Building intercultural competencies in monocultural organisations: issues and perspectives in planning rehabilitation services in Montréal (Québec, Canada)

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This paper presents several issues pertaining to intercultural encounters in the field of occupational health and work rehabilitation. The results are based on a study conducted in Montréal (Québec, Canada), a city where more than one third of the population is of foreign origin. According to the Québec Workers’ Compensation Board (CSST), almost 50% of workers affected by an occupational injury in this area are recent immigrants. This means that encounters between patients and health care providers are increasingly likely to be characterized by intercultural dynamics. After presenting the analytical model and after having taken into account micro and macro data, we suggest (following previous research in this area) that the different stakeholders involved in the healing process face intercultural barriers that significantly hinder the building of a therapeutic alliance. Our data suggest that clinicians and agents in the field might develop strategies on their own to adjust treatment options, but the lack of intercultural competencies at the organisational level leaves employees to fend for themselves in this regard. One consequence is the inability of the organisation to access and organise the expertise that has been developed through clinical experience over time, leading to a never-ending (re)development or reinvention of expertise by stakeholders and agents (e.g. institutional blindness). The lack of organisational intercultural competencies results in the failure to take into account the additional time required for interventions with clients in multi-ethnic settings. This can pose a risk to the health of health care workers: work overload, emotional distress, feeling of failure, and increased employee turnover. In conclusion, we address the question of developing intercultural competencies in organisations that are characterized by monocultural policies or structures. In a financial context of “austerity” and new managerial “twists” where clinicians and agents are asked to do more with fewer resources, it is increasingly difficult to integrate time as a fundamental parameter of the intervention, especially given the additional energy required to enable the co-construction of a therapeutic space.
1 - Introduction

This paper presents several issues pertaining to intercultural encounters in the field of occupational health and work rehabilitation. The results are based on a study conducted in Montréal (Québec, Canada), a city where more than one third of the population is of foreign origin. According to the Québec Workers’ Compensation Board (CSST), almost 50% of workers affected by an occupational injury in this area are recent immigrants. This means that encounters between patients and health care providers are increasingly likely to be characterized by intercultural dynamics.

Context of the study

Every year in Quebec, thousands of people are injured at work or face long-term sickness absence, often due to chronic pain. Some workers must undergo medical treatment such as physical rehabilitation to help them heal and return to work. When they undergo physical rehabilitation, the injured worker also has to adapt to the way of doing things in a medical setting with which they are not familiar. They might even ignore the existence of some health professions involved in the rehabilitation process, which in itself can be a source of misunderstanding. Scientific research shows that the response to pain varies greatly from one society to another, from one cultural context to another, and choices of treatment also vary a great deal. In Quebec, especially in the greater Montreal area, workers come from different backgrounds. About 35% of Montreal residents are born outside Canada which means there is a great deal of social and cultural diversity. There has been limited research to determine whether medical services are properly adapted to facilitate the return to work for people who are injured and undergo medical treatments. In order to answer these questions, we need to know more about the experience of people who were or are currently in physical rehabilitation so we can attempt to understand what happened during their rehabilitation and return to work. We also need to know about the experience of health practitioners’ and workplace representatives having to deal with diversity at work and long-term absence due to sickness. This research was developed to bridge the gap in the knowledge about the different stakeholders’ experience in intercultural interactions. In this paper we present results that describe the realities of intercultural encounters in the context of rehabilitation for work-related sickness. We suggest (following previous research in this area) that the different stakeholders involved in the rehabilitation and
return-to-work process face intercultural barriers that hinder the creation of a therapeutic alliance and positive clinical outcomes.

2 – Theoretical Framework and Methodology
This project draws upon an intercultural model allowing for a systemic analysis allowing for an understanding of cross-institutional interactions/negotiations and within a single organisation. Considering the complexity of occupational injury prevention and rehabilitation, we developed a project that attempts to grasp complementary views from the representatives of different “systems”: the legislative and insurance system, the workplace system, the health care system, and the personal (including family) system. These are the four leading aspects of the Québec workers’ compensation system. Since the beginning of the project we have completed a series of about thirty open-ended interviews with occupational therapists, physical therapists, rehabilitation counsellors and compensation agents, and we are currently recruiting workplace officials and injured workers from immigration backgrounds.

A grounded theory approach to data collection and analysis has enabled the construction of hypotheses grounded in the multiple realities of practitioners. To support this objective we developed an inquiry model inspired by Cohen-Émerique’s notion of “critical incidents” and Vermersch’s interviewing techniques known as “explicitation”.

3 – Results
Our data suggest that clinicians and agents in the field involved in the rehabilitation and return-to-work process face intercultural barriers that hinder the building of a therapeutic alliance. Those barriers can be divided into several different categories: 1) language and communication; 2) differing values, treatment and representations of illness, and 3) institutional blindness. Today, we will focus on the latter of these three categories—institutional blindness—which can be defined as a lack of intercultural awareness or unwillingness or inability to perceive the constraints and the requirement of working within an intercultural environment. This blindness has consequences on practitioners’ daily routine and workload as well as on the global performance of the institution.
Our data suggest that while the practitioners develop strategies to overcome communication barriers and cross-cultural misunderstanding to adapt to patients’ personality, cultural preferences and beliefs about healthcare, they often find themselves without institutional support. Practitioners develop strategies on their own to adjust treatment options, but the lack of organisational intercultural competencies (OIC) leaves employees to fend for themselves in this regard. We describe two aspects of the problem here. First, we describe some strategies and constraints experienced by practitioners (closely related to organisational support), and second, we describe suggestions expressed by practitioners for developing organisational intercultural competencies.

3.1 Strategies and constraints
Practitioners developed strategies to catch up with their patients despite the perceived lack of organisational awareness with regards to intercultural issues. The strategies entail adjusting to patients’ pace and discussing intercultural issues in team meetings. Situation 1 exposes those strategies while situation 2 describes the possible relation between the level of organisational cultural awareness and employee-based support.

Situation 1 Adjusting to patient’s pace

Here is a quote from an interview we conducted with a 40-years old physical therapist (PT) working in a private clinic in Montréal. He addresses the necessity to take time and to adjust to cultural differences while having no OIC to provide clear orientations.

“You must get used to cultural barriers, so you have to develop a strategy of action based on cultural difference as such. You also have to adjust to the client's pace that is not always the same as in North America […] we rarely have time to spend an entire hour talking with the client and ask questions to better understand his culture […] I would like to know more about their culture and how it works [but] it requires more response time to talk with the person to better understand his culture. Here, we do not take the time.”

(Male, 40 years old, physical therapist)
This strategy appears to go against the grain of a work environment and corporate principles that do not allow time for accommodations of this type. A monocultural organisation would not consider it necessary to resolve misunderstandings or disagreements based on cultural difference.

But as the interview progressed, we also found that the time factor was not the only factor to be considered. In fact, some intercultural issues that we defined as “critical incidents” were at times discussed during team meetings, but certain issues related to cultural identity appeared to be a taboo that is not easy to address, especially if this brings out issues related to performance (“personal failure”, “weakness” or “incompetency”), or the fear of evoking value judgements or participating in discriminatory behaviour.

“We tried to address it during interdisciplinary team meetings. But practitioners are uncomfortable in naming a difficult case, because it is often seen as a kind of weakness, you know, a kind of weakness if you have not been able to ?.”

(Male, 40 years old, physical therapist)

So, even if team discussion is suggested as a possible strategy, there are limits in addressing those issues as long as personal performance, a feeling of self-efficiency and discomfort are not defused and overcome. In addition to performance issues addressed by this PT, the fear of lacking intercultural competencies may create a discomfort or anxiety among professionals, many of whom are worried about weakening the therapeutic alliance by asking inappropriate or intrusive questions. So, even if intercultural issues are concealed and not explicitly addressed in team meetings, these issues still have an effect on personal performance, service delivery and treatment outcomes. The inability to name the problem or the fact of denying it an organisational relevance has two effects: 1) it reinforces the belief that acknowledging differences is negative, threatening or potentially compromising; 2) it reduces discussion to the question of personal performance without questioning the role of organisational performance in intercultural interactions, especially when a clinic is located in a socio-economically deprived and multicultural area.

Here we are faced with a paradoxical situation where a consistent practice would be to spend more time with the patient; while on the other hand, the institutional constraints limit the
possibilities for establishing a meaning intercultural exchange. A practitioner may keep in line with the regulations and orientations that apply to the clinic, but by doing so, he or she may deviate from the commitments to his or her professional association, especially if he or she has relevant knowledge with regards to therapeutic efficacy. There are ways to do things differently despite institutional blindness and organisational constraints. For example, as suggested by a public insurer rehabilitation counsellor, spending more time at some critical moment of the rehabilitation process can have the effect of reducing the overall intervention time. The very beginning of the compensation process is often identified as a crucial or critical moment where trust and therapeutic alliances have to be put into place.

**Situation 2 / Cultural Awareness and Employer Support**

The next situation describes a practitioner’s experience within a rehabilitation clinic’s network where the clinic she belongs to is the only one experiencing intercultural issues. When asked about organisational support in intercultural competency development, she says:

“I think we do not have much institutional support because we do not live the same reality in Montreal compare to elsewhere in the suburbs. Maybe the managers know a little bit more about intercultural reality when they are located in Montreal, but we are the only clinic in Montreal. This is new stuff, it's been three years that the clinic is open and they [clinics within the network] are starting to get used to this kind of reality. They are becoming more aware of the intercultural reality. Awareness is the first thing. After that, we need to understand all of this [cultural gaps], but this step is not yet completed. And then you have to [provide institutional] support for this” (Female, 27 years old, occupational therapist in the private sector)

For this practitioner, intercultural sensitivity (or cultural awareness) can be developed within a homogeneous environment, but it is identified as the very first step for developing OIC. Other steps would be the ability to understand intercultural gaps and to support an entire organisation orientation which is not the case at the moment. Acceptance, adaptation and integration are far from being fully integrated in the corporate development.

3.2 Suggestions for Developing OIC
According to the participating practitioners, developing OIC requires: 1) training staff at all levels, including administrative staff and managers; 2) recurring training because of staff turnover, and 3) creating a space for discussion and exchange.

This occupational therapist (OT) summarised the idea of training staff at all levels:

“... better to give training to employees and employers at the same time, as the employer becomes aware of the concerns of employees and becomes aware of the trainer's reply. If everyone hears the same thing, I think it's better” (Female, 27 years old, occupational therapist)

This same OT discusses the staff turnover issue. She traces a causal link between staff turnover and the complexity of working with a multi-cultural clientele. She says:

“We lost three assistants here because they were no longer able to do their job [managing absences and delays]. Two of them have suffered from depression and another has just left her position to find another job. They say it is too difficult a clientele.” (Female, 27 years old, occupational therapist in the private sector)

Finally, creating a space for discussion and exchange is a recurrent idea expressed by many practitioners. Lunch conferences, clinical workshops, continuing education are commonly referred to, in addition to other strategies that are already used on a regular basis (ex. working with interpreters, seeking help from co-workers from the same country or cultural area, seeking help from non-profit community organisations dedicated to the immigrants or to a specific ethnic group, etc.)

But these solutions can work only if performance issues are brought to a team or organisational level where critical incidents relating to intercultural dynamics can be discussed. Intercultural competency is an organisational competency outside of individual communication skills, awareness, and attitudes. Another condition for success would be to overcome the taboos regarding naming cultural gaps and differences. Unfortunately, according to Bennett’s continuum of cultural competency in health care, many organisations are still operating through denial, defensiveness and minimisation.
4 – Implications for Intervention and Emerging Hypotheses

From the point of view of stakeholders, the lack of OIC makes it impossible to take into account the additional time required for interventions with patients in multi-ethnic settings. Additional time requirements pose a risk to the health of health care workers: work overload, emotional distress, feeling of failure, and increased turnover (this factor was suggested by some informants and needs to be further investigated). This factor is not fully acknowledged within monocultural organisations where the performance issue is mainly regarded in terms of cost effectiveness and duration of action regardless of the complexity of a situation. Organisations lacking in intercultural competencies do not pay enough attention to the clienteles’ characteristics and specific needs, and to the field workers’ conditions, ignoring emotional distress and feeling of failure. In this context, efforts devoted to the understanding of the patient’s perspective and trajectory have limited weight in the management of financial and human resources. Despite the fact that immigrants and minority workers often require more time per intervention, this reality seems to be poorly understood at higher levels of decision-making. This is why many clinicians stressed the need to train all the staff at all levels of the organisational hierarchy to sustain a common awareness of intercultural issues in the treatment and recovery process, not only those employees (for example clinicians or compensation agency officers) who have direct, face-to-face, interactions. Acknowledging a given population’s specific needs and characteristics might lead to a culturally-fair design while preventing occupational risks among its own employees. But the road to this ideal is still long and winding in a context of fragmented tasks. This is particularly true where the efficacy of intervention is measured through the lens of cost-performance; a culturally adapted treatment (that implies an extension of duration) still might be perceived as negatively affecting global institutional performance when compared to similar organisations with a clientele that is more culturally homogeneous.

5 – Concluding thoughts

Developing intercultural competencies in monocultural organisations has become a major issue in large cosmopolitan cities. In the financial context of “austerity” and new managerial “twists” where clinicians and agents are asked to do more with fewer resources, and where organisational performance tends to be fragmented into a sum of individual performance, it is not easy to
integrate time as a fundamental parameter of the intervention, especially if this situation requires more energy develop a therapeutic alliance through co-construction\textsuperscript{24,25}. Promoting the development of a clear organisational orientation and commitment in terms of intercultural competencies is not easy either. Organisations, clinics or workers’ compensation regional bureaus, are part of a wider system: health care system (variety of care management), legislative and insurance system (society’s safety net), workplace system (work relatedness, employees assistance and accommodation), and personal system (coping, social relationship, beliefs, communication patterns, etc.). While there is a growing body of evidence supporting the need for a culturally adapted institutional response to health care, it seems that evidence-based policy-making looks like policy-based evidence-making\textsuperscript{26}. Evidence and policy-making are interrelated. To set research priorities we must determine how evidence is made, constructed, and how research capacity is build, planned and sponsored\textsuperscript{27,28}. Political interference in evidence-making is not a new phenomenon. The willingness to take actions may be based on ideological or paradigmatic assumptions where facts or social phenomena may be concealed, misinterpreted, misused, or simply ignored.

References


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1 Basically, a “system” can be defined as a set of interacting or interdependent elements forming an integrated whole. These elements are composed by rules, methods and procedures that govern actions. The term “institution” is also used to describe a system (source: Wikipedia).