The American Occupational Therapy Association
Advisory Opinion for the Ethics Commission

Cultural Competency and Ethical Practice

Vignette 1

Joan, a pediatric therapist, is asked to make a home visit to a Vietnamese child who was recently burned. On examination of the child, she notes red, round, coin-sized marks over the child's back. She never asks the mother about the marks. After leaving the home Joan wonders if the mother is using a traditional healing treatment. She asks herself, "How can I give this child ethical and quality care while allowing the mother to continue with this harmful practice?"

Introduction

People face problems, dilemmas, and issues with ethical significance that necessitate action or nonaction every day. Doing the right thing in practice is always a challenge. In an increasingly pluralistic society, health care providers are finding themselves confronting choices that may depend more on moral and ethical values than on medical knowledge. Joan's dilemma is not a question of what intervention method she should use, but whether she can provide quality ethical care. Culturally competent practitioners realize that behaviors are shaped and defined differently by every culture. Rather than being distressed by another culture's health practice, a culturally competent practitioner welcomes collaboration and cooperation in making sound ethical decisions.

This advisory opinion outlines and discusses the provisions within the most recent version of *Occupational Therapy Code of Ethics and Ethics Standards (2010)* (referred to as the "Code and Ethics Standards"; American Occupational Therapy Association [AOTA], 2010) that address culturally competent services. Vignettes are presented to demonstrate the range of ethical concerns that cultural encounters can generate. This advisory opinion was developed to provide guidance to the AOTA membership so that they can provide ethically and culturally appropriate services to all populations while recognizing their own cultural or linguistic background or life experience and that of their clients, colleagues, or students.

Cultural Competence

Cultural competence is a journey, rather than an end. It refers to the process of actively developing and practicing appropriate, relevant, and sensitive strategies and skills in interacting with culturally different persons (AOTA, 1995). It is a set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals and enable that system or agency or those professionals to work effectively in cross-cultural situations (Cross, Bazron, Dennis, & Isaacs, 1989). Cultural competence entails

> understanding the importance of social and cultural influences on patients' health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system; and finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations. (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003, p. 297)

Clinically, cultural competence means having the self-awareness, knowledge, skills, and framework to make sound, ethical, and culturally appropriate decisions. It is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes (Davis & Donald, 1997). In Vignette 2 below, the therapist does not take into account the socioeconomic level, living environment, or culture of Mrs. Jones before training her to use a variety of adaptive equipment. A culturally competent practitioner is not afraid to ask the client culturally pertinent questions up front.

Competence in practice means learning new patterns of behaviors and effectively applying them in appropriate settings. Examples include the following (Wells & Black, 2000):

- Involving the extended family in the intervention process
- Addressing elderly persons more formally (by their last name and title) than younger clients
- Acknowledging and working with traditional and/or faith healers
- Being cautious about touching

- Engaging in small talk at the beginning of a session, which is considered good manners and keeps one from appearing rushed
- Conducting the session in the preferred language of the client or arranging for a professional interpreter
- Adding culturally related questions during the evaluation process

Cultural competence is key to effective therapeutic interactions and outcomes. It implies a heightened consciousness of how clients experience their uniqueness and deal with their differences and similarities within a larger social context. It enhances the occupational therapy provider's knowledge of the relationship between sociocultural factors and health beliefs and behaviors. It equips providers with the tools and skills to manage these factors appropriately, with quality occupational therapy delivery as the gold standard. Cultural competence is an evolving and developing process that depends on self-exploration, knowledge, and skills.

Vignette 2

Mrs. Jones is in her mid-60s and of Hispanic ethnicity. She is dependent for her existence on food stamps and Supplemental Security Income Benefit. Somewhat hard of hearing, she has a slight tremor in her voice and arthritis in her hands. The three-bedroom house in which she lives is in poor condition and is unkempt. For meals she relies on her neighbors and junk food.

Mrs. Jones is admitted to the rehabilitation unit after experiencing a mild stroke that leaves her impaired on the right side. Her treatment sessions consist of transfer training, learning one-handed cooking, and dressing with adaptive equipment. A variety of equipment and devices are recommended and ordered for her. At the discharge planning session, the occupational therapist states in her report, "Mrs. Jones has refused all the equipment even though she is able to use it safely and properly."

Ethical Conflicts

Several Western bioethical principles and concepts may be in opposition to certain cultural values and beliefs of other cultures, presenting ethical conflicts and dilemmas. Culture affects many therapy-client interactions, but the participants may not perceive the interactions as culturally or ethically related. Western bioethics places the self at the center of all decision making (autonomy). However, many cultures place the family, community, or society above the rights of the individual. The disclosing (truth-telling) of a diagnosis of serious illness or disability to the client is not universally accepted. Many believe that the family, not the client, should make important health care decisions. Some people believe that health is maintained and restored through positive language. When disclosing risks of a treatment or approach, health care providers speak in a negative way (informed consent). Questions of race, ethnicity, and cultural beliefs are part of the equation when resources are finite or scarce (justice). Some cultures believe that it is the duty of the family to care for its sick member (self-independence). When the therapist promotes independence in self-care or activities of daily living, the role of the family may be negated (Wells, 2005).

Ethical dilemmas can be further complicated by the unequal distribution of power in the relationship between the client and therapist. Clients and families faced with medical decisions are often subject to being over- or underinfluenced by the health care system and providers (power and dominance). The therapist-client relationship is one in which the therapist has the ultimate responsibility for developing conclusions and proposing treatment. These issues can lead to dilemmas in which the practitioner must either accede to the family's wishes or withdraw care. Respect for autonomy grants clients, who have been properly informed in a manner appropriate to the client's beliefs and understanding, the right to refuse a proposed treatment (Wells & Black, 2000).

The Issue

In view of the changing demographics in the United States, occupational therapists and occupational therapy assistants will have the opportunity to work with growing numbers of increasingly diverse clients. They will encounter individuals with different values and belief systems about health, well-being, illness, of daily living. They will develop evaluation and

intervention plans for consumers who may not speak their language; who differ from them in socioeconomic and educational level, ethnicity and race, and religion; and who have diverse beliefs about and reactions to illness. Clients and families, as well as practitioners, bring many different cultures to the therapeutic setting. The interaction of clients and practitioners embodies a form of multiculturalism in which several cultures— including the health care profession, institution, family, community, and traditional culture, —are all merged (Genao, Bussey-Jones, Brady, Branch, & Corbie-Smith, 2003). Therefore, every therapeutic interaction is a cross-cultural interaction. It is this overlap and interaction of cultures and dialects that can create ethical conflicts and dilemmas in providing occupational therapy services.

Without cultural competence, one can easily imagine the possible adverse consequences that can result when distrust, miscommunication, and misunderstanding interfere with the therapeutic relationship. The outcome can range from frustration, confusion, or shame to anger in the client, family, and practitioner. Cultural incompetence can result in compromised quality of care, noncompliance by the client, inability to recognize differences, fear of the new or unknown, denial, and inability to look in-depth at the individual needs of the client and his or her family (Wells & Black, 2000). Alternatively, cultural competence can produce a positive outcome for the client and a feeling of professional satisfaction in the practitioner from knowing that he or she helped a client at a time of need.

Individual cultural beliefs affect how occupational therapy practitioners approach, speak to, and measure outcomes with clients. Within a personal context, occupational therapy practitioners tend to make assumptions and judgments about individuals based on their particular culture, ethnicity, race, religion, sexual orientation, language, disability, or life experiences, and such assumptions and judgments can lead to improper intervention. In the clinical environment, responsibility for making sound ethical decisions rests with the individual practitioner. Ethical situations can arise when the behavior of the practitioner is in conflict with the behavior of the client or family. When two values present themselves and a participant chooses one rather than another that participant is saying, on the basis of his or her cultural context and beliefs, that one is more valuable than another (Iwana, 2003). Problems arise when the participants have a different interpretation of illness and treatment and use language or decision-making frameworks

differently. As individuals and professionals, occupational therapists and occupational therapy assistants take a particular action based on their own sense of right and wrong, values, knowledge, and skills.

Application of the Code

Professional codes of ethics provide a moral framework for and define the ideal standard of practice. They and associated documents provide guidelines and standards for resolving ethical conflicts, dilemmas, and issues. The relevant ethical principles of the Code and Ethics Standards that are valid for culturally competent occupational therapists, occupational therapy assistants, and students are as follows:

> Principle 1. Occupational therapy personnel shall demonstrate a concern for the well-being and safety of the recipients of their services. (Beneficence*)*
>
> Principle 4. Occupational therapy personnel shall provide services in a fair and equitable manner (Social Justice)

Occupational therapy personnel shall

> F. Provide services that reflect an understanding of how occupational therapy service delivery can be affected by factors such as economic status, age, ethnicity, race, geography, disability, marital status, sexual orientation, gender, gender identity, religion, culture, and political affiliation**.**

Principle 4F speaks directly to the prohibition of discrimination in the delivery of professional services. This principle holds the welfare of occupational therapy clients as paramount. Occupational therapists and occupational therapy assistants must consider all relevant contexts that influence the performance, skill, and patterns that determine the behaviors of their clients. According to the *Occupational Therapy Practice Framework: Domain and Process* (AOTA, 2008), "the expectations, beliefs, and customs of various cultures can affect a client's identity and activity choices and need to be considered when determining how and when services may be delivered" (p.651).The entire process of service delivery begins with a collaborative relationship with the client and family; therefore, incompetence in cross-cultural interaction, knowledge, and

skill can lead to unethical decision making.

> Principle 1E. Occupational therapy personnel shall provide occupational therapy services that are within each practitioner's level of competence and scope of practice….

> Principle 3I. Occupational therapy personnel shall take appropriate steps to facilitate meaningful communication and comprehension in cases in which the recipient of service, student, or research participant has limited ability to communicate (e.g., aphasia, or differences in language, literacy, culture).

> Principle 5F. Occupational therapy personnel shall take responsibility for maintaining high standards and continuing competence in practice, education and research…to improve and update knowledge and skills.

Principles 1E, 3I, and 5F remind practitioners of the importance and duty of lifelong learning to develop the knowledge and skills required to provide culturally appropriate service. They also speak to requiring occupational therapy practitioners to strive to deliver culturally competent services to an increasingly broad range of clients. They hold practitioners accountable for continuing their professional development and seeking knowledge throughout their careers, which is required to provide culturally competent care. In addition, Principles 5G and 5H prohibit delegation of tasks that are beyond the competence of the designee and require that the certified individual provide adequate supervision, especially important when linguistic differences exist and bilingual assistants, aides, and interpreters are used.

> Principle 7. Occupational therapy personnel shall treat colleagues and other professionals with respect, fairness, discretion, and integrity. (Fidelity)

Principle 7 provides guidance on interactions with individuals, colleagues, and students from diverse backgrounds. It calls on practitioners to "respect the traditions, practices, competencies, and responsibilities of their own and other professions" (Principle 7A). Culturally diverse

students and practitioners bring a special skill and knowledge to the profession. They are entitled to professional equity and should not be exploited or debased because of their differences. They should not be held to different expectations, roles, or behaviors. Discrimination in any professional interaction and against any individual with whom an occupational therapy practitioner interacts ultimately debases the profession and harms all those within the practice.

Discussion

The Code and Ethics Standards recognize that culture may influence how individuals cope with problems and interact with each other. The way in which occupational therapy services are planned and implemented needs to be culturally sensitive to be culturally effective. Cultural competence builds on the profession's ethical concepts of beneficence, nonmaleficence, autonomy, confidentiality, justice, veracity, and fidelity, adding inclusion, tolerance, and respect for diversity in all its forms.

The direct service provider, educator, supervisor, researcher, and professional leader must be mindful of the impact of cultural diversity in interactions with clients, families, students and colleagues. Some materials and approaches may be inappropriate and even offensive to some individuals. Clients and families may choose complementary and alternative medicine or traditional or faith healing practices as opposed to mainstream therapeutic approaches. Colleagues and students approach issues and events from their own cultural perspective.

Cultural competence requires occupational therapy practitioners to enter into the therapeutic relationship with an awareness of their own culture and cultural biases, knowledge about other cultures, and skills in cross-cultural communication and intervention (Wells & Black, 2000). Practitioners need a nonjudgmental attitude toward unfamiliar beliefs and health practices. They should be prepared to be open and flexible in the selection, administration, and interpretation of intervention approaches. They must be willing to negotiate and compromise when conflicts arise. And when cultural or linguistic differences may negatively influence outcomes, practitioners must be ready to refer to or collaborate with others who have the needed knowledge, skill, and experience. Cultural competence requires occupational therapy practitioners to detect and

prevent exclusion or exploitation of diverse clients and to monitor cultural competence in their agencies, policies and procedures, and delivery systems.

Vignette 3

You are attending a lecture about a disabling condition and its effect on specific populations. A multitude of groups and populations are presented and discussed. The only time that gays and lesbians are mentioned is in connection with the total number of deaths resulting from the condition. When asked by an attendee about the effects of this condition on the gay and lesbian population, the speaker ignores the individual and goes on to another question.

Caution must be taken not to attribute stereotypical characteristics to individuals. Rather, an attempt should be made to gain a better understanding of the culture of clients, colleagues, and students. Practitioners should devise a plan to continually acquire the training and education necessary to be culturally competent. The Code and Ethics Standards clearly show that occupational therapists and occupational therapy assistants have an ethical responsibility to be culturally competent practitioners.

Conclusion

To effectively reach diverse populations, the field of occupational therapy must have culturally competent professionals. Cultural competence is a basic reminder to all practitioners of their responsibility in protecting the rights of clients and their families and in acting as their advocates. Recognizing the link among trust, cultural competence, and the therapeutic relationship is critical to providing ethical care. Being culturally competent can help occupational therapy practitioners develop intervention approaches, health delivery systems, and health policies that fully recognize and include the effects of culture on the ethics of health decisions. It can aid practitioners in integrating fair and equitable services for all people and the holistic, contextual, and need-centered nature of such services. It can assist practitioners in achieving their goals of providing sound ethical decision making, practice, and care to all persons.

Ethical considerations dictate that cultural competence should be considered in activities such as hiring practices, teaching, evaluation, and supervision of staff and students. There is an equally

important need for all occupational therapists and occupational therapy assistants to continually improve their level of cultural competence and to establish a mechanism for the evaluation of competence-based practice. Guided by the Code and Ethics Standards, occupational therapists and occupational therapy assistants should take a leadership role not only in disseminating knowledge about diverse client groups but also in actively advocating for fair, equitable, and culturally appropriate treatment of all clients served. This role should extend within and outside the profession. In the principles of the Code and Ethics Standards, therapists have a framework to guide their decisions when cultural conflicts arise.

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