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# MJOT – Editorial

## Occupation Does Matter...and How!

Occupational Therapy is about the business of life. When one takes a closer look at the content and literature allied to the articles carried in this issue, the lingering impression is of the diversity, the impressive range and the extent of development reached by the profession world-wide. The range of concerns, the types of competencies and specialisations within occupational therapy would indeed have been unrecognizable a couple of decades ago. The impression is of completeness, richness and all-encompassing interest about what makes up the occupations of life.

As occupational therapists, we don't have an easy job. The life of a disabled client could present a multiple of challenges, which can further be compounded by the pathologising labels applied by the medical system. These, in turn, tend to categorise and delimit the sufferer's potential. All these, and sometimes more, are the multifarious problems that occupational therapists are called to intervene upon. But occupational therapists, with their intuition, holism and eclecticism, can bring about a change where most other professionals would acknowledge the end-point of a treatment trajectory. Occupational Therapy is in the unique position to open up people's lives to a whole new world of possibilities and expectations which had been previously hemmed-in by fear, apprehension and resignation to disability.

We appeal to our entire and diverse workforce in all settings to take pride in their profession; to advocate its myriad merits and represent it fittingly. Knowing the whole range of challenges that can face an individual with overt and less-overt disability and having our special skills to intervene, places us in a special position where we can anticipate and appreciate issues where others would have missed. We should therefore give voice to those who do not have it and become prime movers to advocate necessary social and health care change in order to ameliorate the holistic health of populations. We should never underestimate the power of our profession to improve the lives of our clients and their carers.

The current veto on employment of newly qualified staff is admittedly frustrating and unfortunate given the current human resources depletion present in our clinics. But this situation is surely finite and the much-augured clinical staff recruitment may just be around the corner. In the meantime, we should embrace the unique character of our profession, take pride in it and advocate its power in all settings.

**The Editorial Board**
**June 2006**

# Principles of verification in qualitative research

*By Maria Daniela Farrugia*

**Abstract**

Most quantitative and qualitative researchers, as well as other interested parties, including occupational therapists, show concern regarding whether a research study is believable, and accurate. If research studies are based on haphazard methods, false findings and incorrect interpretation, clinical practice will possibly be erroneous. Thus, in health-care research, it is important to verify that the findings are the actual results and interpretations obtained and are an accurate representation of human experience.

The aim of this article is to discuss the principles of verification in qualitative research and considers their application to the different traditions of enquiry.

## Introduction:

### Verification and its need

Without rigour, research is worthless, becomes fiction, and loses its utility (Morse et al, 2002). Indeed, the quality of research is crucial both in qualitative and quantitative research. One of the fundamental issues in both research paradigms is whether the quality is sufficient to trust and accept the findings with confidence (Crookes and Davies, 1998).

In view of the importance of rigour in research, this work will mainly focus on verification and its strategies, which help in ensuring rigor and good quality research. Indeed, these brief paragraphs have indicated the importance and need of such a concept such as verification. For the purpose of this work, Creswell's (1998) definition of 'verification' will be used. He described verification both as a process that occurs throughout the data collection, analysis and report writing of a study and, as standards, as criteria, imposed by the researcher and others after a study is completed. This work thus aims to compare qualitative verification with the positivist paradigm, as well as indicating its purpose within the qualitative paradigm. Different strategies for verification will then be described and critiqued.

### Verification & the positivist paradigm

Despite the importance of having high research quality, there is great discussion regarding this issue between quantitative and qualitative paradigms, and within the paradigms themselves (Andrews, Lyne and Reiley, 1996).

Rigor in quantitative studies mainly revolves around validity and reliability. Reliability is the extent to which a test or an instrument such as a questionnaire gives consistent results (Burnard and Morrison, 1994; Crookes and Davies, 1998; McGuire et al, 2000; Mosey, 1996; Nelson, 1980; Royeen, 1989; Thomas and Nelson, 1996). On the other hand, in its broadest sense, validity is the extent to which a study, using a particular instrument, measures what it sets out to measure (Cormack, 1996; Crookes and Davies, 1998; Frankfort and Nachmias, 1996; Nelson, 1980). Statistical tests can test and measure validity. Indeed, there is sometimes also a failure to differentiate between the issues of quantitative validity itself, such as the validity of a measuring instrument, the validity of the interpretation of the data and the validity of the conclusions drawn from empirical research.

On the other hand, qualitative research methods have for long been criticised regarding rigor (Morse et al, 2002). The debate surrounding the methodological rigor of qualitative research is confounded by its diverse designs, by the lack of consensus about the rules to which it ought to conform, and by the issue regarding whether it is compatible to quantitative research (Burns and Grove, 1993). These criticisms might have worsened with attempts to judge the rigor of qualitative studies using rules developed to judge quantitative studies (Burns and Grove, 1993).

Although this further highlights the importance of verification in qualitative research, there exists a gulf of different ideas regarding how to address verification in qualitative studies.

This tremendous discussion is expected when considering that in quantitative research, quality is reflected in narrowness, conciseness, and objectivity and leads to rigid adherence to research designs and precise statistical analyses (Burns and Grove, 1993). Research quality in qualitative research is associated with openness, thoroughness in collecting data, and consideration of all of the data in the subjective theory development phase (Holloway, 1997). Quality in qualitative research is also based, in part, on the logic of the emerging theory and the clarity with which it sheds light on the studied phenomenon. In qualitative research, each single experience is valuable. Qualitative research emphasises the uniqueness of

human situations and the importance of experiences that are not necessarily accessible to validation through the senses.

Despite these differences between the paradigms, one approach to address the verification issue was to import terminology from quantitative methods and to find analogues, which are applicable to qualitative work. However, Avis (1995) added that writers who adopt this position have suppressed the differences between the quantitative and qualitative paradigms.

Moreover, certain threats to internal and external validity in quantitative research are either generally inapplicable as evaluation criteria in qualitative research or they are minimized in quantitative research. For example, statistical regression and instrumentation are generally inapplicable criteria as there is often no testing of subjects per se in qualitative research. Regarding external validity, one might say that in qualitative research, the major purpose is to generate hypothesis for further investigation rather than to test them and so external validity will not be relevant (Sandelowski, 1986).

Therefore, some authors prefer to avoid the terms 'validity' and 'reliability' altogether. They argue that these concepts are based upon positivistic assumptions regarding instrumentalism, reductionism and objectivity (Avis, 1995). Thus, they use terms such as 'soundedness', 'authenticity and plausibility' and 'truth value' (Andrews, Lyne and Reiley, 1996; Carpenter and Hammell, 2000).

Yet, the qualitative researcher still has to provide descriptions and explanations that really emerge from the data and s/he is not permitted to make the data 'fit' any of the researcher's preconceived ideas. So, qualitative research still needs to avoid anecdotes and should be credible and truthful, and thus the importance of verification (Krefting, 1991).

Moreover, since qualitative research is not replicable, since it uses unique settings that change over time (different information may be obtained from asking the same questions to individuals), reliability as viewed from the quantitative perspective is impossible. From the qualitative perspective, it will imply the degree of consistency with which data are allocated to the same category either at

different times by the same researcher or by different researchers (Krefting, 1991).

Similarly, one must add that some authors claim that just as there is a need to look at the accuracy of various kinds of quantitative data in different ways, there is also the need to assess different qualitative studies through the most appropriate ways. For example, the phenomenological approach asks what it is like to have a certain experience. However, the goal of ethnography is to describe social complexities and thus may involve the development of theoretical constructs. Thus, Krefting (1991) concludes that although some principles are basic to all qualitative research, the incorrect application of the qualitative criteria of trustworthiness to studies is as problematic as the application of inappropriate quantitative criteria.

**Strategies of verification and their application**

Lincoln's and Guba's (1985) criteria are well developed conceptually and are the mostly used to assess the trustworthiness of qualitative research within health-care (Krefting, 1991). These criteria are credibility, dependability, confirmability and transferability (Creswell, 1998).

The qualitative criteria for truth value is credibility and roughly analogues to internal validity in quantitative research. It refers to the believability of the data (Masterson, 1998). Dependability of qualitative data, which relates to the consistency criterion, refers to the stability of data over time and over conditions (Polit and Hungler, 1995).

On the other hand, confirmability refers to data neutrality. Independent inquiry audits by external auditors can be used to assess and document dependability and confirmability (Cooper, 2000; Polit and Hungler, 1995). Finally, transferability refers to applicability and the extent to which findings from the data can be transferred to other settings or groups (Munhall, 2001; Rogers and Cowles, 1993).

Different strategies can be used to ensure credibility, transeferability, dependability and confirmability. In view of the fact that similar strategies can address different criteria, they will be all discussed as verification strategies.

Polit and Hungler (1995) described prolonged engagement as the investment of sufficient time in the data collection

activities to have an in-depth understanding of the culture, language or views of the group under study and to test for misinformation and distortions. It is also essential for building trust and rapport with participants (Polit and Hungler, 1995). On the other hand, persistent observation aims at achieving adequate depth of data but this may lead to problems such as making the researcher unable to separate his/her own experience from that of the informants and hence be unable to interpret the findings (Krefting, 1991). To counteract this problem, reflexivity may be useful. It refers to the assessment of the researcher's own background, perceptions and interests on the research process (Krefting, 1991). This can be enhanced through a field journal and reflexive diary, which can be helpful in ensuring verification in biography, phenomenology and ethnography (Creswell, 1998).

Another strategy involves triangulation. Its purpose is to provide a basis for convergence on the truth and helps credibility, dependability and confirmability (Kimchi, Polivka and Stevenson, 1991). Mason (1996) stated that triangulation encourages the researcher to approach the research questions from different angles and in a multi-faceted way. For example, in ethnography, the researcher compares information from different phases of the fieldwork, from different points in the temporal cycles occurring in the setting and from different researchers (Creswell, 1998). Triangulation will also be helpful in case-study design. On the other hand, it is worth noting that Morse et al (2002) stated that confirmability and its strategies are not pertinent to phenomenology, nor to postmodern philosophies, whereby the investigator's experiences become part of data, and which perceive reality as dynamic and changing.

Polit and Hungler (1995) stated that two other important tools for establishing credibility are peer debriefing, wherein the researcher obtains feedback about data quality and interpretive issues from peers, and member checks, whereby informants are asked to comment on the data and on the researcher's interpretations. Creswell (1998) stated that having participants or peers reading drafts or repeating studies would help verification in ethnography and case study. Morse et al (2002) added that the problem of member checks is that, with the exception of case studies and narrative enquiry, study results have

been abstracted from across individual participants and thus, it may be difficult to recognise individual experiences.

Additionally, Baker, Wuest and Stern (1992) claimed that, in 1985, Lincoln and Guba have stated that the issue in any qualitative research is not whether another investigator would discover the same concepts to describe or interpret the data but whether the findings of an inquiry are worth paying attention to. In a phenomenological study this depends on the extent that they truly reflect the essence of a phenomenon as experienced by the informants of the study (Hallett, 1995). It is thus advocated that the phenomenological researcher returns to the informants to ensure that the findings reflect their perceptions of their experience (Hallett, 1995). However, it is worth noting that participants may be troubled if they become aware of the information that the researcher had garnered.

Moreover, one must remember that data collected solely through observation would not necessarily be accurate since the subject may be reacting to being observed. If using interviewing alone, this might lead the participant to state what is socially desireable (Chenitz and Swanson, 1986). For example, factors such as interview questions, timing of interviews, interviewer behaviour and recording/transcription problems may all possibly alter the research's credibility if done in an incorrect way (Hutchinson and Wilson, 1992). Additionally, after coding a data segment, the researcher should leave some time and then try to recode it and then compare results (Chenitz and Swanson, 1986). Verification can also be enhanced through an external auditor. However, by time, the auditor might lose his objectivity.

One of the most delicate issues in verification is transferability since it is believed that generalisation in qualitative research should be avoided (Schofield, 1991). A consensus appears to be emerging that for qualitative researchers, generalisability is best thought as a matter of the 'fit' between the situation studied and others to which one might be interested in applying the concepts and conclusions of that study (Schofield, 1991). This conceptualisation makes in depth descriptions crucial so as to help others know how transferable the findings are. Another means of ensuring transferability is through the selection of

participants (Krefting, 1991). This may be helpful in qualitative research, whereby the researcher must also determine whether the observed events are the typical of the participants' lives (Krefting, 1991).

The foregoing discussion indicates that most of the strategies and criteria are applicable to many qualitative designs. At times, strategies are part of the data analysis (e.g. grounded theory) while others are employed after completion (e.g. phenomenology) (Creswell, 1998). Yet, Morse et al (2002) stated that the above-mentioned Lincoln's and Guba's strategies may be useful in attempting to evaluate rigor, but they do not ensure rigor and neither do they ensure that the research is relevant and useful. Hence, it is crucial that researchers plan how to substantiate the accuracy of their studies and use various verification strategies to ensure rigour in research studies.

## Conclusion

When, as a qualitative researcher, one is fortunate enough to be part of others' lives, due respect must be paid to the rather small place occupied by your 'window' compared to the entire structure of the participants' lives. As qualitative researchers, therapists have a unique opportunity to explore others' perceptions and experiences. By doing so, knowledge about phenomena has increased. With respect to client's experiences in occupational therapy and our professional activities, the task of building this knowledge is just beginning. The challenge before the profession is to do so in ways that are faithful to the research traditions. Issues of verification need to be well-looked at so that resources are not misused and practice will be based on sound knowledge. The increasing interest in rigour, verification and in establishing and maintaining excellent qualitative research is evidence that occupational therapists are taking up this challenge.

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# Experience of Maltese occupational therapists working with physically disabled persons from different cultural backgrounds

*Demis Cachia*

The aim of the study was to explore and gain knowledge on the lived experiences of local occupational therapists in the daily treatment of physically disabled persons from different cultural backgrounds. A phenomenological approach was selected for this qualitative study using an open interview with an interview guide. Six occupational therapists working in the main general hospital took part in this study. Data analysis was carried out using the Empirical Phenomenological Psychological Method (EPPM). 4 main themes emerged from this study - communication and language problems, independence vs. dependence, cultural attitudes and social class.

## Introduction

Cultural diversity should add an exciting and challenging element in the daily occupational therapy practice. Every client has different values and beliefs, which affect all aspects of his/ her occupational performance. The way a person does things, interacts with family members, behaves, looks to the future and views health, are the result of past experiences and expectations. Occupational therapists have to deal with many issues including that of gender, age, race, ethnicity, sexual orientation, religion, family situation and social status.

## Local situation

The Maltese Code of Professional Conduct (COPC) emphasises that as professionals "occupational therapists shall ensure that his/ her professional responsibilities and standards of practice are not influenced by consideration of age, sexual preferences, religion, sex, race, age, nationality, party politics, social or economical status or nature of a patient's health problems". Similarly, Principle 7 of the 1990 COPC of the British Association of Occupational Therapists states that, "occupational therapists must not discriminate against consumers on the basis of race, colour...national origin...religion...". This is followed by Principle 3.2.1. which states that "occupational therapists must be sensitive to culture and lifestyle diversity and provide services which reflect and value these." (College of Occupational Therapy, 1995).

"Occupational therapists should incorporate the patient's cultural background into treatment in order for therapy to be effective" (Sanchez, 1964). However, whether or not this is being considered in daily OT practice needs to be investigated further.

Being a small island in the middle of the Mediterranean Sea, for years Malta was dominated by other people and nations. However, an increase in the number of immigrants and foreigners settling the Maltese Islands is now creating new concerns and a certain amount of uneasiness especially in a society that so traditionalist and closely-knit. Today, being a member of the European Union, means that a further increase in the number of persons coming to live in Malta is expected to bring the issue of cultural diversity to the fore-front of clinical practice.

**Research Question**

What are the experiences of a sample of Maltese Occupational Therapists who work with physically disabled persons coming from different cultural backgrounds?

**Definition of culture**

Culture is a very broad concept and has been defined in many. Culture will here be defined as beliefs and perceptions, values and norms, customs and behaviours that are shared by a group or society and are passed from one generation to the next through both formal and informal learning (Kielhofner, 1995). Culture is a process of behaviour and communication that has been learned by persons in the context of the past experiences (Krefting & Krefting, 1991). Culture is learned, or acquired through socialisation and is therefore not part of our genetic make-up.

**Literature Review**

Before understanding other cultures, it is important for clinicians in all the health care disciplines to be aware of their own cultural orientation and traditions (Hume, 1994; Rothenburger, 1990). The awareness of one's own cultural background and values, knowledge of information specific to each culture and the ability to interact with others successfully, will lead to the concept of cultural competence. Dillard et al (1992) defined cultural competence "as having an awareness of sensitivity to and knowledge of the meaning of the culture". Therefore, occupational therapists need to examine their own values and beliefs before they can explore those of others (Hinojosa & Kramer, 1994).

Fitzgerald et al (1997) found 76 articles that mention cultural issues in the occupational therapy literature. However they stated that "with the exception of a few key articles, much of this literature is

fairly superficial, lacks in-depth analyses or a clear concept of culture".

When Western occupational therapists were interviewed by Kinebanian & Stomph (1992) regarding their experiences when working with clients from different cultural backgrounds, three common experiences were found i.e. concept of independence, the emphasis on purposeful activities and the training/ practice of ADL's. They concluded that 'the philosophy of some professions, such as the norms and values underpinning O.T. may create obstacles to the care of immigrant patients' (Kinebanian & Stomph, 1992, p.751).

Communication and language problems seem to be a common barrier for the occupational therapist who works with persons from a different cultural background. Phipps (1995) investigated occupational therapists working with clients from a non- English background. She found that communication barriers were a common concern for many of the interviewees. To try and eliminate these obstacles, interpreters, client-centred goal setting, increased family participation, giving clear explanations of the treatment procedures and the increased use of cross-cultural activities were used. Yates (1996) called for a certain degree of competency in foreign languages for staff, although the feasibility of this is surely questionable in the light of the number of languages often involved.

In a recent study which was carried out with South Asian carers, language and communication difficulties were also found. Another finding in this study was that health care professionals failed to recognise the carers' needs thus creating a gap between the carers and the health care professions (Katbamna et al, 2002). Therefore, poor consultation and a failure to understand the culture of the family affected rehabilitation outcomes. Kinebanian and Stomph (1992) said that treatment planning and assessment procedures as normally used in O.T. are often inadequate for immigrant patients. Phipps (1995) found out that "only a minority of therapists were found to adapt theoretical models to guide culturally appropriate interventions". To-date, the Model of Human Occupation (Kielhofner, 1985) and the Canadian Occupational Performance Measure (COPM) are the only tools available to assess clients from different cultural backgrounds.

No studies have been conducted in Malta to describe the lived experiences of local occupational therapists on this issue. While some research findings have been discussed above, a study such as this would increase understanding of this phenomenon.

## Methodology

A qualitative method using a phenomenological approach, was used to explore and to gain knowledge on the lived experiences of local occupational therapists in the daily treatment of physically disabled persons from different cultural backgrounds. An open interview format with an interview guide was used. The phenomenon under study was the experience of the O.T. working with persons from a different cultural background. Phenomenology focuses on the meaning of an experiential phenomenon of a human experience from the perspective of the individuals who experience it (Polkinghorne, 1989). "Phenomenologist believes that the meaning can be understood only by those who experience it" (DePoy & Gitlin, (1998). By using a naturalistic inquiry the researcher strives to elicite such life experiences by hearing and reporting the perspective of the informant. Therefore, by using a qualitative method an in-depth understanding and rich information can be obtained from the interviewees within their natural context (Stein & Cutler, 2000).

## Subjects/ Participants

The number of participants in a phenomenological study may vary. According to Polkinghorne (1989), participants should provide a multifaceted description of the experience to ensure that the phenomenon is accurately described through the data analysis. Seven face-to-face interviews were carried out and audio-taped. One of the interviews was a pilot study, which led to some changes of the interview guide. Each interview took about 45 minutes and it was transcribed and analysed. The participants were five females and two male occupational therapists all of whom work in the main general hospital and ranged in age from 28 to 41, with a mean age of 32.3 years. The average number of years working as an occupational therapists was of 6.3 years. All participants were born and have resided exclusively in Malta.

## Sampling Procedure

*Inclusion criteria* – Participants had to have at least 5 years experience working as occupational therapists. They had to be working in the main general hospital with physically disabled persons

*Exclusion criteria* - New graduates or occupational therapists who are not permanently placed at the selected site.

## Data collection

Data collection is the process of gathering information needed to address a research problem (Polit & Hungler, 1995). For this study, open interviews were used together with an interview guide. Probes were used during the interview to give further information and to elaborate further on what the interviewee has said. All the interviews where carried out in English.

## Ethical Concerns

Participants were informed about the purpose, aim and the procedure of the interview. A consent form was filled prior to the interview. Personal information was not disseminated and anonymity was also maintained by using codes rather than the participant names.

## Data Analysis

The Empirical Phenomenological Psychological Method (EPP-Method) was used (Giorgi, 1975). After the initial reading of the interviews, phrases were extracted that related to the lived experience of the occupational therapists. The actual meanings of the phrases, known as meaning condensation, were extracted and organised into clusters of themes. The theme clusters were then reviewed by another occupational therapist not involved in the study to ensure reliablity. To provide further validation, one participant reviewed the final description of the lived experiences of the occupational therapists interviewed.

## Results

### Theme 1: Communication & language problems

The commonest experiences of the occupational therapists in this study were communication and language problems. All the interviewees said that before the actual treatment they prefer to get to know the patient, establish a therapeutic rapport, discover their previous life-style, previous level of independence, personal interest and hobbies, and expectations following treatment. However, the interviewees felt that due to communication and language problems, a

barrier was being created which causing a decrease in understanding, and interaction as well as decreasing compliance during treatment. One of the interviewees said that:

"The problem usually will be the language which proves to be a barrier, sometimes to communicate with them, especially those patients who do not speak either English or Maltese".

The most common strategies used by the therapist to decrease and or eliminate this problem was to use interpreters, family members and health care staff. Since many of these patients were from the south and east of Europe, the use of simple Maltese words and instructions were helpful. Two occupational therapists mentioned that by establishing a good therapeutic rapport with the patient, making him/ her feel safe and at ease, non-verbal communication helps. Making an effort to learn the patient's language was also mentioned by one of the interviewees:

"it is always an interesting experience, especially when I told the patient that I wish to learn something from his language too".

While communication and language problems seem to be a common concern, all the interviewees mentioned that they always find ways and means to solve these problems.

**Theme 2: Independence Vs Dependence**

All the interviewees mentioned and compared the issue of independence in different cultures. While many of their English elderly patients feel that the issue of independence is important to them, Maltese elderly persons seem to have a more dependent mentality.

English elderly patients were seen as being compliant to treatment. Independence is their main aim, and they follow the recommendation and advice given by the therapists. They are eager to re-learn new ways and techniques to cope more independently.

"English people for example will tell you, oh yes we need it, we will do anything to get it [long-handled aids]. Maltese people will say-oh can I do without these gadgets".

"British patients, ... want to be very independent..... they want to do things on their own, they use long handled aids, they usually comply with your advice".

Contrary to this, elderly persons from the south and east of Europe are less complaint, more reluctant and expect that the family should take care of them.

Another interviewee said:

"The Maltese, I cannot understand, they have a dependent personality. Once they are in hospital they expect to be washed, fed,..... This is not the same with many foreigners who are eager to be able to wash, dress, go to the toilet, eat.....independently again. ".

Maltese patients are over protected by their family/care givers, and so dependency increases. The interviewees experience that this attitude is causing an increase in dependency in the daily living tasks, co-operation in treatment decreases, and that the advice and recommendations that they provide are not being followed up after discharge from hospital.

One of the therapists questioned whether the advice given during the home visits is being followed. She said;

"We go to their house to carry out a home visit. We always recommend things, however in reality how many are done. Whether it is a bath board, a raised toilet seat, a grab rail....I don't know if they purchase them. I think a local study should investigate this".

## Theme 3: Cultural attitudes

Another experience which was brought up by all the interviewees was cultural attitudes. Interviewees have reported that certain individuals of a non-native cultural extraction, may feel uncomfortable if they are seen by a person of the opposite sex. This issue becomes more important when dealing with personal ADL's such as bathing and dressing. The therapists feel that this causes some limitations in re-training of personal daily living tasks. One of the interviewees mentioned the importance of knowing the patient's social and cultural traditions before the actual intervention is implemented.

Three of the interviewees mentioned that many of the elderly disabled persons from the south and east of Europe do not follow the advice and recommendations given by the therapists because of social stigma and their cultural attitudes. A person who is using a frame or a stick to walk would prefer to stay inside rather then be judged by his friends and neighbours. Contrary to this, an English elderly person does not care what other people say:

".....You tell them listen, you can go out but you need a walking stick as you will be safer with it.

Oh.... but I don't want to be seen with a walking stick. Everybody will keep asking me how I am, and I don't want that to happen".

Why people seek treatment also differs from one cultural to another:

"The difference lies in the way people come [the mentality they bring to the treatment situation] to treatment and the way they accept their treatment. The English person comes because they feel the need. The Maltese people would sort of tell you yes, yes, yes, I will do the home programme and will not follow it at all. The Maltese people come for treatment but only because the consultants send them. ".

Prioritising goals during treatment is another cultural issue that therapist should be aware of. One of the interviewees said:

"Maltese women are so obsessed with washing the floor and cleaning the house. An English patient thinks more on how to get on the bus because she is more concerned with her social life."

**Theme 4: Patient's Social Background**

Another experience mentioned is that of the patient's social background. According to the interviewees, persons who have a more basic level of education tend to focus more on treatment procedure itself. Also, due to their financial limitations, patients hesitate to buy certain equipment. They prefer to spend money on their family members than on their own needs. The more educated person tends to focus on the treatment process asking many questions and wanting to know everything about his or her condition/ disease. He or she appear to be more compliant to treatment in general. Due to their financial stability, such patients are in a better position to buy the prescribed equipment.

Overall, the interviewees feel that it is important to know the patients' background prior to intervention to modify their approach if necessary.

**Discussion**

The findings from this study illustrate how complex the experiences of the O.T.'s can be when treating a person from a different cultural background. Language and communication problems were found to be a key issue in this study, which is similar to research carried out by Phipps, (1995) and Katbamna et al (2002). The strategies used by the therapists to try and decrease this problem were found to be similar to other findings discussed in the literature review.

Another experience mentioned by the interviewees is that of independence. While in some cultures independence is a key factor during rehabilitation, in other cultures it is not always the case. Locally, the family is expected to take the responsibility in providing the necessary support and care. Here the clinicians mentioned that the aim to increase independence in daily living tasks, may be inappropriate and this is causing some misunderstanding. Similar findings by Kinebanian & Stomph (1992) discussed in the literature review, were also highlighted.

Cultural attitudes were another common experience in this study. The way cultural attitudes have developed in certain countries was found to be hindering the role of the O.T. The priorities given by the patient during and after treatment are different and are highly affected by the patient's culture and his/her social attitudes. Therefore, the O.T. needs to know these attitudes prior to setting up of a treatment program regime. The need to create a therapeutic relationship was mentioned by one of the interviewees. This would help the patient and the therapist to jointly develop treatment programs based not only on the patient's condition but also taking into consideration the patient's cultural attitudes.

The last theme was that of social background. It seems that it is important to know the patient's social background, not only when treating a person from a different culture, but also when treating a Maltese patient. The differences stem from the fact that patients have different educational backgrounds and a different socio-economic status.

**Study Limitations**

The main limitation of this study is that of a small sample size. One cannot generalize these results since they were obtained from six occupational therapists. Moreover, this study was carried out with occupational therapists working with physically disabled persons, and the result might have been different had the participants been therapists working in the mental health field. While the first two themes of this study are similar to other research study findings, the other two appear unique and perhaps could be investigated further.

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# EUPU Leonardo Project
# Derby City General Hospital, Derby, UK

*Carmen Deguara*

**Abstract**

The EUPU Leonardo da Vinci professional exchange programme affords qualified staff a sterling opportunity to gain experience in a practice setting in the EU. This paper describes one such professional practice experience in the Derby City General Hospital, Derby UK. Whilst highlighting the variety of therapeutic settings and practice opportunities which she encountered, the author attests that the range of skills Maltese occupational therapists can call upon can be applied and adapted with confidence in a number of practice milieus in the UK.

## Introduction

My six-week clinical placement which took place between the 17th January and the 1st March 2004 at the Derby City General Hospital in Derby was undertaken as part of the EUPU Leonardo Project. I was placed at the adult acute general medicine Occupational Therapy (OT) section. The staff complement consisted of three Senior I Occupational Therapists, two Senior II Occupational Therapists, three Basic Grade Occupational Therapists and one Occupational Therapy Assistant. All the staff covers the different general medical wards at this hospital.

The aim of the first two weeks of this placement, was to gain a general overview of how the hospital system runs, and the occupational therapists working in the different wards were very kind to guide me through this phase. Eventually, I was working on an acute medicine ward with one of the Basic Grade therapists.

## Overview of the Service Site

Derby City General Hospital is run by the Derby Hospitals NHS Trust foundation. Services provided by this hospital include: integrated medicine, surgery and urology, obstetrics and gynecology, rehabilitation, critical care, and support services.

It is evident that the health care system in the UK is very different from the one we have in Malta, therefore, as a result, the OT approach differs significantly. In the UK, the occupational therapist's role is more defined and most of the hospital staff is aware of what it entails, namely helping the patient to remain independent in self-care, leisure and domestic tasks. When possible, the patient is helped to return safely to his/her home environment with the necessary

adaptations and post-discharge care where this is indicated.

On the wards, once medically stable, the patient is referred to OT. A handover is given every morning by the nurses where the patient's presenting condition is discussed. This helps the clinicians to prioritize the patients' needs. After checking the patient's medical history, the therapist carries out an initial interview. The patient's previous level of function and performance, together with details about the physical environment of the home and any services which were being provided, are reviewed and discussed. This is followed by a functional mobility assessment (transferring from bed, chair, toilet and walking) and self-care assessments, such as washing, dressing and toileting. If necessary, a cookery assessment is carried out by the therapist or the assistant.

Turnover on the wards is quick due to an intensive focus on acute care provision. Therefore, if the occupational therapist finds that the patient might benefit from using particular aids or equipment at home, s/he is assessed using these on the ward or at the department and they are provided before discharge. Where possible, the patient's relatives or carers are notified of the patient's progress and about any equipment which might be needed after discharge. If equipment, such as a toilet-seat raise or a bath-board, need to be used, the occupational therapy assistant is assigned to go to the patient's house to ensure that they are installed properly.

Most of the wards use a team approach and the patient is treated holistically. The team includes the consultant, senior house officer, junior doctor, nurse, physiotherapist, occupational therapist and where necessary, the care manager, social worker and speech therapist. All the team members are consulted during discharge planning. As a member of the team, the occupational therapist can suggest whether further treatment or more specialized rehabilitation is required. In such a case, a team from the hospital's specialized unit is called to assess the patient for potential rehabilitation. Throughout this process, the patient is not discharged until the occupational therapist deems appropriate.

Equipment is supplied by the hospital through a Home Loans Scheme and it is given free of charge for the required time period. If a patient needs help with his

daily tasks, an application for Social Services is made. This means that a home-helper goes to the patient's home from once to four times a day as advised, to help with both self-care needs and meal preparation. If a patient requires further rehabilitation at home, a referral can be made for an Intermediate, Community or Social Services occupational therapist.

Apart from the general medical wards, occupational therapists also work at the Admittance and Emergency Department, and the Medical Assessment Unit to help identify whether a patient is to be discharged home. Other therapists work in different areas such as the Neurorehabilitation Unit, Stroke Unit, Pain Clinic, Splinting Unit, Home Loans, Intermediate, Community and Social Services. I was given the opportunity to visit these units and to spend a day or two in the different areas to observe occupational therapists working in these settings.

Apart from the hospital-based occupational therapists, other O.T. departments outside the hospital setting provide community-based services. There are occupational therapists employed with the Home Loans Section which provide equipment to patients prior to discharge as advised by the therapist. This equipment is given free of charge and for the necessary time period. The Intermediate occupational therapist visits the patient at home to assist with rehabilitation, such as retraining of activities of daily living after a stroke or a total hip replacement, whilst the Community occupational therapist visits the patient if further practice using any aids or equipment supplied by the Home Loans is required. The Social Services occupational therapist is involved when major adaptations are required such as converting an existing bathroom into a walk-in shower.

Besides having a different health care system, cultural differences also have an effect on the attitudes patients have towards life in general. They seem to have a general positive attitude, and seem to be more committed to their rehabilitation. The majority of the patients are willing to return home and continue living within their own environment with any necessary environmental modifications or social and/or community services. If a patient is unable to return home, a transfer to a nursing or residential home in the same area or the vicinity, can be arranged.

Home visits are carried out when necessary to assess the need for any immediate aids or adaptations in the patient's home in view of his discharge. Generally, the therapist is accompanied by the patient him/herself and assesses the patient using any aids within the home setting. When this is not possible, the therapist carries out the home visit in the presence of the patient's relative, or carer only.

Overall, this experience was very fruitful and enriching. The time period of six weeks which was allocated for this placement was sufficient for me to look at occupational therapy from a different point of view, and to get another perspective of its role in enabling a person to continue living as independently as possible. Working within a team setting was very inspiring since seeing all the different professionals working together to be beneficial for the patient himself. Due to the rapid patient turnover, the therapist has to be efficient and effective in assessing and treating the patient in order to help him regain his confidence and to return to his previous level of function. Working within the structured environment provided by the National Health Service (NHS), whose objective is to maintain the people, especially the elderly and people with disabilities, within their own home clearly offers the occupational therapist great job satisfaction.

**First Hand Involvement in Treatment**

This clinical placement in Derby gave me the opportunity to share and discuss different techniques and treatment approaches used. It even helped me to compare and contrast the different working environments and to observe the efficiency and practicality of the treatment provided. Furthermore, I was also given the opportunity to carry out initial interviews with the referred patients, prioritize treatment aims and complete the necessary assessments to guide the patient until discharge.

Communication with other team members on an individual basis, and participation in team meetings was ongoing. When necessary, liaison with the patient's relatives, social services or care managers was carried out to determine further care at home. I also attended various home visits to determine any structural/environmental changes and aids the patient might need, and to identify any hazards which might lead to further falls

or injury to the patient. Throughout the whole placement, I was supervised by a therapist who offered me her support and advised me accordingly.

Keeping a patient's file up to date and noting down difficulties a patients may encounter and which could hinder living independently and safely at home, is of the utmost importance, as it indicates which community services need to be provided. This ensures that staff are safeguarded in case of litigation. Data protection is also given a lot of importance in the UK and patient confidentiality is paramount.

**Occupational Therapy Skills**

From this experience I can confidently say that Maltese occupational therapists are well equipped with the practical skills to cope with different hospital and treatment set-ups. I observed that the occupational therapists in the UK have very specific areas of intervention. For example, basic grade therapists are not required to assess and identify physical (particularly range of motion, hand function, tone), sensory, cognitive and perceptual problems of a patient who had been admitted with a mild stroke. The focus of their treatment is entirely different. The main aim of these wards is to discharge the patients to their home as soon as possible. Therefore the focus of occupational therapy services is assessment and the provision of equipment which would be necessary for the patient to be able to cope at home independently and safely.

Rehabilitation similar to what we are used to finding in our clinics is practiced in the specialized units or by the Intermediate occupational therapists in the community. At times, this proved to be frustrating for me, as in Malta, we are trained to assess in depth all the main problem areas and to devise a rehabilitation programme to address the specific performance components. Compensatory techniques are taught to the patient when his/her potential is reached or in view of discharge home. Practical and possible solutions are explored to enhance and maintain independence and promote safety, in spite of the limited social services available. As a 'Home-Loans' service is not available in Malta, the equipment recommended generally has to be bought by the patients or relatives. As finances are usually a problem for the people who rely on a disability or old-age pensions, the occupational therapists in Malta are faced with further challenges to

be practical and creative in recommending equipment which would be useful and safe for the patient with a low budget.

**Lessons Learnt**

On my return to Malta, I was determined to try and pursue some of the ideas inspired by the placement at Derby City General Hospital. These included the use of particular O.T. assessments and protocols. To implement other ideas would require a change in the occupational therapy perspective and also a concerted effort by all the other different health professions. Working as an interdisciplinary team to achieve the patient's maximal potential, still has to be addressed properly at St. Luke's Hospital which is presently run predominantly on a medical model. It is imperative that during the rehabilitation process, a more holistic view of the patient is taken. In turn, this may reduce the probability of the patient being readmitted into hospital. Other matters would need to be dealt with by a more efficient and effective local health care system. Creating a social services system similar to what has been existing in the UK for quite a number of years, is one example but this requires a radical change in health care service delivery on Malta. Community care services, including occupational therapy, would reduce the number of admissions to hospital, therefore, reducing the ever-increasing number of social cases at St. Luke's Hospital. Having a system within the health department for loaning a wider range of rehabilitation aids and equipment will make the recommendations made by the occupational therapist feasible thus enabling patients to remain independent and safe in their own home.

I strongly encourage other occupational therapists to take such an opportunity to experience first hand how other professionals work abroad in a different set-up. This would certainly help to motivate and inspire them with new ideas as well as affirm their role within their workplace. This placement was a unique experience for me and I would like to thank the people involved in making it possible.

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## BOOK REVIEWS

***Transformation Through Occupation***

***Edited by Ruth Watson and Leslie Swartz (published by Whurr, ISBN 1-86156-425-5)***

The issues of culture and cross-culture practice, have been bandied about for quite some time now in occupational therapy and are often referred to, rather cursorily, in numerous books and articles. Finally we have a revelatory text book which tackles these in all their manifestations, complexities and challenges. Ostensibly about occupational therapy in South Africa, the book looks at the impact of poverty, women with disabilities, women and youth in the criminal justice system, children living with HIV/AIDS and youth at risk – areas which are rapidly gaining prominence in the Europe and in our country often in parallel with the issue of multiculturalism.

The book advocates a sort of new paradigm shift for occupational therapy – from the more familiar remedial or curative approach with individuals, to an outlook that is based on health promotion for communities and populations. The strongest argument that the book presents is that the majority of the world's population lives in developing countries, where they very often experience deprivations brought about by poverty, displacement, violence, disease and discrimination and it is in this milieu that a dramatic contribution can be made to improve the health outlook. Occupational therapy's refocused emphasis on occupational engagement and occupational justice with communities, would be able to target these populations with the principal goal of enabling empowerment and self-advocacy. The book promotes the concept that occupational therapists should be committed to achieve optimal health rather than just maintain and restore health. This could be the result of pre-empting health problems through health-planning and health-promotion programmes as well as enabling people to come to realize their best choices.

Although the perspective of the book is South African, its significance to the rest of the world, including Malta, cannot be denied. Social and health matters being faced by clinicians are becoming more

complex and diversified reflecting a social structure which is becoming more multicultural but is also being transformed from the very grass roots by changing mores and social networks. These impinge on the more traditional problems tackled by occupational therapists creating new practice scenarios and challenging practitioners to cope with burgeoning areas of practice such as HIV/AIDS and rehabilitation within the criminal justice system.

If you are looking for a book that can demonstrate the range and potential of our profession, how it can bring about appreciable change in society and one that challenges established views and conventional wisdom on occupational therapy, then look no further – this is what you should read. *Transformation through Occupation* really makes for mind-broadening reading.

***René Mifsud***

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***Official Publication of the Malta Association of Occupational Therapists***