start to get very creative because at that point we're in the flow. It's a fabulous feeling because we are both connecting, working together for a common goal.

Several of the participants talked about how partnering with their patients became easier over the years. Hazel described how experiences have shaped how she sets goals with her patients for physical therapy:

> It's not your goals, it's yours combined with theirs and really putting emphasis on patient driven care. Knowing that well I think it would be great…you should be able to walk without this walker. But if the patient is not going to walk without it, then understanding that it's not a failure on your part or their part if that's not their goal…Making sure you don't push too much of yourself onto them. I think that was my biggest thing with the clinical education experiences; or looking at someone and saying, "Oh my gosh you have so much potential, we can totally have you do this." Maybe they weren't ready for it at the time. "Just so you know, you probably could do this, but out of respect of your goals this is what we're going to work towards." So, that was the biggest thing so just learning how to communicate and the more you do it the better you get. I was definitely better by my last clinical affiliation than I was on my first one. Just knowing how to establish that relationship and not be manipulated or not being too aggressive. It can go any way, just like meeting any person in life, the person just happens to have an injury or pain…not for you to be too aggressive, or too passive, or be allowed to be manipulated, or overrun; so, it was good to learn that I think.

Hazel seems to understand the importance of sharing power in setting goals and mutual respect in a patient-clinician partnership.

Using the strategy of finding common ground was also expressed by Aliza as a way to approach interacting with a student or peer who is struggling with developing trusting relationships with patients when their cultural beliefs, values and/or histories are different from the patient's. As she noted,

> I don't know that this would be the right way to go about it, but I'd say that it might be good to have some kind of starting point that perhaps takes that out of the equation as long as we're talking about physical therapy. So, I would think that the physical therapist's or the student's goal should be to help a patient restore function or decrease pain, whatever that person's goal is. The patient's goal is likely going to be along the same lines and use that as starting ground. So, focus attention on that and go and build from there to see how you can go about doing things like probably to dumb it down a little bit to begin with and then try and explore different options. So, trying to find the

> common ground first and then, I think once you have common ground it's easy to start overlooking differences [in cultural beliefs and values].

In trying to make sense of why she believes sharing power with patients is essential, Christina described the importance of understanding the context of a person's home and community environments to establish a discharge plan. She stated:

> I think that you shouldn't have power in any setting. Clinically, you know what needs to be done, but you don't know the environment that the patient comes from, so making them a player from the beginning is really important. We get a lot of amputees and we want them to have prosthesis and want them to walk, but I always try to ask them what their goals are with their new condition. Is that something that they want or don't, sometimes I don't think that that is the case, but they want it. It is just open communication, and it is really important on that level and you do so much family training and discharge planning in a rehabilitation setting. Again, from the beginning just being open with them and asking, "What they are returning to? Who is going to be there to help?" Putting the ball in their court in terms of making decisions and we need to work together on how this is going to work at home. I can tell you that it is medically going to be hard for you to do, but if you want to bump up thirty stairs because you want to go home, that is fine and we got to get going and practicing. I guess giving them the power to make decisions and set goals, but also keeping it realistic is my job and attainable, not these far-fetched things. Trying to give them the power as far as directing their treatment and what they want to be able to do by the time that they leave.

Summary and Analysis

In this study, the participants found meaning from relationships where they perceived a strong working alliance, resulting from both the emotional (establishing trust) and cognitive (e.g. collaborative goal setting) domains of care. The working alliance construct seemed to best fit the PTs' descriptions of the optimal patient-clinician relationship. Research in clinical psychology has used this construct for years with more recent application to other health professional disciplines (Fuertes et al., 2007; Hall, Ferreira, Maher, Latimer, & Ferreira, 2010). Bordin (1979) defined the working alliance as having 3 main components: 1) patient-clinician agreement on

goals of treatment; 2) the degree to which there is patient-clinician agreement and collaboration on the intervention plan to achieve goals; 3) the extent to which there is an emotional bond, characterized by liking and trust, between a patient and clinician.

The stories shared by the PTs highlight that it is through a relationship-centered process of finding common ground, establishing dialogue, and sharing power that an effective alliance is formed. This finding regarding the importance of dialogue and sharing power is consistent with previous literature that emphasizes that clinicians have a responsibility to making care participatory and relevant to the patient's goals and needs (Fuertes, Boylan, & Fontanella, 2009; Roter, 2000; Wottrich, Stenstrom, Engardt, Tham, & Kochs, 2004). Sharing of information and relationship power can be conceived to be opposite of dominant clinician communication (Mast, Hall, & Roter, 2008). Each of the PTs revealed that their philosophy of care has evolved with clinical experience to assume a less dominating stance in regards to setting goals and an overall treatment agenda. Yet, these providers also did not advocate a shift in the balance of power to full patient autonomy; they still felt they had important roles as teachers.

Theme 4: Teaching to Engage and Empower

As they develop cultural humility in patient-clinician relationships, PTs seek to be effective teachers in engaging and empowering patients and families in decision-making, adhering to exercise/activity recommendations, and ongoing health promotion. The participants talked about how they believed there was a need to tailor their teaching style to encourage active patient participation. The PTs stressed taking into account and using different teaching strategies based on patients' cultural

contexts, language preferences, and health literacy levels. The participants also spoke about sharing power and empowering patients to take responsibility for their own health and wellness.

April remembered a clinical encounter where she was challenged to adapt her teaching approach when the patient's cultural context was different from her own:

> One that comes to mind was a gentleman who had a Hispanic background and who was say probably about 45 or so, middle-aged with back pain and was extremely nice. His family was extremely nice. I saw in that culture how supportive the family system is. But what was really challenging for me was that I saw that his needs were that he needed to do "X" amount of exercises so many times a day and changing some habits and lifestyle. Though I communicated that and I got a very friendly smile it wasn't happening regularly. When I talked with a friend whose family has a similar heritage and background she helped me understand why maybe they perhaps were not as proactive about doing those things and some of the beliefs in the system. So, it did just pose a challenge. It was a lot of different type of education that I then explored and trying to show him a lot of sort of cause and effect to make him more successful with his exercises. That was just a good learning opportunity but a different challenge.

April demonstrated the value of understanding how cultural beliefs regarding exercise and lifestyle might affect adherence to her recommendations. She expressed a willingness to be adaptable in her teaching style after gaining insight from a friend from a Hispanic background regarding cultural practices. When probed regarding what strategies she used to negotiate the cultural terrain, April commented:

> A lot more demonstration. I would even go as far as to almost show him how he could produce his pain, which normally you don't want to produce pain in therapy. I kind of took that approach of again that demonstration of cause and effect and really having him do the work to see that he had so much impact and power over change. That's where I think it was the most successful.

She also described how she collaborated with the patient's daughter to bridge language and generational differences to foster exercise adherence:

> Mostly [teaching occurred] with him in that situation. There was a little bit of a language barrier with him. So, his daughter was the one that was usually…his wife would also bring him, but his daughter was the other one that would be mostly there. So she sometimes would be a little bit of my communicator and relaying some of that [information/rationale for cause and effect]. A little bit of then too, being a little bit of a different generation and a little closer to my age and more open that then I could get her buy-in. Your dad really needs to do this like five times a day and she'd go, "Okay, I'll get on him," but I think the biggest way we were successful was for him to see that cause/effect relationship of how much change he could make.

Participants described some of the challenges and rewards inherent in their efforts to adapt their teaching and learning strategies to the needs of persons of different backgrounds. Sven discussed how negotiating cultural terrain can be confounded by language differences. For example, in the settings he has worked he has commonly treated persons whose preferred language is Polish or Spanish. He talked about the strategies he utilizes when trying to facilitate communication with a patient through use of an interpreter:

> I think the most important thing when you're working with the interpreter is making sure that the patient feels like you're talking to them, not that you're talking to the interpreter. That you're interacting with them, rather than the interpreter and the interpreter is just there in the background. So, you're still building a relationship with the patient, even though you may not speak the same language. I think that's probably the most important thing because then otherwise it's hard to build a relationship of trust where the patient trusts both your knowledge and then your plan of care.

Sven further described his communication approach to fostering patient engagement and stressed making sure understanding comes through the cultural context, barriers, and translations:

> Yes, yes, eye contact is the first thing. But, also when you're demonstrating an exercise or like when on the evaluation you're making sure you're not getting ahead of the patient. You're waiting for them to respond before you say you're going to do some manual muscle testing or something. You say, "Lift your leg. I'm going to push down on your leg," waiting until the patient actually understands what you're doing before you proceed with what you

> said you're going to do. I think that's important in building that trust in that relationship and it's all those pieces put together. Looking at the patient and keeping in contact with them and also making sure they understand what's going on and are comfortable with what's going on before you're proceeding.

Although Sven's main point of making sure understanding is being achieved when language barriers exist is crucial, his strategy of maintaining eye contact would not be appropriate in some cultural contexts.

Christina also reported that she finds the teaching aspect of her work as a PT to be central to her role as a physical therapist. She talked about how she has had to develop strategies to provide education to persons with less educational attainment and limited health literacy skills. Health literacy as defined by the Institute of Medicine (2003) is the "degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." Christina explained she has learned to engage differently with persons who have lower health literacy from lack of exposure to health care resources:

> For me it's definitely been being direct in what I'm saying and the teaching ability of it and accommodating that to the patient and their family. I know that's what therapists have to do, but it's a different style of teaching. I think when a lot of these patients haven't even finished 8th grade in some of the families and high school education. Not that they don't get it, but it's just kind of how you're going to approach them with this idea. The safety issues also just making sure they do get it. Like this person can't be left alone. So, I think when I first started [as physical therapist working with less literate people in an urban rehabilitation hospital] it was really hard to be direct like, "You can't leave this person alone". Now this [instruction] just rolls out. So making it very clear what needs to be done, giving lots of time for practice and making sure that they [the families] understand that they have to be confident in it [providing care at home]. Repetition I think really does help a lot for them to understand what they have to do. Probably, those are the two biggest strategies.

Christina recognized that a key piece of the patient-clinician interaction process from an educational perspective is being able to better estimate patients' and families' understanding and ability to act on health information. Christina reiterated her belief that building trust and being an effective teacher through proficient communication are central to positive patient outcomes. Christina recounted:

> A lot of times you see the patient getting better and you don't think that you did much. But, I look back and a lot of it is that trust that you formed with the patient; and building their confidence within themselves and you; them knowing that they can get stronger. I think that it is all just teaching, and we are teachers with a medical background. I think for the patient to fully understand what you want them to do, especially in a neurological setting a lot of it comes from the trust and communication. How you can simplify communication, can you expand on it with others, and learning your population that you are treating.

Empowering patients that come from less privileged backgrounds is seen as a particular teaching challenge. Christina provided insight on the delicate balance between wanting to serve others, yet empowering patients to take responsibility for their own health and wellness:

> Right, you learn a lot of that in [this kind of urban rehabilitation hospital] setting. You can go over the top in trying to help people, but then you are the one doing everything for them. Then it becomes "I deserve this is or this is my right" type of feeling from the patient. I don't think that approach is good either. Some of that probably comes just from the government agencies and support that we do get. Which I think is important and is needed, but then at times it promotes dependency sometimes over empowerment. They say, "I deserve this". Well you really aren't doing anything, here is the telephone number and you call them. You need to learn how it is best to empower people and support them socially and give them resources without you doing all of the work and overdoing it.

Hazel described how she tries to act out her approach to patient empowerment:

> I try to find the positive, so even if their [the patient's] medical history looks terrible, try to find something that they've done well and say, "Do you know what? I'm really glad that you took the initiative to follow up with your doctor about this back pain because it's been going on for three years. It also

> looks like from your blood pressure reading that you better get back to your primary care and see what's going on here and just… acknowledging that they took some initiative". Then asking them to take even more responsibility and ownership and saying, "You know this is great." and not as, "You need to do this now". But, "Look how well you're handling this; you're only going to be better if we take care of these other three issues, so let's see about getting that phone call to your doc. I'm going to write this note, but it's still going to be on you", then following up with it. So, I think it's more of knowing that they've had a health care professional, so someone who should know what they're doing, look at their stuff [health information]. Then say, "Okay here we go" and then giving them the responsibility and checking up with them to say, "Did you call the doc to see about your blood pressure or not?" If it's appropriate then if they're not doing it, then before they go say …"There's a phone up front, sit and make this appointment before you leave"; just trying to facilitate them owning their care.

Aliza explained how she serves as an advocate for patients both for transportation services and to help them understand the need to be assertive in the clinical cultural environment to get their questions answered. Aliza noted:

> I think the biggest issue with our patients comes with transportation. In that respect, getting social work involved and helping patients get transportation; and the things that they need. So, I think a big part of it is getting social work involved. Then like on a completely opposite end, that doesn't involve transportation or anything just making sure that a patient knows that they have the ability to speak for themselves. Then when it comes to, this isn't necessarily physical disability, but making sure that they're asking questions. So, that they can know what they can do or can't do in every situation; because I think a lot of times patients tend to think that they're just going to get all that information from everybody that they encounter without asking questions, which unfortunately in today's healthcare world isn't true. If you're not asking questions then boom you're out the door. So, I think those would be the only two things I can think of.

Summary and Analysis

In the fourth theme the participants emphasized the value of being effective "teachers" to engage patients in the care process and empower patients to take responsibility for their own health and wellness. All of the PTs stressed the significance of providing both technical expertise and behavioral recommendations in

a manner that is understandable, useful, and motivating based on the person's cultural background and practices. The PTs talked about utilizing teaching strategies to: 1) provide knowledge to patient's to help them understand their health conditions; 2) instill expectations of physical therapy interventions to patients and families in order to alleviate anxiety and build confidence; 2) engage patients in a collaborative process to restore movement capabilities for meeting goals; and 3) empower persons to take responsibility for self-management of their health.

The PTs underscored the importance of having the appropriate tools and skills for teaching when interacting with persons with limited English proficiency or less health literacy. Inequities in health care may be linked to how information is delivered to vulnerable members of our society who have language barriers or lower literacy skills (Hasnain-Wynia & Wolf, 2010; Ratzan, 2001; Roter, Erby, Larson & Ellington, 2007). Participants such as Sven, Aliza, and Hazel stressed the importance of knowing when and how to work with interpreters to meet the needs of people with limited English proficiency. Past research has shown that clinicians underutilize interpreters, despite awareness of their own language limitations (Diamond, Schenker, Curry, Bradley, & Fernandez, 2009; Karliner, Jacobs, Chen, & Mutha, 2007). The findings from this study support previous literature that contends learning about language barriers, and how to overcome them, should be an essential component to all health professional curricula (Diamond & Jacobs, 2010; Jacobs, Diamond, & Stevak, 2010; Marion, Hildebrandt, Davis, Marín, & Crandall, 2008).

Similarly, health professionals need to adapt their teaching and learning style to serve persons with less health literacy. PTs and other health care providers need to

be aware of how medical dialogue may be made more effective and relationship-centered for persons and communities with lower literacy skills by monitoring use of technical terms in their vocabulary; decreasing language complexity; and attending to structural aspects of dialogue such as pacing, density and interactivity (Roter et al., 2007). Further study is needed to explore how PTs and other health care providers can learn to engage more effectively with persons with less health literacy and decrease the potential for approaches to induce shame or stigma. For example, additional research is needed to examine how health providers can develop proficiency in more nuanced levels of communication to promote trust and understanding in the patient-clinician relationship in populations at risk for lower health literacy skills.

The participants were committed to adapting their teaching approach to meet individual needs through understanding of the local community's sociocultural dynamics and health care resources. Part of their approach was also to help patients navigate the complexities of the health care system by coaching patients and families on strategies such as how to ask questions in clinical encounters. Optimally, a relationship-centered health care provider who practices with cultural humility also seeks out community dialogue to promote community health (Beach et al., 2005; Pyles & Kim, 2006).

Theme 5: Evolving Awareness of Community Needs and Assets

Physical therapists' life histories revealed an awareness of health care vulnerabilities and disparities at both individual and community levels. This group of physical therapists expressed a clear commitment to making an impact on the quality

of individual patient lives, albeit with differing levels of motivation and support for community relationships. For instance, on an individual level Aliza explained how she reaches out to patients with less privilege by trying to optimize community resources:

> I think one of the ways that we do that is we try and seek out things like opportunities that a patient might not know about. I don't know if I'm taking this too literally, but let's say patients don't have the financial resources and you're advising them to get exercise. They feel like they can't do exercises at home and they need to have equipment to do it. There's the Park District where they'll let you workout for free under certain circumstances. There are a bunch of other free senior classes and things of that nature where we'll take the time to do research on that and have those resources available for patients. So in that respect we're showing them different opportunities that they might not have thought they had. I think it's just a matter of understanding what resources somebody does have and trying to utilize those resources to address a patient's needs.

The participants recognized a need for building community partnerships, yet voiced there are a number of barriers such as lack of time, professional culture emphasis, health care institution support, and grassroots community member involvement. Sarah discussed the difficulty of balancing community involvement with personal commitments from a time perspective:

> Community involvement also is a wonderful idea; I haven't done much of that since I became a physical therapist. I did much more when I was in high school and college. I think it is just a time issue where working full time I feel that there are only so many hours in the day—work, family, husband, house—those sort of things. I would like to do more community work, I haven't done much at all. It is a good idea.

Hazel expressed a desire to have a broader commitment to community. However, she perceived a lack of institutional commitment to allow her professional time to increase involvement:

> I think that falls within our spectrum. I don't think it is valued maybe from an employer perspective. So, I would think it would be great if I had one

> Thursday afternoon every month to present a community based inservice on arthritis and joint protection. I think that would be great and those opportunities at least within our system don't exist. Maybe they do in other settings or maybe they're more through different health fields. I feel with physical therapy that we're still trying to make sure we're billing units and dropping charges. That at last if you want to pursue community partnership you have to pursue that on your own or as a service activity. I think it would be great if it was incorporated more. Say oh yeah every Wednesday from eight to noon you can go to the senior housing center and do your monthly in-service. That would be great. I don't think it's there, at least not where I am.

Jackie expanded her discussion of barriers beyond time constraints to describe how the medical professional culture, health care institutional priorities, and lack of community member engagement inhibit meaningful clinician community relationships:

> That's a hard one because I don't really see it happening. I don't because I don't see it as a focus. I think it's hard for me because I'm so limited in my time that if I have some free time, yes I don't really want to give it to doing free services because I want to do something else. Again I don't see it as being a focus of our profession or the medical profession at large, unless you really seek that out. I've been a part of a few medical fairs, but that was more to drum up business to be absolutely blunt. I think it's probably a two-way street. The medical community doesn't reach out, but the community doesn't reach out either. So, I think it's that problem. One of the things that I always found astounding about working in public hospital was the fact that I felt the services that I had to offer were valuable to give to these people and I can't believe as a community they haven't raised up in outrage at the way their services have been cut. How they've been denied access. So, I see it as a two-way street and maybe somebody needs to give them permission that this is not a privilege this is a human right.

In contrast to Jackie who has experienced lack of health care institutional support for community involvement, Christina views the urban rehabilitation center she works for as being committed to community advocacy. Christina also seems to envision community as having multiple layers—clinical community, neighborhood (local) community, and global community. Christina remarked how she values the clinical practice community:

> I think growing up in the community I did, probably has fostered me to be the one that sits down and says hi to everybody and to do all those things because that's what I grew up around. Like my mom worked at a grocery store so we didn't go anywhere without knowing somebody and we'd be out to dinner, we'd be at Wal-Mart whatever and she would know ten people and it was always respectful, it was always genuine it was always a positive interaction. I think you miss that sometimes in the city. I think work is kind of a good place that I enjoy for that purpose. Because I know those people and you can kind of welcome them without even realizing that you're doing it just by saying hi, how I was brought up. So that's a good piece to have.

Christina appreciates working for an institution that is committed to a positive clinical practice community atmosphere and to community advocacy; however, she expressed that physical therapists in her current work setting are minimally involved in community engagement.

> Then unfortunately we [physical therapists] don't get involved…much too much in the community at [urban rehabilitation hospital]. There is a huge amount of community advocacy, I personally haven't been involved, but they have a computer lab on the first floor when you walk in that is always open to anybody who is a patient there. There is a huge support group for the spinal cord injury population. They have people who go out in the community who give talks at schools about gun violence and gangs, because unfortunately a lot of them were in gangs. There is a core group of four or five guys and one lady who get out and promote that stuff. They recently had a huge increase in national media, with Ted Kennedy passing away and the Americans with Disabilities Act, they were on the news talking about how things would have been different if he wouldn't have been involved in that [legislation]. I feel that they are gaining a presence too in the general community. I think that it works well because the people that are speaking to those kids in the schools; or the people going to the churches, talking about strokes; are people from the community that have been affected. Sometimes therapists will go to provide education in the community. Recently a couple of PTs went to some churches and talked about stroke warning signs for stroke month. I feel that they [the institution Christina works for] does a really good job in trying to get out and educate the community.

Christina talked about the need for partnerships between community members, institutions, and health providers to mitigate the consequences of social determinants on community health. She also expressed that she has come to

appreciate the political and economic context for health care disparities and the importance of preventative health care through her involvement in global health initiatives. Christina stated,

> In Guatemala, I think it is harder because it is a bigger problem and there are not the government resources that we have here. The government is being more involved in Guatemala. I feel that they are getting more referrals from that, it is just that the population that needs to be served is so much greater I think. The means to get to the clinic, a twelve hour bus ride, no cars, it is more difficult than we have here with Pace buses and Medicar. I think that when we do go down, we make a good difference as far as giving people medical attention, catching things that may not be seen, or preventing things that may not need to be done. A lot of time patients down there become above knee amputees because their only allowed one surgery in their lifetime. They are not just going to mess with a toe; they're just going to go up to the thigh. If we can come in and educate people on wound care, on foot wear, on diabetes, and stuff like that to prevent diabetes [efforts have different level of impact]. That is how it [community outreach effort in Guatemala] is becoming more in the recent years whereas in the past patients seen were more from accidents and trauma, the diabetes population is showing up down there. That is helping a lot with the education and preventing things [health problems] down the road.

Hazel discussed the potential benefit of more emphasis on community engagement and social responsibility during professional education:

> I think that's something that can be started at the…in the early like your first year as a student. I think that [social responsibility] needs to be instilled more. Thinking back on my first couple of semesters it was gross anatomy lab, neuroscience, and physiology. Then I was like, "What day is it? Why am I here?" I don't even remember. All I need to know is where this origin and insertion is [referring to knowing origin and insertion of muscle] because I have a test. So even remembering why you're doing what you're doing. Maybe if it's… making students go to the clinic once a week just to observe and even better if it's a clinic that serves the community...I think the idea of having a community service requirement, however you want to fulfill it, is a nice way just to show as a human you're responsible for society and if it needs to have that PT focus okay, but I think just promoting involvement in general is something that's worth that. But trying to instill it from a program's core values letting them [professional education faculty members] to communicate to students you know we want you to be proficient in these skills and then also demonstrate this responsibility to society. I don't think that's always noted.

Summary and Analysis

The participants expressed varying levels of motivation to develop clinician-community relationships. All of the participants were committed to taking into account community contextual influences and assets when interacting with patients or families in making decisions and carrying out individual treatment plans of action. Although all the participants considered community engagement valuable to reducing health disparities and enhancing the health of the public, the participants' expressed concerns that community engagement is not a consistent priority of peers, the health professions, or health care institutions. Several of the participants' reflections illustrated a tension between valuing on a personal level social responsibility to community service and knowing that health care institutions and the culture of medicine lacks support and recognition for this area of professionalism. The participants talked about having to commit time outside of work and their own funding to fulfill their innate drive to have impact as health providers or citizens on more of a community or societal level. Community-academic and community-health organizations partnerships have been advocated as vital for reducing health disparities (Lucey & Maurana, 2007; McGinnis, 2006; Saha, Beach, & Cooper, 2008). Yet, the findings in this study suggest that the participants felt more constrained rather than enabled by the institutional structure of health care organizations, by time, and by the culture of medicine to develop cultural humility in clinician-community relationships.

CHAPTER 6. DISCUSSION AND CONCLUSION

Introduction

In Chapters 4 and 5, I discussed results based on the eight life histories and the cross-case analysis. The analysis of the data revealed five recurrent themes for building trusting relationships with persons of diverse cultural backgrounds. In this, the final chapter, I bring these findings to bear on the research questions guiding the study, the theories that framed the research (RCC, sociocultural, and insurgent multi-culturalism), limitations, implications for education as embedded in answering Research Question # 4, implications for clinical practice, and recommendations for future research.

Research Question # 1

What types of life experiences do PTs perceive frame the way they address cultural differences and build relationships in health care settings?

What meaning do PTs' ascribe to their life experiences as they strive to make sense of their approach to interacting with persons from diverse backgrounds in healthcare?

Learning how to build and maintain effective relationships in one's care is no simple matter, yet many times we assume that this is more of a natural process, rather than a learned capacity in fields such as teaching and medicine (Grossman et al., 2009). This study found that foundational early life experiences, clinical education experiences, and ongoing patient-clinician interactions that trigger practitioners to reflect deeply on their assumptions and biases frame the way PTs address cultural differences and build relationships. To a lesser extent classroom and early field-based experiences impacted how these PTs approach connecting with persons from diverse backgrounds and delivering effective care. Professionals in relationship-centered

fields need rich, challenging opportunities that keep stretching their comfort zones to foster technical expertise, reflective capacity, emotional growth, and cultural humility. Over the course of one's career, developing these critical dimensions of professionalism enhances a practitioner's ability to deliver relationship-centered care to persons from a variety of cultural backgrounds and to increase professional satisfaction (Murinson et al., 2008).

Foundational Early Life Experiences

Six of the PTs cited their parents or their familial upbringing as foundational for their beliefs and attitudes toward building trusting relationships. Christina, Hazel, Art, and Sven all described their parents as instilling positive attitudes that centered on being open-minded and nonjudgmental of persons from backgrounds different than their own. Sarah recounted how her parents and great uncle emulated showing respect to persons by providing a comfortable environment for interactions. Aliza related that she was shaped by her parents and early schooling to attend to strategies to reduce discrimination. Several previous studies in medicine and education show that core values of professionalism such as compassion, altruism, and respect for patients or students are well established by the time of college through early background experiences (Castro, 2010; Pohan & Aguilar, 2001; Richardson, 1996; Wear & Zarconi, 2007).

A second foundational influence was exposure to diversity during undergraduate experiences. Intercultural friendships and attending liberal arts colleges were described by the PTs as fostering openness to diversity. For instance, Art and Aliza both described how interactions with their roommates influenced how they appreciate cultural differences. Sarah, Hazel, Sven, and April felt the holistic

nature of coursework at liberal arts undergraduate universities shaped their attitudes and behaviors prior to entering PT professional education degree programs. Health professional educators need to be aware that students commonly enter health professional education with attributes that include caring for others and showing respect in interpersonal interactions with persons of different backgrounds. Thus an important aim of the curriculum is to continue to nurture empathy and raise critical consciousness as clinicians wrestle with unsettling aspects of practice such as disparities in care and prioritizing of technical skills (Mostow et al., 2010; Wear & Zarconi, 2007).

Professional Education Classroom and Early Field-based Experiences

Data analysis revealed that PTs varied in how classroom and field-based experiences shaped how they learned to build relationships in practice. Jackie, the PT with the most years of clinical experience, was the only participant who perceived that her entry-level professional PT education did not focus on any course-oriented learning that helped her address differences in building relationships. The rest of the participants discussed beginning to develop a relationship-centered oriented compass from psychosocial issues coursework which included role playing, communication skills training with instructor feedback, practical exams with simulated patients, and field trip experiences in health care settings integrated early in the curriculum. The field-based experiences were followed by small group classroom discussion activities to stimulate reflection and perspective taking on the challenges of providing effective care.

The types of activities discussed by the participants represent opportunities to rehearse and develop components of complex practice in settings of reduced complexity, what have been called approximations of practice (Grossman & McDonald, 2008; Grossman et al., 2009). Grossman and colleagues (2009) have emphasized the importance of designing classroom activities that emphasize enactment of tasks that may be difficult for new professionals and can benefit from guided coaching. For example, having students conduct an initial interview with a simulated patient or community volunteer to practice communication skills, is an approximation of practice that can occur in the university classroom prior to the clinical setting. Although approximations of practice are not entirely authentic, use of this type of pedagogical strategy can provide opportunities for experimenting with new skills and ways of thinking with more support and feedback than actual practice in the field allows (Grossman & McDonald, 2008; Grossman et al., 2009). The findings of this study suggest that approximations of practice be utilized increasingly in health professional curriculums to allow learners to hone their RCC skills before they have to manage all the competing demands of complex cases and environments as they move into clinical education experiences.

C*linical Education and Ongoing Patient Driven Experiential Learning*

All participants voiced that engagement in clinical education experiences were critical for providing opportunities to learn about providing care that bridges cultural differences. Clinical education experiences in health care professions are parallel types of pedagogical experiences to student teaching in educational fields. A student teacher is supervised by an experienced teacher in carrying out classroom activities,

while the novice PT is supervised by an experienced clinical instructor in a health care setting. Similar to previous studies in nursing and physical therapy (Benner, Sutphen, Leonard, & Day, 2010; Plack, 2008; Spouse, 2001), the PTs in this investigation emphasized experiential learning, or learning from the actual immersion experiences of caring for patients during clinical education experiences was key to framing the way they address cultural differences and build relationships.

The findings also support that learning how to address cultural differences in an ongoing process where complex cases and social interactions continually shape development of different ways of thinking, feeling, and behaving (Renshaw, 2003). The PTs shared multiple stories that related to challenging patient interactions that had occurred within the week preceding their interviews where they had to wrestle with how best to approach developing an effective patient-clinician relationship. The results are consistent with previous models that have emphasized that interacting effectively with persons of different cultural backgrounds is an ongoing developmental process (Campinha-Bacote 1999, 2003; Cross et al., 1989; Purnell, 2002; Suh, 2004). Solving complex problems, with patients or colleagues from different cultural backgrounds reinvests skilled practitioners in a process of reflection and renegotiation of meaning making, which facilitates positive patient outcomes and professional growth.

Research Question # 2

What contextual influences do PTs perceive have facilitated or constrained their development of cultural humility in relationships?

Participants in this study expressed that a multitude of contextual influences shaped their development of cultural humility. Sociocultural theory helped to situate

how this group of PTs made sense of life experiences on the three contextual planes of interaction-personal, interpersonal, and community/cultural (Rogoff, 1995) to develop trusting relationships. The PTs' life histories demonstrated that development of cultural humility occurs in all three planes, yet these planes also influenced and mediated each other.

Personal plane

The participants were able to articulate a self-awareness of their cultural life stories and to describe a sense of accountability for examining their privileges and biases in developing relationships in clinical practice. Boler's pedagogy of discomfort provided a framework for interpreting the importance of health practitioners confronting relational gaps within the personal plane. Building trusting relationships requires an attitude of openness, an ability to listen attentively to patient stories, and a willingness to explore the emotions, beliefs, and behaviors that lie beneath the surface of the patient's narrative and one's own life story. For example, Hazel talked extensively about how she had to learn the importance of creating a comfortable space for dialogue to understand a person's experience with pain from their cultural perspective. Hazel and the other participants learned how to confront difference and form trusting relationships by exploring their sense of self in relation to others in clinical encounters that stretched their comfort zones and caused them to honestly examine their attitudes, biases, and uncertainties.

Additionally, from a sociocultural perspective these PTs shared the attitude that it is not enough to have cognitive knowledge expertise, they also believed one needs to adopt the conceptual tool of emotional understanding to build trust and

working alliances. Despite growing awareness of the complexities of providing care, most health professional curriculums focus on knowledge-based learning versus fostering the development of emotional competence and reflective capacity (Murinson, Agarwal, & Haythornthwaite, 2008). Future research should examine how specific teaching practices and curricular components foster the emotional and reflective development of health care providers.

Interpersonal plane

The participants indicated relational skills were enhanced by supportive guidance from outstanding clinical instructors, role models, and mentors in the physical therapy culture. The findings can be viewed as consistent with the guided participation concept from sociocultural theory (Rogoff, 1990; 2003) that proposes that learning is facilitated by interactions with capable members of the culture. For instance, April gave multiple examples of how skilled peers in her work setting have influenced how she prioritizes taking time to understand a patient's needs based on their cultural background, emotional state, and community resources.

The PTs' reflections on their clinical education experiences emphasized the significant impact clinical instructors have on the development of relational skills and attitudes through role modeling, both positive and negative. Art described the affirming influence of having a clinical instructor who was an exemplar for being open-minded, non-judgmental, and compassionate in interacting with a diverse patient population. Conversely, he spoke candidly about interacting with another clinical instructor in a different setting who provided an example for the type of PT he did not want to become based on her negative attitudes. For Art, interacting with

positive and negative role models fostered a critical consciousness of how he wanted to approach patient-clinician interactions. All the participants described clinical instructors or mentors in their early career phase as being important in instilling a diligence to connect with patients and build trusting relationships. Positive role models and mentors shaped the participants' overall philosophy of care, as well as provided guidance on practical tools such as interviewing techniques to promote understanding a patient's perspective.

Current research in health professional education supports the notion of positive clinician role models stimulating critical reflection and development of professionalism (Murinson et al., 2010; Plack, 2008; Shapiro, 2002; Wear and Zarconi, 2007; Wright & Carrese, 2002), while literature on the impact of negative clinician role models is less clear (Murinson et al., 2010; Wear and Zarconi, 2007). Positive role models can influence a learner if they foster dialogue and debriefing in a safe environment to address challenging issues such as the different forms of prejudice in health care settings (Kumagi & Lypson, 2010) or depersonalization of care by practitioners they may encounter (Shapiro, 2002; Wear and Zarconi, 2007). Future research is needed to gain deeper understanding of the process through which learners are shaped by role models and the type of academic and clinical environments that support learning to provide care that bridges cultural differences.

The participants consistently expressed that patient-clinician interactions motivated them for ongoing professional development of cultural humility. The PTs connected their experiences and learning across many patients. The insights they described from patient stories constitute an unbundling of clinical narratives to derive

at mean making. For example, Christina spoke about "I think it's just all the little pieces that have come together over time" to explain how her experiences with challenging patient situations in different health care settings in an urban region and internationally have stimulated growth and a passion for social responsibility. When asked whether her ability to reflect on her own privilege has evolved, Sarah described: "I think back to how I was when I was a student, I think it's pretty different now just from my years of interacting with all different types of people." The participants also acknowledged that they have learned to negotiate the complexities of patient-clinician interactions through working in clinical environments that encourage clinician-clinician collaboration and mentoring.

Community (cultural plane)

The stories of the participants in this study revealed that learning how to develop cultural humility was both facilitated and impeded by community plane influences. The PTs discussed that the cultural and social practices of the physical therapy profession, as well as academic and health care organization institutional contexts, have influenced how they approach providing care. For example, Aliza stressed that the university she attended shaped her philosophy of focusing on the patient's individual needs and preferences. Her philosophy has been strengthened by working for a public medical center and physical therapy department where the cultural belief systems are focused on patient-centered care and reducing health care disparities. Christina recounted that her entry-level physical therapy educational program helped her become more open-minded and willing to question the reasoning behind her clinical decisions during classroom and clinical education experiences.

Her clinical reasoning, reflective capacity, and cultural humility have further evolved as she has worked most recently for a health care institution with a long history of providing quality health care to an underserved urban community and its people.

Community or cultural plane influences on patient-clinician and clinician-clinician interactions has been a relatively neglected topic in medical literature on how health providers learn how to develop relationships and carry out treatment plans with persons of different cultural backgrounds (Charles, Gafni, Whelan, & O'Brien, 2006; Pyles & Kim, 2006; Safran et al., 2005). Interestingly, the PTs in this investigation chose to work in health care settings where they felt they had the autonomy to be able to be creative and dynamic in their interactions with patients and carry out a treatment plan. Yet, concomitantly they valued an institutional climate that encouraged respectful, collaborative clinician-clinician connections including connections with physicians who traditionally have been on the highest pinnacle of the health care team hierarchy. For example, Jackie appreciated that there was much autonomy in her first work setting, an urban public hospital, which allowed her to deliver the best care possible to a culturally diverse, often underserved patient population. She attributed the autonomous practice environment and supportive clinician-clinician relationships as being influential in shaping her holistic approach to patient care. When administrative changes eventually created a more bureaucratic environment, she decided to transition to working for a home care agency where she again could be creative and dynamic in her interactions with patients, family members, and co-workers.

The results of this study showed that Jackie and the other participants felt more constrained rather than enabled by the institutional structure of health care organizations, by time, and by the culture of medicine to develop cultural humility in clinician-community relationships. The participants expressed concerns that broader community engagement is not a consistent priority of health professional educational institutions or health care organizations. The PTs voiced that community partnerships are not commonly supported beyond a marketing strategy. The findings of this study suggest that fostering necessary collaboration in clinician-community relationships will require changes in: 1) professional education to emphasize the importance of social responsibility to community health; and 2) the culture of medicine, as practiced in most health care institutions, that although patient-centered, is not community-centered.

Research Question # 3

How do PTs' life histories elucidate how they attend to or resist facing issues of privilege and power in relationships?

Results from this study support the assertion that to effectively interact with people from culturally diverse backgrounds practitioners need to pay attention to the relational aspects of care (Beach, Rosner, et al., 2007; Canales, 2000; Mostrow et al., 2010). These clinicians viewed that neither dominance nor total abdication of power in patient-clinician or clinician-clinician relationships was what formed quality relationships. Rather, power needs to be shared as connections are created and cultivated in clinical encounters, with trust as a central component of relationships. Rauner (2000) and Beach, Rosner, et al. (2007) have proposed that caring for those

outside our cultural background is often more challenging, as cultural differences often create barriers to trust and connection.

How do health providers negotiate power relations so trust can be built in patient-clinician relationships? The first step the PTs expressed is vigilance to remain open-minded as patients tell their stories and communicate their desires, versus making assumptions. Each of the therapists emphasized the importance of creating a comfortable environment for interaction, listening attentively, and not dominating dialogue to better understand a person's history, social context, values, and preferences. These findings are consistent with the relational models for addressing race, ethnicity and culture in medical training by Mostow et al. (2010) and Beach, Duggan, Cassel, and Geller (2007), which emphasize the following professionalism elements: 1) attitudes and behaviors that translate into sincere respect for patients as persons; and 2) communication skills to counter power differentials in culturally challenging situations. Further research is needed to examine how health providers can develop proficiency in more nuanced levels of communication, both verbal and nonverbal, to promote trust and cultural understanding.

Mutuality and Embracing the Role of Teacher

Each of the PTs also revealed that their philosophy of care has evolved with clinical experience and development of cultural humility to assume a less dominating stance in regards to setting goals and an overall treatment agenda. In parallel, the participants more fully embraced the role of teacher in patient-clinician interactions. The importance of dialogue and collaborative empowerment is consistent with previous literature that emphasizes that clinicians have a responsibility to making care

participatory and relevant to the patient's goals and needs (Fuertes, Boylan, & Fontanella, 2009; Roter, 2000; Wottrich, Stenstrom, Engardt, Tham, & Kochs, 2004). From the perspective of the PTs in this study, honoring patients' preferences should be paired with effective teaching and advocacy. A health professional serving as an effective teacher empowers by equipping learners (patients) with what they need to help themselves in their cultural context; this includes not just information but also enhancing patients' beliefs that they can manage and adhere to the treatment plan and ongoing health promotion (Canales, 2000; Fuertes et al., 2009; Roter, 2000; Zubialde, Eubank, & Fink, 2007).

Challenges and Complexities of Relationships in Practice

Although the PTs described several approaches to establishing mutuality and sharing power, the participants also discussed the ongoing, challenging process of making sense of the complexities of social and culture differences within relationships. One of the complexities of practice is sorting out how both cultural and social class differences can affect patient-clinician relationships and care delivery. There was lack of clarity in whether participants viewed culture and class-based differences together or as two parallel aspects of difference. Interestingly, the participants felt that it was important not only to develop strategies to communicate with persons who have faced oppression or disparities in care, but also with people who by their privileged status feel entitled to more physical therapy services than the clinician felt was warranted. The PTs were motivated to work with persons of varying cultural and social class backgrounds, however it was harder at times than I expected for the PTs to articulate how to engage differently with persons if they are

less educated and lack exposure to medical terms and jargon. A bit surprising too was the number of times the PTs discussed wrestling with not being biased when interacting with persons whose insurance coverage is through workers' compensation benefits. I sensed that the PTs saw this group of patients as a cultural group.

Overall, these clinicians had an empathetic stance to the situations of patients where social oppression seemed to be a component of the patient's story and were motivated to impact individual lives by providing quality care. Although the PTs described they were privileged, they only minimally discussed how they or the medical culture might be implicated in the social forces that create the climate of obstacles for persons to receive quality health care. The participants were also less descriptive about how they might advocate for social change through addressing structural issues found in work settings or through participating in activities that benefit the health of communities.

Research Question # 4

What are the implications that attention to one's own culture, privileges, and biases from a life history perspective hold for health professional curricular and pedagogical choices?

A great challenge facing health professional educators is to prepare clinicians to advocate and care for persons who may be very different from themselves. The importance of this mission is underscored by an ever increasing body of evidence of racial, ethnic, and social class-based disparities in health care delivered (Smedley et al., 2003). Health professional education, therefore, is a matter of developing not only technical competence and solid knowledge of biomedical subject matter, but also attuned relational skills to be able to deliver care to the diversity of patients that characterize contemporary health care. The following section presents a set of

recommendations to promote development of cultural humility based on the findings of the study.

Narrative pedagogies and learning to listen across differences

The findings of this investigation support that learning to build trusting relationships with patients as a health care provider involves developing skill with narrative structures and narrative thinking. A narrative approach to understanding patient-clinician interactions fosters learners to put their patients' experiences into context; including integrating the patient's cultural background, the patient's community environment, and illness experience into a plan of care (Benner et al., 2010; Kumagai, 2008; Kumagai et al., 2009). Academic departments and health care institutions need to support educators in learning how to use narrative pedagogies in the classroom and clinical settings (Boudreau et al., 2009; Charon, 2006). A positive exemplar is Kumagi and Lypson's (2009) framework for using illness narratives to facilitate critical consciousness in medical students trained at the University of Michigan. Their pedagogical approach uses literature and a series of scheduled visits over two years to the homes of volunteer patients and their families to understand the lived experiences of persons with chronic illnesses (Kumagai, 2008; Kumagai et al., 2009). This type of narrative approach puts a human face on cultural conflicts, cultural biases, and health care disparities and allows for learning in affective, experiential, and cognitive dimensions (Kumagai & Lypson, 2009). The findings of this study support that because illness and injuries occur with the context of a person's life, health care practitioners need to develop proficiency in listening to patients in an unbiased manner in order to understand their stories and perspectives.

According to participants, PTs must learn to listen across differences and develop empathetic listening skills to practice with cultural humility. These findings are important since learning to listen across difference in relationships has only begun to be explored in education (Boler, 2004; Schultz, 2003; Thompson, 2005) and in medicine (Boudreau, Cassell, & Fuks, 2009; Charon, 2006). I sense that educators, including myself, have too often thought of listening as an intuitive skill. Attention in the future to using pedagogical practices that prioritize learning how to listen may promote health professionals sharing power in relationships and responding to others in the contexts of their individual needs.

Emotional development and reflective capacity

In the development of communication and relationship building skills in professional education, the emotive and affective component cannot be ignored. Although the participants in this study have been influenced by the biomedical model of striving for objectivity, they likewise recognize that effective physical therapy practice includes developing emotional understanding, respect, and empathy in building trusting relationships. Encouraging better emotional understanding and the quality of care that comes from it may require a rethinking of educational pedagogy in health professional fields. A key curricular aim may be to prevent the development of a double-blinded, dichotomized clinical gaze where biomedical, cognitive expertise aspects of care are separated from other aspects of human experience (Murinson et al., 2008; Pedersen, 2010; Wissow, 2007). For example, in communication skills training, interview practice conditions could be simulated to

promote attention to patients' emotional concerns in the face of time pressure and seeking medico-scientific information.

Several educational and medical scholars have also advocated that educational experiences be designed for novice and experienced health professionals, such as the mainstream PTs in this study, to explore their sense of self in relation to others in social and societal interactions (Aultman, 2005; Kumagai & Wilson, 2009; Wear and Aultman, 2005). The participants in this study were introspective regarding their own life story, cultural beliefs, and feelings based on their family, community, and professional backgrounds. As a group, the PTs realized they have been accorded with privileged status by virtue of their ages, racial/ethnic backgrounds, educational opportunities, and socioeconomic class. Self-awareness of one's own life story and examining one's own privilege has been advocated to be integral for clinicians' to have genuine, effective relationships with patients, colleagues, and community members (Dobie, 2007, Wear 2006b). Encouraging reflection during health professional education and throughout ones career allows practitioners to revisit their patient encounters, challenges, and successes and evaluate how they could have been handled better for the patient and for themselves (Murinson, Agarwal, & Haythornthwaite, 2008).

Learning Through Experiences Out of Comfort Zone

Although development of cultural humility is an ongoing process, learners in this investigation seemed to require educational activities and clinical experiences outside their comfort zones to stimulate growth. This finding agrees with Boler's pedagogy of discomfort (Boler, 1999), which proposes that encounters that are

unfamiliar and cause one to take a critical gaze on one own's values, beliefs, and assumptions enhance the growth of a professional. Questioning of personal, medical culture, and societal assumptions may give rise to a worldview that is more complex, inclusive, and oriented to moral action regarding confronting disparities in health care (Aultman, 2005; Kumagai & Lypson, 2009; Wear & Aultman, 2005, 2007). The PTs in this study expressed that learning during out-of-comfort zone experiences was facilitated by positive peer interactions, clinical instructors, and mentors. Clinical instructors and mentors provided a supportive environment for learners to discuss challenges in clinical encounters and helped them identify skills and behaviors to try in future encounters. Emerging literature in health professional education suggests that fostering critical consciousness through out-of-comfort zone experiences and engaged dialogue with peers and mentors allows for the testing of the moral validity of one's position in areas of social relevance such as addressing cultural differences to reduce disparities in care (Mostow et al., 2010; Kumagai & Lypson, 2009).

Learning through Community Engagement

Beyond meeting individual patient needs, health professionals are expected to identify and address community needs as part of their responsibility to society (Beach et al., 2005; Pyles & Kim, 2006). In the last decade there has been increased discourse by professional health care associations, academic institutions, and accrediting agencies to commit time in the curriculum for preparing graduates to attend to community and societal needs (Lucey & Maurana, 2007; Reynolds, 2009). If developing mutually beneficial partnerships with communities is to become a true professional expectation, health professional programs need an overarching

framework to guide these efforts and ought to require some form of community engagement for pedagogical purposes. The RCC and insurgent multiculturalism frameworks could help ground the reasoning for implementing pedagogical choices for community engagement. Pedagogical choices that academic institutions might use for community engagement include community service, service learning, community-based research, and classroom educational interventions that use community teachers (Jacobs, Kohrman, Lemon, & Vickers, 2003; Jensen & Royeen, 2002; Lucey & 8Maurana, 2007; Reynolds, 2009).

Limitations of Study

This study focused on the meaning-making of a purposive sample of eight PTs from an urban area. Although the participants were diverse with respect to their types of clinical experiences, years of experience, and settings, given the small sample size, limited geographic location, and that all the participants were from a white racial background the findings may not generalize to the experiences of all PTs engaged in clinical practice. However, the main goal of this narrative life history inquiry was not to generate generalizable data. Rather, I aimed to locate the main themes, tensions, and beliefs that these practitioners hold regarding the relational aspects of working with persons from diverse cultural backgrounds. In exploring their stories, I strived to provide a sufficiently thick description of the particular contexts of the participants' lives, so that readers may adequately judge the transferability of the findings to their own contexts. By identifying points of resonance and divergence in the relational landscape drawn by these eight clinicians, this research seeks to inform clinical practice and provide direction for future study.

Implications for Clinical Practice

Developing cultural humility within practice is crucial to holistic patient care and serving communities. The everyday experiences shared by the PTs in this study suggest that neither dominance nor total abdication of power in patient-clinician or clinician-clinician relationships is what forms quality relationships. Rather, power needs to be shared as connections are created and cultivated in clinical encounters. A starting point for building trust during culturally challenging clinical situations is to be open-minded as patients tell their stories and communicate their desires, versus making assumptions. Next narrative reasoning, accomplished through attentive listening and exploring feelings, can be used to understand patients' concerns, cultural contexts, and to incorporate preferences into personalized goals. Effective teaching by health providers can serve to engage patients in the care process and empower patients to take responsibility for their own health and wellness. Professional development efforts are recommended to improve health care providers' skills in more nuanced listening and medical dialogue skills such as pacing, density, and interactivity (Roter et al., 2007). Hopefully, clinicians will feel empowered in the current climate of government health care policies changes to question institutional values and ideologies that lack commitment to community health initiatives.

Recommendations for Future Research

Future qualitative and mixed method research studies should be conducted that utilize the RCC, insurgent multiculturalism, and sociocultural theories to further unpack the perspectives of patients', other health care team members', and community stakeholders' on how PTs can better incorporate cultural considerations

into practice, share power, and decrease health disparities. An important extension of this investigation would be to conduct an ethnographic study over several years in a health care setting with a diverse team of patients and health care practitioners to examine the actual interactions and power sharing in patient-clinician, clinician-clinician, and clinician-community relationships. Future research should also examine how specific teaching practices and curricular components foster the emotional and reflective development of health care providers as they strive to practice with cultural humility. For example, it would be interesting in the future to study pedagogical practices in the academic setting, as well as the clinical setting, that prioritize learning how to listen and dialogue effectively. Looking more broadly, how can the physical therapy profession most effectively and ethically expand its role in local and global community health to improve the lives of those with less privilege?

Conclusions

Throughout this study I have tried to explore how life experiences, set within their social, cultural, and historical contexts, shaped the development of cultural humility in PTs. Cultural humility involves health professionals being actively engaged in an ongoing process with patients, colleagues, communities, and themselves to make sense of the complexities of social and culture differences within relationships in practice. Given demographic trends and health care disparities, it has become critically important to better understand the dynamics of developing trusting relationships to provide quality care. This study was influenced by relationship-centered care, sociocultural, and insurgent multiculturalism theories. A qualitative, life history study design was used to collect data on how eight PTs learned to interact

with persons from diverse cultural backgrounds. The process of developing cultural humility was examined through analyzing the participants' narrative understandings of lessons learned in relationships in practice. Although experienced clinicians may have great insight and skill in understanding the complexities of forming caring relationships, little of that narrative understanding has been uncovered or codified in the literature (Greenfield & Jensen, 2010).

Five major themes centered on the development of cultural humility and building trusting relationships could be traced through the life histories: (1) being open-minded and listening attentively as patients tell their stories; (2) responding to a person's emotions matters; (3) focusing care around a patient's goals and needs; (4) teaching to engage and empower; and (5) evolving awareness of community needs and assets. This study found that foundational early life experiences, clinical education experiences, and ongoing patient-clinician interactions that trigger practitioners to reflect deeply on their assumptions and biases frame the way PTs address cultural differences and build relationships. Although development of cultural humility is an ongoing process, learners in this investigation seemed to require educational activities and clinical experiences outside their comfort zones to stimulate growth. Emerging literature in health professional education suggests that fostering critical consciousness through out-of-comfort zone experiences and engaged dialogue with peers and mentors allows for the testing of the moral validity of one's position in areas of social relevance such as addressing cultural differences to reduce disparities in care (Mostow et al., 2010; Kumagai & Lypson, 2009). Taking into account how participants used their life stories to make experiences and contextual influences

meaningful, this study offers a framework for educators who are interested in using narratives to foster professional development. By virtue of ongoing reflection on practice and ones biography, including ones privilege, health professionals can be habitually engaged to action to build trusting relationships across difference.

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Appendix A-IRB Approval

DEPAUL UNIVERSITY

Institutional Review Board
1 East Jackson Boulevard
Chicago, Illinois 60604-2201
312-362-7593
Fax: 312-362-*8105*

Research Involving Human Subjects
NOTICE OF INSTITUTIONAL REVIEW BOARD ACTION

To: Marjorie Johnson Hilliard, Graduate Student, School of Education
Karen Monkman, PhD., Faculty Sponsor, School of Education

Date: June 28, 2010

Re: Research Protocol #MJ061709EDU-C1
"Stories and Cultural Humility: Exploring Power and Privilege through Physical Therapist Life Histories"

Please review the following important information about the review of your proposed research activity.

Review Details

☐ Full Committee Review
☒ Expedited Review, under 45 CFR 46.110

☐ Original Review
☒ Continuing Review (Renewal)
☐ Amendment
☐ Incident Report/Adverse Event

Your research continues to meet the criteria for expedited review under the following categories:

Category of Review: 5, 6, 7

"(5) Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for nonresearch purposes (such as medical treatment or diagnosis)."

"(6) Collection of data from voice, video, digital, or image recordings made for research purposes."

"(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies."

Approval Details

☒ Approved ☐ Approved (Previous contingencies have been resolved.)

Review Date: June 22, 2010
Approval Period: June 30, 2010 – June 29, 2011
Consent Documents: #10-097-C1, Version 6-26-2009, Adult Consent (enclosed)

Other approved study items: 1) flyer and email recruitment text; 2) recruitment letter; 3) recruitment follow-up email; 4) recruitment follow-up telephone script (all documents as submitted to the IRB on 6/17/09)

Number of approved participants: 10
Funding Agency: None

Reminders

- Only the most recent IRB-approved versions of assent/consent forms may be used in association with this project.
- Prior to implementing revisions to project materials or procedures, you must submit an amendment application detailing the changes to the IRB for review and receive notification of approval.
- You must promptly report any problems that have occurred involving research participants to the IRB in writing.
- If your project will continue beyond the approval period, you are responsible for submitting a request for renewal to the IRB at least 3 weeks prior to the expiration date. The renewal form can be downloaded from the IRB web page at http://research.depaul.edu.
- **Once the research is completed, you must send a final report closing the research to the IRB.**

The Board would like to thank you for your efforts and cooperation and wishes you the best of luck on your research. If you have any questions, please contact me by telephone at (312) 362-7593 or by email at sloesspe@depaul.edu.

For the Board,

Susan M. Loess-Perez, MS, CIP, CCRC
Director, Office of Research Protections

Appendix B
Life History Interview Protocol

Interview 1: Focused Life History

1. How did you decide to become a physical therapist?

2. What experiences in your background led to your decision?

    - Potential probes:
    - Early experiences in family
    - School experiences
        - Classroom
        - Extracurricular
    - Early work experiences
    - Community activities
        - Service, religious, political
    - Exposure to health care while growing up

3. What was the route or process you followed for becoming a physical therapist?

    - Potential probes:
    - Undergraduate experience
        - Setting
        - Degree
        - Organizations, volunteer activities, or service experiences
        - Clinical education experiences

    - Professional education experience
        - Setting
        - Degree
        - Organizations, volunteer activities, or service experiences
        - Clinical education experiences

4. How did you decide on where to practice with your first physical therapist job?

    - Potential probes:
    - Job search experience
        - How did the job search process shape your choice of where to practice?
    - How did you decide where to practice if you had more than one job offer?
    - Patient populations served
    - Specialty or leadership training opportunities
    - Type of health care setting
    - Community environment

5. How would you describe your first physical therapist career experience?

    - Potential probes:
    - Relationships with patients/families
    - Relationships with other clinicians
    - Involvement in community activities linked to social responsibility

6. How would you describe the patient population and colleagues in the health care setting in your first physical therapist career experience?
    - Potential probes regarding cultural categories
    - Race/ethnicity
    - Gender
    - Age
    - Languages spoken
    - Educational levels
    - Religious affiliation
    - Economic status background

7. How did decide on where to practice with your 2nd and (subsequent if applicable) physical therapist positions?

   - Potential probes:
   - Job search experience
     - How did the job search process shape your choice of where to practice?
     - How did you decide where to practice if you had more than one job offer?
   - Patient populations served
   - Specialty or leadership training opportunities
   - Type of health care setting
   - Community environment

8. How would you describe your 2nd and (subsequent if applicable) physical therapist career experiences?

   - Potential probes:
   - Relationships with patients/families
   - Relationships with other clinicians
   - Involvement in community activities linked to social responsibility

9. How would you describe the patient population and colleagues in the health care setting in your 2nd and (subsequent if applicable) physical therapist career experiences?
   - Potential probes regarding cultural categories
   - Race/ethnicity
   - Gender
   - Age
   - Languages spoken
   - Educational levels
   - Religious affiliation
   - Economic status background

10. What are the significant events or milestones of your career to date?

11. How have these significant events or milestone experiences shaped the ways you think/feel about the work of physical therapy in developing relationships with patients, colleagues, and communities?

12. What is culture to you?

Interview 2: Details of Experience

A. Early Foundational and Pre-Physical Therapy Educational Influences

1. What were some of the ways you learned about culture and addressing cultural differences in building relationships prior to your education as a physical therapist?

    - Potential probes:
    - Early experiences in family
    - School experiences
        - Classroom
        - Extracurricular
    - Early work experiences
    - Community activities
        - Service, religious, political

B. Professional Education in Physical Therapy

2. What were some of the ways you learned about culture and addressing cultural differences in building relationships during your education as a physical therapist?

    - Potential probes:
    - Class oriented learning
    - Clinical education experiences
    - Peers and friends
    - Faculty members/ mentors

C. Patient/Family-Clinician Relationships

3. Tell me about clinical encounter(s) where you were able to interact effectively with a patient/family in making decisions, even if your cultural beliefs, values, and/or histories were different than the patient's or family's?

    - What were the encounters?

    - How did you navigate the cultural terrain in the encounters?

4. Are there other clinical encounter(s) as you think back across your professional career to date that have been influential in the way you approach developing relationships with patients/families when your cultural beliefs, values, and/or histories are different than the patient's or families?

    - What were the encounters?
    - How did you navigate the cultural terrain in these encounters?

5. How would you articulate your philosophy of providing care to patients from diverse cultural backgrounds? How has your philosophy changed over the time you have been a physical therapist?

D. Clinician-Clinician Relationships

6. Tell me about clinical encounter(s) where you were able to interact effectively with another clinician in making decisions, even if your cultural lenses were different?

    - What were the encounters?
    - How did you navigate the cultural terrain in these encounters?
        - Possibly probe-Did the culture of medicine influence how you interacted?
        - Possibly probe-Did differences in race, gender, age, language spoken, educational level, or other cultural background categories influence how you interacted?

7. What other experiences during your career do you believe have been influential in the way you approach developing relationships with other clinicians when your cultural beliefs, values, and/or histories are different?

    - How did you navigate the cultural terrain in these encounters?
        - Possibly probe-Did the culture of medicine influence how you interacted?
        - Possibly probe-Did differences in race, gender, age, language spoken, or other cultural background categories influence how you interacted?

E. Clinician-Community Relationships

8. Tell me about experiences where community influences shaped how you approached interacting with patients or families in making decisions and carrying out a plan of action? I am defining community broadly to include home and neighborhood contexts; as well as economic, political, cultural, and social contexts that foster people to connect as they live in families, work, worship, and socialize in leisure activities.

9. Tell me about experiences where community influences shaped how you approached interacting with colleagues or community members in making decisions and carrying out a plan of action to impact an individual or a group of people in the population?

10. Describe a situation(s) where you felt institutional policies promoted providing a patient(s) care in what you perceive was a culturally holistic approach?

11. Describe a situation(s) where you felt institutional policies worked against providing a patient(s) care in what you perceive was a culturally holistic approach?

12. How would you articulate your philosophy of social responsibility to communities and society in addressing health care needs? How has your philosophy changed over the time you have been a physical therapist?

Interview 3: Reflection on Meaning

Given what the participant has said in interviews #1 and #2 regarding their life experiences and the contexts of those experiences…

1. How do you make sense of your present approach to interacting with persons from diverse cultural backgrounds in healthcare based on ____? (Personalize series of questions based on answers from previous two interviews)?

2. How do you envision your involvement in the community impacting health disparities ____? (Personalize series of questions based on answers from previous two interviews)?

3. What does it mean to you to share power in relationships with patients, families, and colleagues in making clinical decisions?

4. What recommendations do you have for physical therapy education, research, and practice to encourage developing professionals who understand their own culture, privileges, and biases?

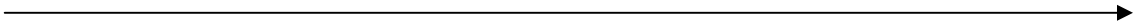
Appendix C

PROFESSIONAL DEVELOPMENT: TIMELINE OF SIGNIFICANT EVENTS/ MILESTONES IN CAREER

Participant ID #:_____ Pseudonym: _____

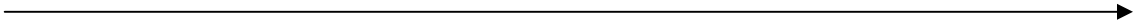
Think about your career: On the paper below, record or draw in the significant events or milestones of your professional development to date. What are the personal experiences, educational experiences, professional experiences, or people that have shaped the ways you think/feel about the work of physical therapy in developing relationships with patients, colleagues, and communities?

Personal



Educational

Professional



Influential People