

Physiotherapy students' perceptions of engagement with people from culturally and linguistically diverse communities during clinical placement

R. Martin¹, C. Neish², Y. Su², A. Mandrusiak², M. Donovan², R. Dunwoodie²
& R. Forbes²

Abstract

Introduction: Student physiotherapists' perceptions and experiences when working with people from culturally and linguistically diverse communities in Australia have not been explored. Understanding the perceptions of student physiotherapists in this context may inform educational experiences in the pursuit of culturally responsive care. Therefore, this paper explores the perceptions and experiences of student physiotherapists engaging with people from culturally and linguistically diverse communities during clinical placement.

Methods: Semi-structured telephone interviews (n = 13) were conducted between March and September 2022 with final-year physiotherapy students from a single cohort at a single tertiary institution. Data were subject to reflexive thematic analysis.

Results: Four themes were generated from the data: 1) culture is a challenge for all stakeholders in health, 2) adapting care and communication, 3) modelling from clinical educators and 4) university preparation. Students understood that culture significantly impacts health and that healthcare must be responsive to culture to be appropriate for a person from a culturally and linguistically diverse community. Understanding and being responsive to the unique attitudes, values and beliefs of each individual underpinned student physiotherapists' perception of how healthcare can be culturally responsive, and this was viewed as a pivotal principle of person-centred care.

Conclusion: Recommendations are made for stakeholders in physiotherapy clinical education to support opportunities for the development of cultural responsiveness during physiotherapy training. University educators are encouraged to consider evaluating the volume and method in which cultural responsiveness training is included in physiotherapy programs. Similarly, clinical educators are encouraged to integrate available frameworks for culturally safe practice that are appropriate to their setting of work.

Keywords: culturally and linguistically diverse; physiotherapy; clinical placement; qualitative interviews; experiences

¹ School of Health Sciences, The University of Tasmania, Launceston, Tasmania, Australia

² School of Health and Rehabilitation Sciences, The University of Queensland, St Lucia, Queensland, Australia

Correspondence: Dr Romany Martin romany.martin@utas.edu.au

Introduction

As a multicultural nation, Australia comprises many people from diverse cultural backgrounds. It was estimated in 2021 that 7.5 million Australians (29.1%) were born overseas (Australian Bureau of Statistics, 2021). The term culturally and linguistically diverse (CALD) is commonly used in the Anglo-Australian context to refer to individuals who were born in non-English speaking countries and/or who predominately speak a language other than English at home (Pham et al., 2021; Te et al., 2022). With this term, Aboriginal and Torres Strait Islander Peoples are considered separately. People from CALD communities may encounter barriers in healthcare settings and face health disparities and poorer health outcomes compared to native-born Australians (Comino et al., 2001; Jatrana et al., 2018; Zhou, 2016). Despite a slight decrease in immigration in 2020, likely due to the COVID-19 pandemic, the average upwards trend of immigration in Australia calls for more culturally appropriate healthcare (Australian Bureau of Statistics, 2021). With this, healthcare professionals hold the responsibility to ensure that interactions with people from CALD communities are safe, appropriate and responsive to their needs.

Research from healthcare professions that explores experiences of caring for people from CALD communities highlights several barriers. These include perceived unique challenges relating to language barriers (Bernard et al., 2006; Coleman & Angosta, 2017; Ian et al., 2016; Sjögren Forss et al., 2019; Williams et al., 2018), differing cultural values, attitudes, beliefs and practices pertaining to health (Aldous et al., 2018; Ian et al., 2016; Newbold & Willinsky, 2009; Sjögren Forss et al., 2019; Williams et al., 2018) and time constraints to deliver adapted approaches (Ian et al., 2016; Williams et al., 2018). The use of supportive resources, such as interpreters and written materials, may complement healthcare professionals' approaches to patients from CALD communities (Coleman & Angosta, 2017; Ian et al., 2016; Shepherd et al., 2019; Sjögren Forss et al., 2019; Williams et al., 2018).

Physiotherapists engaging with individuals from CALD communities may experience associated challenges and, thus, attempt to adapt care in a way they deem to be culturally responsive. Research has highlighted that adapting care to respond to patients' cultural beliefs and values may improve patient engagement (Brady et al., 2018). Te and colleagues (2022) explored new-graduate physiotherapists' experiences and perceptions of engaging with people from CALD communities. Despite new-graduate physiotherapists having good intentions, they were found to lack appropriate culturally responsive skills to care for patients from CALD communities (Te et al., 2022). In addition to identified language barriers (Grandpierre et al., 2018; Mirza et al., 2022; Taylor & Jones, 2014), physiotherapists may also make cultural assumptions about patients' preferences for passive roles in treatment (Te et al., 2022; Yoshikawa et al., 2020) and apply strategies to adapt treatment in a superficial manner, without necessarily integrating patients' cultural perspectives (Te et al., 2022). Research exploring the preprofessional preparation

of physiotherapy students to provide culturally responsive care has been undertaken amongst Australian and Aotearoa New Zealand physiotherapy programs (Te, Blackstock, & Chipchase, 2019). The main barrier to the inclusion of cultural responsiveness content in physiotherapy programs was a perception among academic staff that curricula are already “overcrowded”, and cultural responsiveness was less important (Te, Blackstock, & Chipchase, 2019). Furthermore, predictors of self-perceived cultural responsiveness in Australian and Aotearoa New Zealand entry-level physiotherapy students have been explored through an online survey (Te, Blackstock, Fryer, et al., 2019). Interestingly, fourth-year undergraduate students had significantly lower levels of self-perceived cultural responsiveness compared to first- and second-year students (Te, Blackstock, Fryer, et al., 2019). Potentially, students’ understanding of culturally responsive care may develop throughout pre-professional training, which may also increase their awareness of their limitations in this space and lead to lower self-reported scores. Ultimately, whilst physiotherapists may be well-intentioned, there are several gaps in the provision of culturally responsive care for patients from CALD communities in Australia.

New-graduate physiotherapists’ perceptions and experiences when working with people from CALD communities in Australia have been explored (Te et al., 2022), however the experiences of student physiotherapists are not known. Understanding the perceptions of student physiotherapists in this context warrants exploration, as it may inform what variables contribute to effective educational experiences in the pursuit of culturally responsive care. Furthermore, with research highlighting the challenges of appropriate culturally responsive care within the current healthcare system, it is important to explore how student physiotherapists in Australia experience working with people from CALD communities to identify areas for improvement. To our knowledge, there have been no studies on Australian physiotherapy students’ views or experiences when interacting with patients from CALD communities during clinical placement. Therefore, this study explored student physiotherapists’ perceptions and experiences of engaging with people from CALD communities while on clinical placement. This research may assist with the development of strategies to guide university educators, placement coordinators and clinical educators to support student physiotherapists’ practice of culturally responsive care.

Methods

A qualitative inductive approach was undertaken to achieve the aims of the research. Semi-structured telephone interviews were conducted with final-year student physiotherapists to explore their perceptions and experiences of engaging with people from CALD communities in Australia. An interview guide was designed following a review of the literature and in consultation with sitting members of The University of Queensland Cultural Inclusion Council. Ethical clearance was obtained from The University of Queensland—Institutional Human Research Ethics, project number 2022/HE000257.

Participants

Potential participants were entry-level program students in 2022 at The University of Queensland, who were recruited via a convenience sample (Patton, 2002). For inclusion in the study, participants were required to be in their fourth week of a full-time clinical placement to allow for adequate experiences to reflect upon. Participants were recruited via professional contacts of the research team, including clinical education liaison managers at The University of Queensland. Potential participants received a single email from the lead researcher (RM) with an invitation to take part in the research. The lead researcher (RM) was not involved with clinical placements, and participants were assured that their decision to participate or decline would not influence their current or future relationship with the university in any way. If the potential participant replied, a mutually convenient interview time was agreed upon via email. If no response was received within 7 days, no further contact was made, and recruitment continued via emails to other potential participants. Written informed consent was obtained from all participants.

Data collection

An interview guide (see Appendix) was developed following a review of the extant literature regarding cultural responsiveness and in collaboration with sitting members of The University of Queensland Cultural Inclusion Council. Feedback from members of the Cultural Inclusion Council resulted in minor changes to the interview briefing. The interview guide was designed to encourage an appropriate depth of response to topics including cultural responsiveness, interactions with people from CALD communities and experiences during clinical placement (Patton, 2002). Telephone interviews were conducted by a researcher experienced in interviewing (RM) from March to September 2022, with audio data recorded to facilitate accurate transcription. On beginning the interview, informed consent was reconfirmed, and participants were provided with the working definition, below, of people from CALD communities.

Culturally and linguistically diverse is used as a broad and inclusive descriptor for communities with diverse language, ethnic background, nationality, traditions, societal structures, and religious characteristics. In Australia, people from CALD communities are generally defined as those people who identify with a cultural and linguistic group that is not the dominant Anglo-Australian culture (Te et al., 2022).

One author (CN) transcribed all interview data verbatim, and this was checked by the lead author and interviewer (RM) for accuracy. Transcripts of the interview data were returned to the participants via email for member checking. No changes to the data resulted from this process. Data saturation was determined in part by the depth of meaning that was interpreted by the researchers in the data, however the researchers acknowledge that their positioning within the research and the generated results are inseparable (Braun & Clarke, 2021b). Following concurrent data collection and analysis, the researchers feel that conceptual density of the results was achieved (Nelson, 2017).

Data analysis

Data were subject to thematic analysis using a reflexive approach, in that the themes were developed from generated and explicit codes and are conceptualised as patterns of shared meaning (Braun & Clarke, 2021a). Analysis was undertaken independently by two researchers (RM/RF). The six steps recommended by Braun and Clarke (2021a) were adhered to and included the researchers familiarising themselves with the data through multiple read-throughs, the coding of explicit concepts and ideas in the transcripts, the generation of initial themes, the refinement of the themes and their concepts, the defining and naming of the themes and, finally, the writing of the results (Braun & Clarke, 2021a). The researchers conversed regarding the generation of initial themes and the refinement of the themes and concepts. The themes and codes evolved as the researchers gained a deeper understanding of the data. The researchers then met to discuss codes and themes, with discrepancies debated until consensus was reached. The final themes and codes were reviewed by the broader research team, which allowed for the integration of a breadth of experiences and researcher perspectives, including physiotherapy students, a physiotherapy lecturer and a physiotherapy senior lecturer.

Efforts were made to promote the trustworthiness, transparency and credibility of the results, including audio recording of the interviews to allow for accurate transcription and adherence to the interview guide. To promote reflexivity of the analysis, both researchers embarked on the process of epoch and documented their own opinions and beliefs relevant to the phenomenon under investigation (Englander, 2016). The lead researcher (RM) is an Australian who practises as a physiotherapist, has a Doctor of Philosophy and has published research in new-graduate experiences and rural practice. The second researcher undertaking analysis (RF) is a New Zealander who is an expert musculoskeletal physiotherapist with a Doctor of Philosophy, who has published research in patient education and work integrated learning. Neither researcher identifies as being from a CALD community. At the time of data analysis, both researchers (RM/RF) were employed as teaching and research academics. The process of epoch allowed the researchers to acknowledge how their previous experiences may have influenced the data analysis, as is required of the qualitative analysis process (Varpio et al., 2017).

Results

A total of 13 students were interviewed for the study, 10 of whom were female ($n = 10$, 76.9%), which is a distribution reflective of the Australian physiotherapy workforce (Physiotherapy Board of Australia, 2021). Five (38.5%) of the students identified as being CALD themselves, with the remaining students identifying as Anglo-Australian ($n = 7$, 53.9) or Anglo-Canadian ($n = 1$, 7.7%). Further demographic data are available in Table 1 and Table 2. The interviews were approximately 20 minutes in length.

Table 1*Demographics of the Sample*

Demographic	N (%)	Demographic	N (%)
Age		Setting	
20–24	12/13 (92.3%)	Hospital	9/13 (69.2%)
25–29	0/13 (0%)	Private practice	3/13 (23.1%)
30–34	1/13 (7.7%)	Community healthcare	1/13 (7.7%)
Gender		Previously engaged with patients via an interpreter	
Female	10/13 (76.9%)	Yes	4/13 (30.8%)
Male	3/13 (23.1%)	No	9/13 (69.2%)
Other	0 (0%)		
Prefer not to say	0 (0%)		

Table 2*Participant Background Information*

#	Gender	Age	Self-Identified Ethnocultural	Location	Previously Engaged With Patients via an Interpreter	Estimate of CALD Caseload in 1 Week (%)
1	Female	22	Anglo-Australian	Brisbane	Yes	50%
2	Female	22	Asian-Australian	Mackay	Yes	5%
3	Female	21	Anglo-Australian	Brisbane	No	40%
4	Male	22	Anglo-Australian	Gladstone	No	30%
5	Female	23	Egyptian-Australian	Brisbane	No	50%
6	Female	32	Anglo-Canadian	Brisbane	No	25%
7	Female	21	Chinese	Brisbane	Yes	20%
8	Male	21	Filipino	Toowoomba	No	15%
9	Female	21	Anglo-Australian	Logan	No	40%
10	Female	21	Anglo-Australian	Gympie	No	50%
11	Female	20	Anglo-Australian	Brisbane	No	10%
12	Male	22	Fijian Indian	Logan	No	25%
13	Female	21	Anglo-Australia	Townsville	Yes	50%

Four themes were constructed from the data by the research team. These themes are: 1) culture is a challenge for all stakeholders in health, 2) adapting care and communication, 3) modelling from clinical educators and 4) university preparation.

Theme 1: Culture is a challenge for all stakeholders in health

Participants felt that a person's culture "definitely" (P1, P2, P3, P7, P8, P10, P13) impacts how they engage with healthcare. Cultural differences were perceived as a significant challenge for people accessing healthcare. Cultural factors that influence healthcare were perceived to be the specific values and beliefs of the person and their previous experiences of healthcare:

There was this really sad case ... They recently got married as a young couple, moved to Australia from China, and they found the tumor suddenly and then they had to operate, and then basically really bad outcomes from that ... trying to understand and navigate a very difficult situation in a completely new country, not being able to speak English well. (P2)

With different cultures come different beliefs, so how people perceive, let's say, the importance of healthcare is very different ... In more poverty-stricken countries, healthcare isn't necessarily their top priority because they can't afford that so it's differences in beliefs ... can affect how [they] can perceive health and healthcare. (P8)

Challenges from cultural differences experienced by participants were perceived to limit the quality of care provided to the individuals. The limitation most commonly discussed was the effectiveness of the communication that participants were able to achieve with people from CALD communities, which was perceived to limit the outcomes of the interaction:

You've got to ... really limit your questions to get ... the "bare bones" of what you want to know, and what you need to convey. (P1)

When I was talking to them, they didn't even realise they had a screw put in. They didn't realise what the operation was for, or anything like that. So, I went – I used a lot of diagrams and a couple of videos to explain what the screw meant and what it allowed them to do ... and reassurance that it wasn't a bad thing. (P13)

Similarly, cultural differences were perceived to introduce an additional challenge for student physiotherapists to existing clinical placement challenges. Participants felt that they were trying to obtain the basic skills of physiotherapy and that providing culturally responsive care was an extension of their skills that were required in addition to their basic clinical skills. One participant went as far as to state that "it's really difficult to explain medical things in simple terms when you're still learning about them yourself" (P6).

Especially on placement, it's like, you're trying to consolidate what you've learnt in general, like the basic stuff, and then it's hard to even try to branch off to go "Ah no, I've really got to adapt—adapt to this person's history and what they're saying, what they believe". Cause you're just trying to get it out of your brain ... I feel like, not integrated enough, so that I can just go "yep, okay, here's [how] I'll adapt that". (P3)

Understandably, participants who identified as being from CALD communities felt that their lived experience positively influences their preparedness to engage with people from CALD communities. For example, one participant stated that “*most people don’t understand the difficulties that immigrant or immigrant families go through when they move to a brand-new country. ... It’s definitely something that is really difficult to explain or like understand unless you have lived through it*” (P2).

Theme 2: Adapting care and communication

Participants firmly believed that healthcare should be responsive to a person’s culture in order to improve the quality of their care. Ultimately, providing culturally responsive care was seen as a vital part of a person-centred model of healthcare practice. This ties into the participant’s understanding that person-centred care requires physiotherapists to be responsive to the attitudes, values and beliefs of all patients and that culturally responsive care was central to this concept:

I like to think that whatever this person’s definition of health or whatever their commitment is, I guess is my commitment. ... I’d like to think I’d be able to adjust, but I don’t know what that would look like. (P4)

I mean I see it [cultural responsiveness] as patient-centred care ultimately, and I feel like that’s been the kind of the core focus of things. (P6)

However, when asked if they adapted their care and how they adapted their care, participants voiced that they did “*not necessarily*” (P1) adapt their assessment and treatment to those from CALD communities. One participant suggested that because they were educated in Australia, they did not know “*how people practise in a different culture or ... in different countries*” (P2) or “*in terms of care, [what] they’re expecting*” (P2), with another postulating that it was “*more so about changing the communication than changing the treatment*” (P9).

The focus for effectively engaging with people from CALD communities was felt to be adapting both non-verbal and verbal communication. Participants discussed responding to the communication needs of people from CALD communities, however the goal of these adaptations was to convey the intended message of the participant rather than to respond to the needs of the patient:

I guess that can be a little bit difficult in kind of communicating that, like we’re here to help? We’re the professionals ... getting them on side with us. I think that was, that’s kind of like a, an initial thing that you’ve kind of got to make sure that they understand. (P1)

Obviously the first few minutes, trying to gauge what kind of language to use, just how much they understand and what words they pick up on and all like the non-verbal features as well, like eye contact, body language, tone—all that sort of stuff. (P9)

This communication barrier was further attributed to the perception that people from CALD backgrounds were more passive in their engagement with healthcare. This stemmed from people from CALD backgrounds not being as talkative during their engagement with the participants. Additional passive stereotypes that were discussed included a resistance to completing exercise for rehabilitation and following the advice of healthcare providers:

Especially with Asian cultures, I feel like the expectation is really passive, and it's like "you're the health professional, you're supposed to fix me", and they just kind of not really engaging and expecting things to happen and that kind of makes sense. (P2)

Theme 3: Modelling from clinical educators

Participants were guided by the implicit perspectives and behaviours modelled by their clinical educators for the provision of culturally responsive care. When asked about explicit mentorship from clinical educators to overcome the barriers to culturally appropriate care, participants responded that it was “*not something that's overly front and centre*” (P1). Participants reflected on experiences of case-by-case guidance rather than frameworks or policies for culturally appropriate care:

I have been exposed to a much wider population of people [on clinical placement], different ages, different cultural backgrounds ... linguistically and culturally. I think with practice it just comes, and with the guidance of CEs [clinical educators], it helps as well. (P2)

Whilst viewing the actions of their clinical educators positively, participants felt that their clinical educators were not always responsive to culture. The participants stated, “*if that's who we're watching ... then what does it mean for our, kind of, cultural learning?*” (P3). One participant felt that she was “*aware*” (P3) that the cultural needs of the patient were not being met and found herself advocating for the patient to her educator. Similar sentiments were voiced by participants, whereby they felt that the needs of the patient were not being met and that more could be done:

I'd be trying to be culturally sensitive. ... I think maybe just because they [the clinical educator] have been in it [practice] for so long, it's just kind of glazed over? And it's like "yep, this this this" and it's like "oh, I don't know if they [the patient] are comfortable doing that?" ... The consent's there, but it's also kind of like "Is that fine? Yep, okay great. Keep going". (P3)

I just feel they're quite blunt or they would be, I feel like at times, might be dismissing the person; they weren't really listening to what the patient was saying. Or they were there and listening, but they weren't really kind of seeing or taking on what that meant to the patient. (P13)

The inconsistency between the students' expectations and the reality of the practice of their clinical educators, was balanced by their acknowledgement of the time pressures that health professionals are subject to and a sense that people from CALD communities “*need more time*” (P5) from their health professionals. Furthermore, there was acknowledgment

of an evolutionary shift in healthcare that might reposition the lens of best practice on concepts such as person-centred care for people from CALD communities:

Even ... talking to clinical educators or ... older clinicians, ... they always go ... “Oh we weren’t really ... honed in on that stuff when we went through it; it was just very much, okay this is physio ... this is what you do”, whereas now ... with how the world is developing and all these different cultures ... it’s taken such a more central role, to ... optimise that patient-centered care. ... I feel like it’s super important, definitely. (P8)

Theme 4: University preparation

Whilst some participants reflected on the implicit ways in which their university curriculum prepared them to provide culturally appropriate care for patients from CALD communities, most participants felt that providing culturally appropriate care could be taught more explicitly. Teaching and learning for the provision of culturally appropriate care was perceived to be stand-alone and predominantly featured at the beginning of the program, or manifested as a small adaptation to existing curricula, for example, efforts to “switch up the names (in case-based learning) from anything that’s not typically Anglo-Australia” (P1):

I just found like, surprised in how little we did, especially given the change in demographics of Australia over the last, I don’t know, 20 years? (P13)

When asked what appropriate university training would look like to prepare students to provide culturally appropriate care, participants were unsure that a single unit would be of value. Instead, it was felt that systemic change is required to integrate culturally appropriate care considerations into all facets of physiotherapy practice:

I guess it would be more of just slipping into each class, how like physio can kind of like be adapted to accommodate different things, rather than having like one set chunk of learning about it. I feel like it’s got to be more of a systemic thing, rather than a, here, let’s just learn for 2 weeks about this. (P1)

Participants acknowledged that the concepts taught at university were theoretical and that clinical placement was, then, where you would apply and cement these skills:

We always talk about “oh yeah, you have to be adaptive”, and it’s all about patient-centred care and you know, it’s part of that; you’re needing to take into consideration someone’s diverse background, etcetera, but then, to actually put that into practice ... I do feel like it has all been a bit abstract in terms of the way it’s been approached throughout the degree. (P6)

Discussion

This study has explored student physiotherapists’ perceptions and experiences of engaging with people from CALD communities in Australia during their clinical placements. Student physiotherapists understood that culture significantly impacts health and

that healthcare must be responsive to culture to be appropriate for those from CALD communities. Understanding and being responsive to the unique attitudes, values and beliefs of each individual was integral to how student physiotherapists perceived that healthcare can be culturally responsive, and this was viewed as a pivotal principle of person-centred care. However, when discussing adapting their own practice, making adaptations to their verbal and non-verbal communication was the most common strategy discussed. Cultural responsiveness training provided to students prior to clinical placement was felt to be limited and standalone rather than integrated and may have contributed to the students' discomfort whilst providing culturally responsive care. Students who identified as CALD felt that their lived experience positively influenced their preparedness to engage with people from CALD communities. Interestingly, students felt that they could recognise a lack of culturally responsive practice despite voicing that they had not learnt what it meant to be culturally responsive during their university training. Furthermore, students in this study reflected on their experiences of behaviour modelled by their clinical educators and felt that, at times, the approaches taken by educators when engaging with those from CALD communities did not reflect culturally responsive care.

Providing culturally responsive care to people from CALD communities was viewed by student physiotherapists to be an extension of providing person-centred care. This appeared to stem from the student physiotherapists' belief that healthcare should be specific to the values and attitudes of each individual. A pilot randomised control trial by Brady et al. (2018) has demonstrated that aligning treatment with the beliefs and cultural attitudes of people from CALD communities resulted in increased therapy attendance, increased patient satisfaction and a reduction in pain-related suffering (Brady et al., 2018). University educators are encouraged to extend on student physiotherapists' understanding of person-centred care as a foundation for development of culturally responsive care, especially within constructivist approaches to teaching and learning (Mukhalalati & Taylor, 2019). That is, student physiotherapists may build their cultural responsiveness skills more effectively if this is positioned within their understanding of person-centred care. The inclusion of cultural responsiveness training within established teaching and learning for person-centred care may also help to overcome the barrier identified by academics, whereby they perceive that cultural responsiveness training is difficult to implement in already "overcrowded" physiotherapy curricula (Te, Blackstock, & Chipchase, 2019). Whilst students in this study demonstrated theoretical understanding of culturally responsive care, they were unable to provide examples of how they had adapted their practice to be culturally responsive. This uncertainty regarding the provision of culturally responsive care is unsurprising given the lack of published research available in physiotherapy that is inclusive of people from CALD communities (Brady et al., 2016). Further research is warranted to explore provision of culturally responsive care across all contexts and levels of experience in the physiotherapy profession.

Student physiotherapists in this study felt a sense of conflict on occasions where they

observed their clinical educators engage with people from CALD communities in a manner that they perceived to deviate from culturally responsive practice. Students were uncertain regarding the appropriateness of engaging with their clinical educators regarding such deviations whilst also acknowledging that they didn't feel that the needs of the person were being met. Clinical educators' perceptions of student-initiated conversations regarding perceived deviations from evidence-based clinical practice have been explored amongst a sample of Australian clinical educators, 22% of whom were physiotherapists (Sevenhuysen et al., 2021). Most of the clinicians interviewed were able to reflect on occurrences where student-initiated conversations had influenced their practice, with all clinicians acknowledging that conversations initiated by students had the potential for both positive and negative impacts when conducted through appropriate methods. Ultimately, the research recommended that the inclusion of communication skills specific to conflict, through pre-professional simulation, may support students to appropriately question the practice of their educators (Sevenhuysen et al., 2021). Our research adds to the literature, as it explores student perceptions of witnessing deviations from perceived culturally responsive practice and identifies that whilst students feel discomfort, they are unsure about how to advocate for their patient. This study supports Sevenhuysen et al.'s (2021) recommendation regarding the use of simulation as a training approach to enhance student readiness to appropriately question their clinical educator.

Students voiced that they desired integration of both explicit and implicit cultural responsiveness training throughout their physiotherapy programs. This contrasted with their own experiences of cultural responsiveness training, which were perceived to be units that were not contextually integrated or case-based learning that was seen to be somewhat tokenistic, for example, simply changing the name of the person in the clinical case. Whilst name changes to case-based learning might be perceived as largely superficial, combining multiple approaches to developing cultural responsiveness may be more effective, for example, ensuring the provision of culturally diverse training equipment, such as advanced life support manikins that reflect people of colour (Lam et al., 2022).

Multiple recommendations can be drawn from the findings of this study for both university-based pre-professional training and clinical educators involved in clinical placements. University educators are encouraged to consider evaluating the volume and method in which cultural responsiveness training is included in physiotherapy programs, as pre-professional opportunities for cultural training were valued by students. This recommendation is supported by Te, Blackstock, & Chipchase (2019), who undertook a survey of Australian and Aotearoa New Zealand physiotherapy programs and found that the majority of programs appear to rely on didactic teaching methods along with knowledge-based and implicit assessment methods. Our research encourages universities to imbed cultural responsiveness training throughout physiotherapy training as opposed to standalone educational approaches. Opportunities and initiatives to increase diversity of university faculty and physiotherapy teaching staff, including those from CALD

backgrounds may also be a driver for positive change. Students in this study valued opportunities to explicitly discuss cultural responsiveness with others during their clinical placements, however they perceived that not all clinical educators were providing culturally responsive care. Our study recommends that cultural responsiveness be part of the initial onboarding and ongoing auditing of clinical placement providers and, perhaps more meaningfully, that conversations are conducted between universities and clinical placement providers to highlight the importance of modelling culturally responsive care. Similarly, clinical educators are encouraged to integrate available frameworks for culturally safe practice that are appropriate to their setting of work to ensure students are aware of the tacit decisions made by clinicians to ensure culturally safe care. Finally, universities are encouraged to consider the diversity of cultural communities that physiotherapy students have opportunities to engage with during clinical placements. Diversity in clinical placement opportunities is encouraged, for example, the mandatory completion of a rural placement (Flinders University, 2023; James Cook University, 2023). Universities are encouraged to prioritise the immersion of physiotherapy students amongst people from CALD communities given the surface level adaptations reported by students in this study and previous research demonstrating that new-graduate physiotherapists may not provide appropriate culturally responsive care (Te et al., 2022).

Limitations

The participant sample is a limitation of the research that must be taken into consideration, as all participants are from a single cohort at a single tertiary institution. The participants may have been impacted by a social acceptability bias, whereby they may have provided responses that they perceived to be desirable for the research. Furthermore, participants who had extreme experiences during clinical placement may have been more likely to participate in the research, which may have impacted the results of the study. Finally, the interviewer (RM) was known to some of the participants from previous university study, which may have influenced the responses provided.

Conclusion

Physiotherapy students view the provision of culturally responsive care as an extension of their understanding of person-centred practice, however they feel that they do not adapt their practice to be culturally responsive during clinical placement. Strategies that were used by physiotherapy students centred on adapting verbal and non-verbal communication to achieve their own physiotherapy goals. Physiotherapy students voiced that they perceived their interactions with people from CALD communities during clinical placements as an additional challenge above the usual challenges of learning clinical skills. Recommendations are made for universities and clinical educators to encourage ongoing discussion and prioritisation of culturally responsive care during clinical placements.

Acknowledgements

The authors would like to acknowledge the students who lent their voices and insights to this project.

Conflicts of interest and funding

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as potential conflicts of interest. This research did not receive any specific grant from funding agencies in the public, commercial or not-for-profit sectors.

References

- Aldous, C., Van Rooyen, D. R. M., Marais, L. C., Goliath, V., & Brown, O. (2018). Cultural factors that influence the treatment of osteosarcoma in Zulu patients: Healthcare professionals' perspectives and strategies. *Health SA Gesondheid*, 23, Article 1095. <https://doi.org/10.4102/hsag.v23i0.1095>
- Australian Bureau of Statistics. (2021). *Australia's population by country of birth*. <https://www.abs.gov.au/statistics/people/population/australias-population-country-birth/latest-release>
- Bernard, A., Whitaker, M., Ray, M., Rockich, A., Barton-Baxter, M., Barnes, S. L., Boulanger, B., Tsuei, B., & Kearney, P. (2006). Impact of language barrier on acute care medical professionals is dependent upon role. *Journal of Professional Nursing*, 22(6), 355–358. <https://doi.org/10.1016/j.profnurs.2006.09.001>
- Brady, B., Veljanova, I., & Chipchase, L. (2016). Culturally informed practice and physiotherapy. *Journal of Physiotherapy*, 62(3), 121–123. <https://doi.org/10.1016/j.jphys.2016.05.010>
- Brady, B., Veljanova, I., Schabrun, S., & Chipchase, L. (2018). Integrating culturally informed approaches into physiotherapy assessment and treatment of chronic pain: A pilot randomised controlled trial. *BMJ Open*, 8(7), Article e021999. <https://doi.org/10.1136/bmjopen-2018-021999>
- Brady, B., Veljanova, I., Schabrun, S., & Chipchase, L. (2018). Integrating culturally informed approaches into physiotherapy assessment and treatment of chronic pain: A pilot randomised controlled trial. *BMJ Open*, e021999. <https://doi.org/10.1136/bmjopen-2018-021999>
- Braun, V., & Clarke, V. (2021a). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*, 21(1), 37–47. <https://doi.org/10.1002/capr.12360>
- Braun, V., & Clarke, V. (2021b). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health*, 13(2), 201–216. <https://doi.org/10.1080/2159676X.2019.1704846>
- Coleman, J. S., & Angosta, A. D. (2017). The lived experiences of acute-care bedside registered nurses caring for patients and their families with limited English proficiency: A silent shift. *Journal of Clinical Nursing*, 26(5–6), 678–689. <https://doi.org/10.1111/jocn.13567>
- Comino, E. J., Silove, D., Manicavasagar, V., Harris, E., & Harris, M. F. (2001). Agreement in symptoms of anxiety and depression between patients and GPs: The influence of ethnicity. *Family Practice*, 18(1), 71–77. <https://doi.org/10.1093/fampra/18.1.71>
- Englander, M. (2016). The phenomenological method in qualitative psychology and psychiatry. *International Journal of Qualitative Studies on Health and Well-being*, 11(1), Article 30682. <https://doi.org/10.3402/qhw.v11.30682>

- Flinders University. (2023). *Physiotherapy professional experience placement*. Retrieved February 7, 2023, from <https://students.flinders.edu.au/my-course/placements/compliance/physiotherapy>
- Grandpierre, V., Milloy, V., Sikora, L., Fitzpatrick, E., Thomas, R., & Potter, B. (2018). Barriers and facilitators to cultural competence in rehabilitation services: A scoping review. *BMC Health Service Research*, 18, Article 23. <https://doi.org/10.1186/s12913-017-2811-1>
- Ian, C., Nakamura-Florez, E., & Lee, Y. M. (2016). Registered nurses' experiences with caring for non-English speaking patients. *Applied Nursing Research*, 30, 257–260. <https://doi.org/10.1016/j.apnr.2015.11.009>
- James Cook University. (2023). *Clinical placements*. Retrieved February 7, 2023, from <https://www.jcu.edu.au/college-of-healthcare-sciences/student-resources/clinical-placements>
- Jatrana, S., Richardson, K., & Pasupuleti, S. S. R. (2018). Investigating the dynamics of migration and health in Australia: A longitudinal study. *European Journal of Population*, 34(4), 519–565. <https://doi.org/10.1007/s10680-017-9439-z>
- Lam, R., Hillsley, R., Steele, J., & Whitfield, S. (2022). Developing cultural competence in paramedic education: An analysis of culturally diverse training equipment amongst universities in Australia and New Zealand. *Australian Journal of Clinical Education*, 11(2), 27–36. <https://doi.org/10.53300/001c.40320>
- Mirza, M., Harrison, E. A., Roman, M., Miller, K. A., & Jacobs, E. A. (2022). Walking the talk: Understanding how language barriers affect the delivery of rehabilitation services. *Disability and Rehabilitation*, 44(2), 301–314. <https://doi.org/10.1080/09638288.2020.1767219>
- Mukhalalati, B. A., & Taylor, A. (2019). Adult learning theories in context: A quick guide for healthcare professional educators. *Journal of Medical Education and Curricular Development*, 6. <https://doi.org/10.1177/2382120519840332>
- Nelson, J. (2017). Using conceptual depth criteria: Addressing the challenge of reaching saturation in qualitative research. *Qualitative Research*, 17(5), 554–570. <https://doi.org/10.1177/1468794116679873>
- Newbold, K. B., & Willinsky, J. (2009). Providing family planning and reproductive healthcare to Canadian immigrants: Perceptions of healthcare providers. *Culture, Health & Sexuality*, 11(4), 369–382. <https://doi.org/10.1080/13691050802710642>
- Patton, M. (2002). *Qualitative research and evaluation method* (3rd ed.). Sage Publications.
- Pham, T. T. L., Berecki-Gisolf, J., Clapperton, A., O'Brien, K. S., Liu, S., & Gibson, K. (2021). Definitions of culturally and linguistically diverse (CALD): A literature review of epidemiological research in Australia. *International Journal of Environmental Research and Public Health*, 18(2), Article 737. <https://doi.org/10.3390/ijerph18020737>
- Physiotherapy Board of Australia. (2021). *Registrant data. Reporting period: 01 July 2021 to 30 September 2021*. Retrieved June 21, 2023, from <https://www.physiotherapyboard.gov.au/About/Statistics.aspx>
- Sevenhuysen, S., Kent, F., Wright, C., Williams, C., Bowles, K., Matthews, K., Ayton, D., & Maloney, S. (2021). “Why have you done it that way?” Educator perceptions of student-initiated conversations about perceived deviations from evidence-based clinical practice. *Nurse Education Today*, 98, Article 104768. <https://doi.org/10.1016/j.nedt.2021.104768>
- Shepherd, S. M., Willis-Esqueda, C., Newton, D., Sivasubramaniam, D., & Paradies, Y. (2019). The challenge of cultural competence in the workplace: Perspectives of healthcare providers. *BMC Health Services Research*, 19, Article 135. <https://doi.org/10.1186/s12913-019-3959-7>

- Sjögren Forss, K., Persson, K., & Borglin, G. (2019). Nursing students' experiences of caring for ethnically and culturally diverse patients. A scoping review. *Nurse Education in Practice*, 37, 97–104. <https://doi.org/10.1016/j.nepr.2019.05.003>
- Taylor, E., & Jones, F. (2014). Lost in translation: Exploring therapists' experiences of providing stroke rehabilitation across a language barrier. *Disability and Rehabilitation*, 36(25), 2127–2135. <https://doi.org/10.3109/09638288.2014.892636>
- Te, M., Blackstock, F., & Chipchase, L. (2019). Fostering cultural responsiveness in physiotherapy: Curricula survey of Australian and Aotearoa New Zealand physiotherapy programs. *BMC Medical Education*, 19, Article 326. <https://doi.org/10.1186/s12909-019-1766-9>
- Te, M., Blackstock, F., Fryer, C., Gardner, P., Geary, L., Kuys, S., McPherson, K., Nahon, I., Tang, C., Taylor, L., Van Kessel, G., Van Der Zwan, K., & Chipchase, L. (2019). Predictors of self-perceived cultural responsiveness in entry-level physiotherapy students in Australia and Aotearoa New Zealand. *BMC Medical Education*, 19, Article 56. <https://doi.org/10.1186/s12909-019-1487-0>
- Te, M., Blackstock, F., Liamputtong, P., & Chipchase, L. (2022). New graduate physiotherapists' perceptions and experiences working with people from culturally and linguistically diverse communities in Australia: A qualitative study. *Physiotherapy Theory and Practice*, 38(6), 782–793. <https://doi.org/10.1080/09593985.2020.1799459>
- Varpio, L., Ajjawi, R., Monrouxe, L. V., O'Brien, B. C., & Rees, C. E. (2017). Shedding the cobra effect: Problematising thematic emergence, triangulation, saturation and member checking. *Medical Education*, 51(1), 40–50. <https://doi.org/10.1111/medu.13124>
- Williams, A., Oulton, K., Sell, D., & Wray, J. (2018). Healthcare professional and interpreter perspectives on working with and caring for non-English speaking families in a tertiary paediatric healthcare setting. *Ethnicity & Health*, 23(7), 767–780. <https://doi.org/10.1080/13557858.2017.1294662>
- Yoshikawa, K., Brady, B., Perry, M. A., & Devan, H. (2020). Sociocultural factors influencing physiotherapy management in culturally and linguistically diverse people with persistent pain: A scoping review. *Physiotherapy*, 107, 292–305. <https://doi.org/10.1016/j.physio.2019.08.002>
- Zhou, Q. (2016). Accessing disability services by people from culturally and linguistically diverse backgrounds in Australia. *Disability and Rehabilitation*, 38(9), 844–852. <https://doi.org/10.3109/09638288.2015.1062925>

Articles published in *Focus on Health Professional Education (FoHPE)* are available under Creative Commons Attribution Non-Commercial No Derivatives Licence (CC BY-NC-ND 4.0).

On acceptance for publication in *FoHPE*, the copyright of the manuscript is signed over to ANZAHPE, the publisher of *FoHPE*.

Appendix

Semi-Structured Interview Guide

Do you think a person's culture influences how they engage with healthcare? How?

What have been your experiences of working with patients from CALD communities during clinical placement?

Do you adapt your interactions when providing physiotherapy to patients from CALD communities during clinical placement? How?

How did your university experience influence your perception of working with patients from CALD communities?
