JÖNKÖPING UNIVERSITY
School of Health and Welfare

Danish Certified Prosthetists and Orthotists' experience of their intercultural competencies in the treatment of immigrants

A qualitative interview study

PAPER WITHIN *Prosthetics and Orthotics*

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Resumé

Baggrund: For at være i stand til at imødekomme social harmoni i en kontinuerligt globaliserende verden, er interkulturelle kompetencer vigtige at besidde som individ. Dermed er det også vigtigt for autoriserede bandagister og andet sundhedspersonale, eftersom de møder mange mangfoldigheder i forbindelse med deres arbejde.

Formål: Formålet med dette studie er at undersøge danske autoriserede bandagisters oplevelse og opfattelse af egne interkulturelle kompetencer i behandlingen af immigranter.

Metode: Denne undersøgelse er en kvalitativ interviewundersøgelse med en fænomenologisk tilgang. Semistrukturerede interviews er brugt til at indsamle data fra fem autoriserede bandagister, som arbejder i danske klinikker. En indholdsanalyse med en induktiv tilgang, er brugt til analysen.

Resultater: Ud fra analysen af deltagerinterviewene blev der fundet syv underkategorier som blev yderligere inddelt i tre kategorier: Behandling, arbejdsmiljø og udvikling af kompetencer. Disse bidrager til at beskrive hovedkategorien og formålet af studiet.

Konklusion: De danske autoriserede bandagister, som deltog i denne undersøgelse, oplevede, at de ikke behandlede immigranter anderledes end ikke-immigranter. De oplevede dog, at der kunne være udfordringer forbundet med behandlingen af immigranter, såsom kommunikationsvanskeligheder, men de havde alle en opfattelse af, at de brugte specifikke værktøjer og strategier for at imødekomme disse udfordringer. Desuden oplevede de alle, at deres interkulturelle kompetencer havde forbedret sig ved erfaring, men de fleste af dem var også interesseret i yderligere udvikling af sine kompetencer.

Nøgleord:
Interkulturelle kompetencer, Immigranter, Oplevelse, Bandagist, Danmark

Abstract

Background: To be able to meet social harmony in a continuously globalizing world, intercultural competencies are important to possess as an individual. Thus, it is also important for Certified Prosthetists and Orthotists (CPOs) and other health care providers since they meet many diversities in connection to their work.

Aim: The aim of this study is to investigate Danish CPOs' experience and perception of their intercultural competencies in the treatment of immigrants.

Method: This study is a qualitative interview study using a phenomenological approach. Semi-structured interviews are used to collect the data from five CPOs working in Danish clinics. A content analysis, with an inductive approach, is used for the analysis.

Findings: From the analysis of the participant interviews, seven sub-categories were found and further divided into three categories: Treatment, work environment, and development of competencies. These contribute to describe the main category and the aim of this study.

Conclusion: The Danish CPOs, who participated in this study, experienced that they did not treat immigrants differently than non-immigrants. However, they experienced that some challenges could be connected to the treatment of immigrants, such as communication difficulties, but they all had a perception, that they used specific tools and strategies to accommodate these challenges. Furthermore, they all experienced that their intercultural competencies had improved with experience, but most of them were also interested in further development of their competencies.

Key words:

Intercultural competencies, Immigrants, Experience, Prosthetist and orthotist, Denmark

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1. Introduction

In a continuously globalizing world, where people, societies, and individuals live more and more close together, an increasing diversity of cultures arise. Thus, intercultural competencies are required for individuals and societies to meet personal fulfilment and social harmony. Typically, competencies do not depend on any one single skills, attitude, or type of knowledge. Instead, it consists of a complex set of skills, attitudes, and knowledge (UNESCO, 2013).

Health care practitioners' experiences of different aspects within intercultural competencies have been investigated in previous studies within other health care professions (Alizadeh & Chavan, 2015; Jensen et al., 2011; Paternotte et al., 2016; Watt et al., 2016; Yilmaz et al., 2020). However, the authors of this present study have not been able to find any literature about Danish CPOs' experience of intercultural competencies. Thus, the research question of this study is: "What are Danish CPOs' experience and perception of their intercultural competencies in the treatment of immigrants?". Thereby, this study can contribute with important knowledge within the prosthetic and orthotic (P&O) field in a continuously globalizing world.

To be able to describe the participants' experiences and feelings, a qualitative approach has been used with semi-structured interviews. The findings are compared to existing similar studies.

2. Background

The number of immigrants living in Denmark has grown during the last decades. In October 2020, Udlændinge- og Integrationsministeriet stated that the number of immigrants in Denmark was 616.454 which corresponds to 10,5% of Denmark's entire population (Udlændinge- og integrationsministeriet, 2020). Data from January 2019 shows the four largest groups of immigrants in Denmark which was Poland, Syria, Turkey, and Germany (Udlændinge- og integrationsministeriet, 2019). This shows that people from all over the world live in Denmark, and thereby, many people with different cultures live among each other. Due to the growth of immigrants, it can be assumed that the Danish health care services, including the CPOs, will also encounter a larger diversity of patients. Thus, all health care providers need to develop their intercultural competencies to be able to recognize their own cultural norms, understand the patient's unique viewpoint, and effectively adjust their behaviours to be able to provide the best possible care (Anand & Lahiri, 2009). Intercultural competencies can be described as the ability to function across cultures and to interact appropriately with people from different cultural backgrounds. The concept of intercultural competencies includes communication, cultural awareness, skills, and attitudes, which are all crucial qualities to possess when treating people from different cultures (Monash University, 2021). These qualities within intercultural competencies can prevent misunderstandings, conflicts, and specific barriers to occur in the interaction between Danish CPOs and patients who have immigrated to Denmark (UNESCO, 2013).

Culture can be described in several ways depending on the context. According to Jahoda, it is not appropriate to try to define culture, but if a clarification is needed, the author should describe it in a way that is appropriate for the context (Jahoda, 2012). "Culture is in some sense a magic word - positive in connotations but hard to pinpoint in any science that attempts to use it as its core term" (Valsiner, 2009, p. 10, as cited in Mironenko &

Sorokin, 2018). The quotation shows that most people have an idea of what culture means, but due to the many perceptions of culture in different contexts, it is difficult to describe it with a single word or sentence. Two definitions according to the Merriam-Webster dictionary are: "The customary beliefs, social forms, and material traits of racial, religious, or social group", and "The set of values, conventions, or social practices associated with a particular field, activity, or societal characteristic" (Merriam-Webster, 2021).

In this study, the focus will be on the cultures existing in the different countries, since it can be assumed that most countries have some general similar beliefs, set of values, conventions etc. The authors are also aware that multiple different cultures are present in a single country. The previous Director General for International Organization for Migration William Swing (2015) has raised awareness to the world becoming more and more multicultural due to the demographic changes.

The authors operate with the term immigrants, which is defined by "... a person who moves into a country other than that of his or her nationality or usual residence..." (International Organization for Migration, 2021). The authors in this study identify immigrants from Denmark's perspective, which means people who move to Denmark and get a new residence in that country.

Zazzi (2020) writes that individuals who feel that they differ from the majority may experience discrimination due to several factors such as ethnicity, language, gender, and disability. Generalization and prejudices from health care providers will affect the treatment and care of the patient.

In another study, the authors report that several research studies in the health care have shown that some cultural groups were more likely to be underserved, receive different treatment, and perceive negative treatment (Shepherd et al., 2019). An example of a certain cultural group, which is mentioned in the study, can be found in the article written by Johnson et al. (2004), p. 101: "Recent work shows that ethnic minorities, who are commonly in ethnic-discordant relationships with health professionals, rate the quality of interpersonal care by physicians and within the health care system in general more negatively than whites." This indicates that the patients in that study experience a difference in the treatment. In another study, conducted on nurses in a paediatric hospital in Turkey, Yilmaz et al. (2020). They found that some nurses rated themselves as being culturally competent, even though many of them had not received adequate training in cultural care. According to Shepherd et al., multiple health care clinics are getting access to cross-cultural education models which have given temporary improvements in the healthcare but the impact on patient treatment outcomes has been largely negligible (Shepherd et al., 2019).

It is important to note, that cultural competence is an ongoing process, and that it has no endpoint. This means that it can continue to be improved over time (Alizadeh & Chavan, 2015).

In a systematic review, Watt et al. (2016) investigate the development of cultural competencies in general practitioners. In this study they write that many studies suggest cultural competence training because it is an ongoing process where workshops are only an introduction to the topic. In the systematic review, most of the articles highlight that this area needs to be developed within all health care facilities.

Several educations, including health care educations, are becoming more international, and have put an effort into teaching students about the importance of intercultural competencies (Jönköping University, About the University, 2021).

The Danish education, as a CPO, is placed in Jönköping in Sweden and is an international programme where the students learn to apply the P&O knowledge into practice with an international perspective (Jönköping University, Prosthetics and Orthotics, 2021). This indicates that the education has a focus on improving the cultural awareness and cultural competencies for the students.

It is important that the focus on intercultural competencies keeps increasing within the P&O field, since the world becomes more and more globalized. Thus, more cultural meetings with a larger diversity of patients appear in the clinical practice within the P&O field.

2.1. Aims

This study aims to investigate Danish CPOs' experience and perception of their intercultural competencies in the treatment of immigrants.

3. Method

The study design was chosen to fit the aim of the study, and it was conducted according to a qualitative method with a semi-structured interview and a phenomenological approach. The thoughts and theory behind the choice of study design are described in detail in this section.

3.1. Qualitative Method

The qualitative method can be used in research. This method uses a wide- and deep-angled lens to describe a phenomenon and learn more about it. Qualitative researchers interpret and examine specific individuals or a group on choices, behaviour, and perspectives based on their experiences. They aim to understand the multiple dimensions of people within a specific area by analysing material which is collected through e.g., in-depth interviews, observations, or open-ended questions. In qualitative methods, the natural setting is important to achieve a natural flow of behaviour where details occur naturally (Johnson & Christensen, 2016).

The qualitative method operates primarily with inductive reasoning, which is also used in this study. This approach interprets the world from "below" where it is searching for the rules (Reichertz, 2014). This means that the inductive approach identifies patterns and formulates potential explanations of the patterns (Brinkmann & Kvale, 2018). Thus, in this study the inductive reasoning is used, as it seeks to gain a deeper knowledge within the phenomenon of Danish CPOs' experiences and perception of their intercultural competencies.

3.2. Phenomenology

The qualitative approach used in this study is called a phenomenological approach. It is a philosophy which focuses on individuals' experiences through their own descriptions of a phenomenon (Johnson & Christensen, 2016; Todres, 2005). Thus, the purpose is to gain an insight of the inner world of each participant to understand their personal meanings and experiences. An important concept used within the phenomenology

is "Life-world", which can be described as an individual's inner world of an immediate experience. It is a combination of feelings, thoughts, and self-awareness at any moment in time (Johnson & Christensen, 2016). It is common knowledge, that not all individuals share the same feelings and experiences about a specific phenomenon. Within phenomenology, it is assumed that some individuals will share some aspects of their feelings and experiences. Those commonalities are called an "essence", which is aimed to be described within this approach (Johnson & Christensen, 2016).

A common strategy for data collection is by conducting in-depth interviews, where the researcher attempts to find the essence of the participants' experiences and descriptions (Johnson & Christensen, 2016).

The phenomenological approach fits well to this study, since it makes it possible to gain an insight of the CPO's perspectives, thoughts, and feelings about their experiences.

3.3. Semi-structured interview

In a semi-structured interview, an interview guide is written before the interview session. The interview guide is provided with specific open-ended questions which are asked by the interviewers in any order, and at the same time, it allows spontaneous follow-up questions. In this type of interview, the interviewer will cover the same general topic with all the participants, and the interviewer will keep the interview on track e.g., if the participant goes off the relevant topic for the research (Johnson & Christensen, 2016). The mix between predetermined questions and the spontaneous questions makes sure that the interviews cover specific topics which are desired to describe the aim. At the same time, it allows the participants to speak freely, since it is still possible for the participants to lead the interview into some new and spontaneous directions (Brinkmann & Kvale, 2018).

3.4. Participants and recruitment

A purposive sampling method was used in this study, since the authors had specified the characteristics of the participants as CPOs working in Denmark (Johnson & Christensen, 2016).

Different clinics were contacted by telephone to receive the e-mail addresses to the CPOs working in the Danish clinics. Afterwards, an e-mail, containing an information letter with information about the study, was sent to all the CPOs (see Appendix A). Those who had an interest in participating, responded by e-mail and received a statement of content, which was signed before the interview (see Appendix B).

The inclusion criteria of this study were CPOs who are working in Danish clinics with more than one year of experience to ensure that the participants had enough experience with working in a Danish context. The participant list involved five CPOs from three different companies, one of whom was a male, and the rest of the participants were female. They were aged from 35-53 years and had between 5-23 years of experience in Denmark. They worked in clinics distributed around in different regions in Denmark, where the size of their respective clinics varied between having 2-12 CPO employees. The exact locations of the clinics are anonymized due to confidentiality. Two of the participants worked in the same clinic. Since the authors' native language is Danish, and the interviews were conducted in Danish, participants were excluded if they could not speak fluent Danish.

3.5. Equipment and data collection

The entire data collection was performed in Danish, where semi-structured interviews, containing qualitative open-ended questions, were used to collect the data and to investigate the experience of intercultural competencies as a Danish CPO in the treatment of immigrants. Before the interviews were conducted, an interview guide was developed (see Appendix C). Some of the questions were formulated and based on the questionnaire used in the study conducted by Shepherd et al. (2019). Moreover, the interview guide was conducted and inspired by different guidelines and techniques (Brinkmann & Kvale, 2018; Johnson & Christensen, 2016; Taylor M. C., 2005).

The interview guide contained some overall questions to make sure that some specific topics related to the aim of the study were covered. However, not all the same questions were proposed to the different participants, and the questions were not necessarily asked in the same order, since it depended on what the participants answered to the different questions.

Before the participants were interviewed, two pilot interviews were performed for the authors to get practice in the process and to test the interview guide. The persons, who agreed to participate in the pilot interviews, did not meet the inclusion criteria, but they still had some experience with the treatment of immigrants. After each of the pilot interview, the interview guide was adjusted.

The interviews were conducted in an online communication platform, Zoom. For data safety reasons, the interviews were not recorded on Zoom, but only on private mobile phones, and notes were taken during the interviews. During the interviews, the authors performed as the interviewer and the observer. The interviewer and the observer were placed in Jönköping and the participants were placed in their home or at their workplace, and the time frame for all the interviews were between 30-60 minutes.

3.6. Data analysis

For the analysis of the interviews, "the conventional content analysis" was used. It is described by Hsieh and Shannon (2005), who has described three different approaches to the qualitative content analysis. The conventional content analysis is often used when the researchers aim to describe a phenomenon where the literature is limited. In this analysis, the authors do not use any predetermined categories, but on the contrary, categories are determined from the data collected through the interviews (Hsieh & Shannon, 2005). This is also known as the inductive approach which was described previously. Inductively coded data aims to identify patterns and formulate potential explanations of these patterns (Brinkmann & Kvale, 2018). When making a content analysis, the meanings of a text are divided into categories to clarify specific themes in the text. This is also known as coding (Brinkmann & Kvale, 2018). However, Gibbs (2018) prefers to use the term "themes" in the phenomenological analyses instead of "codes". This process also makes it possible for the researchers to compare the themes and to find out how often the same themes arise in different texts (Brinkmann & Kvale, 2018).

To ease the analysis process, the recordings from the interviews were transcribed. The authors of this study transcribed the interviews separately and checked it together afterwards to make sure that an agreement was reached. A transcription key was developed (see Appendix D) to make sure that the interviews were transcribed evenly following the same structure. The transcriptions were then used to code and analyse the interviews.

Furthermore, the authors analysed and coded the interviews separately, and compared their findings afterwards.

According to Gibbs (2018), the coding process can be divided into three steps: Description, categorization, and analytic codes. In the first step, the authors of this study searched for significant themes and statements in each of the interviews, which had any relevance to the aim of the study. This could be a few words or sentences which described the essence of what the participants said in relation to their experience of a certain situation (Johnson & Christensen, 2016). Next step was to categorize the significant statements and themes, where different themes and statements were divided into different categories. This helped the process of retrieving the different themes within the same category from each interview (Gibbs, 2018). An example of the coding process can be seen in (Table 1) below.

Table 1: Example of the coding process.

Significant statement	Description of significant statement	Theme	Sub-category	Category
"They [intercultural competencies] develop all the time. The more you deal with people with a different cultural background, the more you also learn how their culture is and how (…) they usually act seen from a broader perspective. It gets better by time, and it will probably always evolve." (Q:17)	Experiences a continuous development of intercultural competencies. The more experience, the more evolvement.	The intercultural competencies improve by experience	Personal Growth	Development of the competencies

After the transcriptions were analysed and coded, a summary of each transcription was compiled and sent to the participants separately, and thereby, member checking was used. A follow-up e-mail was sent to the participants who did not respond to the first request for feedback. This was done to make it possible for the participants to add any comments and to make sure that there had been no misunderstandings. Since the interviews were conducted in Danish, the entire analysis process was also performed in Danish. Only the quotations and examples were translated to English by the authors.

3.7. Ethical Considerations

The participants had received an information letter containing information about the study, whereafter they could decide whether they wanted to participate in the study (see Appendix A). They were informed about the aims of the project and that there were no risks involved with their participation in this study. They were also

informed that it was completely voluntary to participate, meaning that they could withdraw at any time during the study and that they could omit answering specific questions if they did not want to. Furthermore, they were aware that the data would be anonymized and processed with confidentiality.

Before the interviews, they signed a statement of consent, to make sure that they agreed with the terms of their participation to the study (see Appendix B).

After the interviews had been analysed, the compiled summary was sent to the participants to make sure that they agreed with the results of their interviews, and that their information was not misinterpreted in any way. By agreement with the supervisor of this study, no application was sent to the Research Ethics Committee. This was decided using the document "Form for Self-Assessment of Ethical Issues in Degree Projects at the School of Health and Welfare", as a checklist to ensure that the study complied with the ethical principles expressed in the Act concerning the Ethical Review of Research Involving Humans.

According to (National Videnskabsetisk Komité, 2020), this study was not obliged to be notified to a science ethics committee, since it is an interview survey which does not include human biological material, interventions, or randomization.

4. Findings

In the beginning of the interviews, the participants were asked to explain their understanding of the terms: "culture", "immigrant", and "intercultural competencies". This was to make sure that the participants and the authors had the same perception of the meaning of those terms, which were also described in "2. Background". A mutual understanding of these terms was important for the findings, since it was discovered that the participants had different perception of the terms.

As mentioned in "3. Method", the quotations used in this section are translated from Danish to English by the authors. The original quotations in Danish can be seen in the Appendix (see Appendix E). The participants are not mentioned next to the quotations to avoid identification from the data.

The findings of the interviews were divided into different categories and sub-categories, which can be seen in (Table 2) below.

Table 2: Table describing the overview of the main category, categories, and sub-categories.

Sub-category	Category	Main Category
The interaction between the CPO and the patient	Treatment	Danish CPO's experience and perception of their intercultural competencies in the treatment of immigrants
Challenges and differences during treatment		
Specific tools and strategies		
Different cultural backgrounds at the workplace	Work environment	
Cooperation between colleagues		
Personal growth	Development of competencies	
Competencies to improve		

4.1. Treatment

This category contains the participants' shared experiences of the treatment of immigrants. It covers different aspects experienced within the treatment including the important characteristics in a treatment, their experienced challenges, and differences during the treatment. Furthermore, the category covers specific tools and strategies they use to ease the treatment and the entire process.

4.1.1. The interaction between the CPO and the patient

All the participants had a similar perception of what is needed in a good treatment. Everyone mentioned that they do not have any perception of themselves treating immigrants differently than non-immigrants. They aim to treat everyone the same with the same starting point and mindset. They take everything into consideration when deciding the treatment, but they do not consciously treat patients differently based on them being

immigrants. One of the participants said that he is aware of how he uses humour and sarcasm in the treatment, since it may differ how different patients appreciate it.

> "*But in relation to values and these things, I do not think that I act very differently than towards a native Danish patient. But of course, you must consider in terms of humour, sarcasm, and such things which you may not be sure that they [immigrants] understand or appreciate.*" *(Q:1)*

All the participants mentioned that it is very important with a good chemistry between the CPO and the patient. Thus, it is important that they understand and respect each other and their differences. Some of the participants mentioned that the chemistry between the CPO and the patient is almost more important than the assistive device itself, since it makes the entire process easier and there will be a greater trust and patience to each other.

> "*... if you have a good chemistry, you are also willing to try different things. There is a greater patience and faith that you work in the same direction...*" *(Q:2)*

Another important thing that many of the participants mentioned is that they meet the patient with an open mindset with no prejudices. They meet the patient with a curious mind and attempt to read the patient. Furthermore, the CPO attends to sense the atmosphere to figure out which direction to go. Thus, they analyse the situation and act on it.

> "*I find it very important that you, as a CPO, do not have any prejudices and that you are very open-minded in a way that you cannot be narrowminded in relation to culture, religion, etc. It is really about reading people.*" *(Q:3)*

Also, many of them agreed that the communication between the patient and the CPO is important to be able to explain and understand each other's expectations and ambitions in the entire process. To achieve a good communication, some of the participants mentioned that listening to the patients' needs was something they valued. At the same time the CPO explains what is possible seen from a practitioner's perspective. Thereby, it is possible to find a compromise that fits both the CPO and the patient.

> "*Sometimes, as a CPO, you can have huge ambitions for them [the patients] but it is not always certain that it is the right thing to do. That is why I think that it is extremely important to listen to the citizen's needs.*" *(Q:4)*

4.1.2. Challenges and differences during treatment

The biggest challenge experienced by all the participants when treating immigrants, is the communication and language difficulties which may be present in some cases. This can make it difficult for the CPO to explain things related to the treatment as well as making sure that both parties understand each other. As mentioned in the previous section, they think that the communication is an important aspect of the treatment, and thereby those difficulties may influence the treatment process. However, all of them stated that they make it work and

do their best to make sure that everyone understands each other, and thereby they do not see it as a problem to treat immigrants where communication difficulties are present.

> *"It is not a problem [to treat patients with a different cultural background]. (…) There may be something regarding knowing whether they understand it. If they come to you and speak Danish, it does not matter." (Q:5)*

In relation to the communication difficulties, many of the participants expressed that they have experienced that it takes extra time to make sure that everyone understands each other during some consultations with immigrants.

Another thing they all mentioned as a challenge, or something to be aware of, is the gender relations which they have experienced with all patients, and not only immigrants. However, two of the participants said that they experience it more often when treating immigrants. They have all experienced that some patients prefer having a CPO with a specific gender which, for example, may be due to difficulties of being touched by a CPO of the opposite gender. Furthermore, many of the female participants have experienced, that patients expected them to be a male.

> *"I often hear, 'Are you a girl?' 'Yes, I would say.' 'Oh, but we thought that it would be a man'." (Q:6)*

Two of the female participants also mentioned that they had experienced male immigrants who did not want to shake their hand because they were women. However, they do not see this as a problem, and they have learned how to act around it and to sense if it is something that they should be aware of in the treatment. Some of the participants reasoned that it may be remains of the belief of authority that has previously existed, and that the profession has previously been male dominated.

> *"It may be a relic of the belief in authority etc., but it is mainly with the elder people, and it is extremely rare. But sometimes you can sense that there are some things that will come through easier, if it is told by a [male] practitioner, who they expect." (Q:7)*

Two of the participants had experienced that some immigrants cared more about the appearance and the aesthetics of their assistive device to a greater extent than non-immigrants. They have the perception that it, in some cultures, is seen in a negative way to have a disability. Thus, some patients do not appreciate the assistive devices since it makes their disability visible, and thereby, they would choose the aesthetics over the functionality. Some of the participants mentioned that they find it a challenge to be aware of more than a problem.

> *"… you visualize a child's disability by, for example, giving them splints on. It is kind of a stigma in the culture. Multiple times, I have received the comment that 'But the pants cannot get over [the splints]. Then they can see that my child is wearing splints'." (Q:8)*

Furthermore, two of the participants explained that they have experienced, there can be a difference in how people perceive punctuality. Some of their patients, who are immigrants, are always late to their appointment

or do not show up without cancelling the appointment. One of the participants has learned to see it as positive feedback if her patient does not show up to the appointment, since she assumes that everything is working with the assistive device. As mentioned previously, the participants find this a challenge to be aware of, more than a problem.

4.1.3. Specific tools and strategies

The participants explained that they use specific tools and strategies if they experience challenges during the treatment. These tools and strategies are not only used for immigrants but also for non-immigrants because these tools and strategies help them through the challenges, mentioned previously.

The use of a translator is a frequently mentioned tool. Many of the participants agreed that it can be difficult to get a professional translator through the local authority, and it is the patient who should provide themself with a translator. They are sometimes forced to use a friend, family member, or a caregiver to translate for them. In relation to this, two of the participants expressed that they did not prefer when children translate for their parents. One of the participants mentioned that she has seen the use of a video translator at a hospital, but the participant also said that it is not relevant at her clinic because they would rarely use it. Another participant mentioned that Google Translate can be used if the patient is without any kind of a translator.

> *"... it is really a tough process if you want to get a [professional] translator." (Q:9)*

All the participants experienced that they adjusted their language unconsciously. They mentioned that they talk clearly, slowly, and keep it simple with less details, so the patient can understand the CPO better. Here, they found it a good strategy to make the patient repeat what the CPO has said, or that the CPO repeats and asks if it is correctly understood when the patient states something.

> *"I speak slowly, and I am very clear and distinct in my announcements. I do not fill in unnecessary talk. I try to ensure that they understand what I am saying by making them repeat it." (Q:10)*

Another strategy, which most of the participants mentioned is that they make use of other languages such as English and German, as well as body language and gestures. One of them said that it is important to be able to see each other's body language when the language is not present which also could be done by mouth reading.

> *"In most cases, you can manage with English, broken German, or something else. But occasionally, if someone only speaks Polish, for example, then it will be sign language, gestures etc." (Q:11)*

Two of the participants mentioned that they bring products into the clinic room and show the product to the patient so they can explain from the product. Then the patient is more included in the process, and it makes the explanation clear for the patient, for example about the design. They both mentioned that they do this with immigrants as well as non-immigrants, but one of them had the perception that she would do it in the treatment of immigrants.

"I bring the products so they [patients] can point on it [the product] and then we are sure of what we choose. This applies with colours, laces, Velcro etc." (Q:12)

Several of the participants said that when they have a patient where more time is needed, they try to make more time for the patient in their working schedule. In relation to this, one of the participants mentioned that they do not get paid from the local authority, in case that they need more time if the patient does not speak Danish.

Some of them said that when a patient wants to book an appointment at the clinic, they consider placing the patient in a CPO's working schedule of the same gender, for example if a male patient has inguinal hernia, he would be placed in a male CPO's working schedule.

This category showed that the participants do not have any perception of themselves treating immigrants differently than non-immigrants. They aim to treat everyone from the same starting point. A good chemistry, respect, open mindset, and the knowledge of the ambitions for the treatment are key factors for the treatment of any patient according to CPO's. The participants stressed that they analyse the situation and act on it. The participants mentioned that they have experienced some challenges and differences in the treatment of immigrants, where communication difficulties were seen as the biggest challenge. Other challenges were related to time, gender, and appearance. Due to the biggest challenge, communication difficulties, the participants expressed that they make use of specific tools and strategies. They all mentioned the possibility of using a translator, but they found the process to be difficult. If they did not have the opportunity for a translator, they adjusted their language, showed products, or made time in their work schedule.

4.2. Work environment

This category covers aspects of the work environment which contributes to the CPO's work. This includes cultural diversity at the participants' workplace as well as their experiences of the possibilities to cooperate with their colleagues.

4.2.1. Different cultural backgrounds at the workplace

It differed among the participants whether they have colleagues with different cultural background at their workplace. In some of the clinics none of the employees had a different cultural background, while others had colleagues from Sweden, Germany, Australia, New Zealand etc.

All the participants mentioned that there are no disadvantages to having colleagues with a different cultural background. Most of the participants say that it could be nice to have the opportunity to receive help from a colleague in case of language difficulties. However, one of the participants has had previous experience working with people with different cultural backgrounds, who did not prefer to help translating, since that was not what they were hired to do. Furthermore, the participants agreed that it would increase the diversity at work which could be exiting since it may increase the opportunity for employees to contribute with some different aspects in the daily work. Thereby it would also increase the possibility for colleagues to provide a greater insight into how some things are received by the patient from a cultural point of view.

"… if you had problems with the communication, then you could ask, 'Do you have five minutes? Because I could use your help?'. It could also provide a greater insight into the perception of how it can be received by the other side [the patient]." (Q:13)

However, several of the participants state that they do not feel limited by not having any colleagues with a different cultural background, since they make it work anyway. None of them perceived that they treat immigrants differently than non-immigrants.

"… it could be nice to be able to make use of. But I do not miss it, because I do not think that any of us think, 'I should treat them [immigrants] second-rate'." (Q:14)

4.2.2. Cooperation between colleagues

Everyone feels that they have a great opportunity to discuss different issues and support each other if needed. In relation to this, one of the participants mentioned that she often calls her colleagues by telephone, if she has any questions related to the treatment or if she needs help from someone who has experience with something specific.

Two of the other participants mentioned that they are sometimes more than one practitioner in the clinic room. This could be, for example, another CPO, a technician, or a physiotherapist. Thus, they have an extra set of eyes and ears as well as a second opinion to the treatment. They expressed that they do this both with immigrants and non-immigrants. They said that it is nice to have that opportunity in case they experience any insecurities or uncertainties, or if any disagreements between the CPO and patient arise. However, one of the participants points out that it can also be a disadvantage to be two practitioners in the same room, since it enhances the possibility of speaking to each other and increasing the speed of the speech.

"We back up one another very much, and that is no matter what it is. We talk about it if anything comes up. Also, when we are two in [the clinic room], if I miss anything, the other [practitioner] asks about it." (Q:15)

All the participants mentioned that it is possible for them to hand over a patient to a colleague if needed. One of them expressed that she sees it as a great advantage of being able to switch patients among colleagues, because it sometimes enhances the treatment.

"We are good at making it work. If the chemistry is not right, you can get help or hand it over to someone else." (Q:16)

The participants were all asked if they had ever experienced handing over or taking over the treatment of a patient due to cultural differences, to which they all replied, no. However, they have all experienced it if the chemistry between them and their patient was non-existent, if they had different expectations, or if they were out of ideas. Some of the participants also mentioned that they, or some of their colleagues, had experienced it due to gender relations, age, or something else, but never related to cultural differences.

This category covered that most of the participants' work environment include some colleagues with a different cultural background, and all the participants found it as an advantage with increased diversity in the CPOs'

workplace. All the participants felt that they have a great opportunity to cooperate with their colleagues in their daily work.

4.3. Development of competencies

Within this category, the development of the participants' intercultural competencies is explained from their own perception. This includes both their perception of how their intercultural competencies have evolved over time, as well as their perception of what could be improved, and whether they are willing to receive further education within the topic.

4.3.1. Personal growth

There is a big variation in the number of immigrants who the participants treat. Some rate it as multiple times each week, while others estimate that they treat approximately one or two immigrants each month. All the participants say that they have the perception that their intercultural competencies have developed over time and that it is based on their experience.

Some of the participants say that their intercultural competencies constantly develop, and that they will continue evolving when they have new experiences. This both accommodates their personal growth as well as the development of their intercultural competencies.

> *"They [intercultural competencies] develop all the time. The more you deal with people with a different cultural background, the more you also learn how their culture is and how (…) they usually act seen from a broader perspective. It gets better by time, and it will probably always evolve." (Q:17)*

None of the participants have undertaken any courses or other education about intercultural competencies. Two of them mention that they have been taught about crisis management or some cultural differences they could experience at school, but none of them have been taught specifically about intercultural competencies.

Two of the participants also mention that they have gained experiences within different cultures from travelling before starting the education and in connection with work and that it may have increased their cultural awareness. Furthermore, one participant has been raised in a multicultural environment, which she believes has given her experience and knowledge in relation to other cultures.

4.3.2. Competencies to improve

All the participants find it important to learn about intercultural competences within the P&O field. Furthermore, they said that they are willing to undertake further courses, lectures, or other education in relation to intercultural competencies, which could help improve the efficiency of the treatment. One of the participants mention that if you met immigrants daily, the need for education would increase. Most of the participants would be willing to take further education if their company find it relevant for their work skills, but they said that the education should be placed in the working hours or straight after work. A few of them talked about undertaking further education in their spare time because they found the topic interesting and not only as a supplement for their work skills.

Most of the participants said that they would like to improve their intercultural competencies. Cultural awareness was frequently mentioned as a competence they wanted to improve. They are interested in learning more about the different cultures to gain knowledge about where people come from and what possible boundaries to be aware of. Some of them mentioned that you can take into consideration what kind of culture the patient is from, but it should not be the main focus in the treatment of a patient.

> *"Of course, it is also important to learn about the cultures, but I do not think that it should be all-important. The treatment is always the priority and then you try to (…) find the golden mean…" (Q:18)*

Communication was perceived as the greatest challenge, but the participants do not comment on this as a thing they could improve. There was one participant who mentions that she wants to improve her skills in English. Another participant said that a word list with the most basic words for a treatment could be great. She said that the word list could be in the most common foreign languages in Denmark so if there are any language difficulties, the patient and the CPO can point to the word they want to say. She thinks that it would make the process easier, and they would meet the shared goals faster.

> *"It would be ten times easier to show it [word list] and say, 'Does it hurt?', 'Are we happy?', 'How can we help?'. If they point at the foot, it is probably there." (Q:19)*

This category explained that the participants have the perception that their intercultural competencies have developed over time, and that it is based on their experiences which continuously develop as their personal growth does. None of them have undertaken any education within intercultural competencies, but most of them are willing to do so in relation to their work. The participants mainly wanted to improve their cultural awareness even though they addressed the communication as the biggest challenge in the treatment of immigrants.

5. Discussion

5.1. Discussion of findings

The findings of this study illuminate Danish CPOs' experience and perception of their intercultural competencies in the treatment of immigrants. Several aspects within their experience of the treatment have been covered such as challenges, barriers, strategies, work environment, and development of their intercultural competencies.

It was discovered that the participants, in this present study, did not have any experience of them providing different treatment to immigrants compared to non-immigrants. The participants aimed to provide the best possible care to all their patients, which also accommodates the World Health Organizations statement, that: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (Ghebreyesus, 2017).

Two similar studies (Jensen et al., 2011; Paternotte et al., 2016) have shown the same findings, which are that the practitioners do not treat people differently based on their cultural background. The two studies investigate emergency room (ER) physicians and general practitioners (GP's) in the treatment of undocumented migrants in Denmark, and how health care professionals think they practice intercultural communication. The participants in the study by Paternotte et al. (2016) expressed that they had an open attitude, and that the patient's cultural background did not influence their communication. This was also some of the important characteristics to possess as a CPO, mentioned in this present study. Moreover, an important finding of this present study was, that a good chemistry between the patient and the CPO is vital.

The Intentional Relationship Model (IRM) (Figure 1) illustrates how to develop a relationship between the therapist and client within occupational therapy. It consists of four central elements: the client, the interpersonal events occurring during therapy, the therapist, and the occupation (Taylor R. R., 2008).
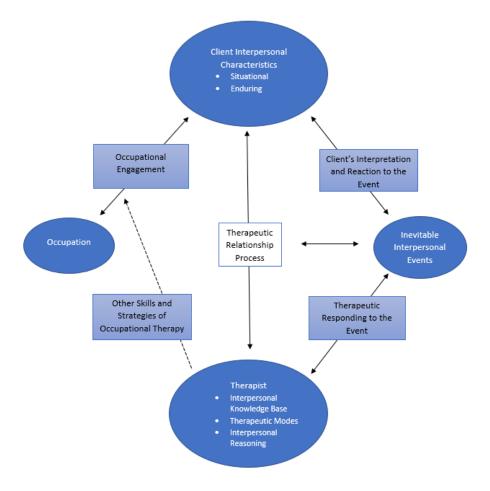
Figure 1: The Intentional relationship Model (IRM) from Taylor R. R. (2008).

The three boxes in the left side are related to occupational therapy. However, the remaining boxes can be adapted to other professions, such as the P&O field, and then the model describes how to establish a good relationship between the CPO and the patient. The findings of this present study have shown that the CPO needs to take some other aspects into consideration in the treatment of immigrants, since they have a different cultural background.

When implementing the model in this present study, the client can be replaced by patients, who are immigrants. The situational interpersonal characteristics describe how the immigrant reacts to a specific situation in the treatment, while the enduring are more stable and consistent aspects, such as how the immigrant usually reacts. An example of enduring interpersonal characteristics can be their capacity for trust and their preferred style of communication (Taylor R. R., 2008).

The interpersonal event can be described by, for example, a naturally occurring communication, reaction, or general circumstance that occur during the treatment, which can affect the relationship between the CPO and the immigrant either positively or negatively (Talyor R. R., 2008).

The CPO will replace the therapist in the model, who is responsible for acting in an appropriate way to both the immigrant's interpersonal characteristics and the interpersonal event. This can commonly be done in six different modes: advocating, collaborating, empathizing, encouraging, instructing, and problem-solving (Talyor R. R., 2008).

With that in mind, it can be stated, that the CPO's reactions are vital to be able to build a functioning relationship to the immigrant. This can, for example, be in case they experience communication barriers in the treatment, which was found to be the biggest challenge in this present study. Thus, it is very important that the CPO reacts appropriately to this interpersonal event, and to the immigrant's reactions to this as well. This can, for example, be by adapting their language to accommodate the language difficulties.

The communication and language difficulties were also the biggest challenges found in the two studies mentioned previously (Jensen et al., 2011; Paternotte et al., 2016), as well as another study which, among other things, investigated the elements of cultural competency that needed to be developed in GP's and GP registrars (Watt et al., 2016). However, the participants in this present study mentioned that they did not consider the language difficulties as a problem, but rather a challenge to overcome. This was also found in the study by Paternotte et al. (2016). Due to the communication difficulties related to the treatment of some immigrants, the consultations may be more complex and require more time, since it is time-consuming to make sure that there is a mutual understanding (Watt et al., 2016). This was also a finding in this present study.

In addition to this, some participants in this present study mentioned that they had experienced that some immigrants have a different time perception than non-immigrants. Clark (2012) also mentions that the perception of time can differ depending on the culture, such as being late or not showing up.

Findings of the tools and strategies used in the treatment of immigrants within this present study are also found in similar previous studies. Everyone within this present study mentions a professional translator as a possible tool to use in case of communication difficulties in the treatment of immigrants. However, it is also stressed by the participants that it can be a challenge to get a translator in Denmark, since it is the patients themselves who must find a translator. Moreover, it is not possible to be granted a translator through the region, if you have lived in the country for three or more years, unless it is special conditions (Sundheds- og Ældreministeriet, 2018). In the study by Watt et al. (2016), it is stated that the availability of a translator is also sometimes seen as a challenge, and untrained translators are commonly used. This is also the case in this present study, where it was mentioned that many immigrants use, for example, family or friends to translate. However, the participants in the study conducted by Paternotte et al. (2016) expressed that they found it difficult to talk to the patient through a translator, and that they preferred non-professional or family

translators, since they could adapt the questions more effectively to the patient's level of understanding. Two of the participants in this present study expressed that they did not prefer when children translate for their parents. It can be assumed that some problems and ethical issues may arise when using relatives as translators. Examples of this can be that mistranslation may occur since the relatives are not educated. Furthermore, it can be assumed that the involvement in the treatment may affect the relation between patient and the relative, who translates.

A common strategy, used by the participants to accommodate the possible language difficulties in this present study, was that they adjust their language by speaking clearly and slowly while using body language and gestures. They also try to keep it simple and repeat what has been said, as well as making the patient repeat to assure that a mutual understanding is accomplished. The same findings are mentioned in the study by Paternotte et al. (2016).

Several of the participants from this present study worked in clinics with employees with a different cultural background. They all saw it as an advantage to have diversity in the workplace, since they thought that it could give some different points of view in certain situations. In a previous study, it was also seen as an advantage with a diversity of the staff to provide opportunities for cultural education (Watt et al., 2016). Furthermore, the health professionals in the study by Jensen et al. (2011) suggested to use bilingual employees to help attend in case of communication difficulties. However, one of the participants in this present study had previously experienced that some of her bilingual colleagues did not prefer to act as translators, which means that it may not always be ideal to use the staff for translation.

Within the category "Development", some of the major findings were that the participants based their development of their intercultural competencies on their experience. The same was discovered in three previous studies (Jensen et al., 2011; Paternotte at al., 2016; Watt et al., 2016). In addition, the participants of this present study had not undertaken any specific education or courses within the topic which was also the case in the study by Paternotte et al. (2016).

In this present study, another finding was that some of the participants agreed that their intercultural competencies will constantly develop, since they keep experiencing new things. This was also expressed by Watt et al. (2016), and Alizadeh and Chavan (2015), where they stated that it is a lifelong process, and it has no endpoint.

Moreover, most of the participants in this present study found it important to learn about intercultural competencies, when you work as a CPO. The importance of learning about intercultural competencies, when working as a health care provider was also mentioned in previous studies (Jensen et al., 2011; Paternotte at al., 2016; Watt et al., 2016). However, Watt et al. (2016) mentioned that there was a fear of stereotyping as a potential consequence of cultural competence training. Thus, Paternotte et al. (2016) and Watt et al. (2016) stated that a combination of experience and training within intercultural competencies is preferred to achieve awareness of a proper communication behaviour. Thus, it can be stated that it may not be enough with only training or experience, but that a combination is the best way to improve intercultural competencies.

Most of the participants in this present study showed a willingness to undertake education or courses about intercultural competencies to further improve their own intercultural competencies. This was also the case in the study conducted by Watt et al. (2016), but the participants in that study mentioned that they required more

resources and support of the training. In this present study, most of the participants stressed that the education should be in their working hours or directly after work, for them to be willing to undertake the education in relation to their work. This was not mentioned in the other study by Watt et al. (2016).

The participants of this present study mainly wanted to improve their cultural awareness even though they all addressed the communication and language difficulties as the major challenge in the treatment of immigrants. This can be assumed to be because it requires more to improve language skills, than it does to improve knowledge and awareness about a specific subject. However, one of the participants in this present study proposed to have a word list, with some of the most common foreign languages in Denmark, to ease the entire treatment process in case of communication difficulties. Morville and Erlandsson (2016) has stated that some ethnic minorities, especially refugees from underdeveloped countries have a high rate of illiteracy. This indicates that the word list would probably not be applicable in the treatment of all immigrants. However, it can be assumed that it would increase the applicability in treatments if pictures were also included in the word list.

5.2. Discussion of methodology

Qualitative studies make use of another terminology than quantitative studies in the evaluation of a study's quality. The terms, reliability and validity are known from the quantitative perspective whereas it is the term trustworthiness in the qualitative perspective. These terms are used to reflect on the truth in the study which is achieved by different criteria (Polit & Beck, 2004). Within the qualitative research, the most used criteria for evaluation of trustworthiness, was presented by Lincoln and Guba in 1985 and in 1994 they added a fifth criteria (Lincoln & Guba, 1985, as cited in Cope, 2014). These criteria were credibility, dependability, confirmability, transferability, and then authenticity (Cope, 2014).

Polit and Beck (2004) described the criteria by: Credibility refers to confidence in the truth of the data and interpretations of them. Dependability refers to the stability of data over time and conditions. Confirmability refers to the objectivity or neutrality of the data, which has the potential for congruence between two or more independent people about the data's accuracy, relevance, or meaning. Transferability refers essentially to the generalizability of the data, that is, the extent to which the findings can be transferred to other settings or groups (Polit & Beck, 2004). Authenticity refers to the ability and extent to which the researcher expresses the feelings and emotions of the participant's experiences in a faithful manner (Polit & Beck, 2012, as cited in Cope, 2014).

Specific strategies are used by the authors to address the mentioned criteria, to make the authors reflect upon their study. Thus, the strategies are performed in different phases of the research process, to support the enhancing of the trustworthiness of the study.

In the beginning of the research process, the authors performed literature searches where other similar studies were found. This was to gain a preunderstanding and more knowledge about the topic which is investigated in this study. However, Tanggaard and Brinkmann (2020) stated that too much preunderstanding may limit the objectivity. To avoid this, the authors have tried to have an open mind and be neutral, to which Tanggaard and Brinkmann (2020) has stated that no research interviews can be neutral, and it is important to have a

preunderstanding of the phenomena in a study. The inductive reasoning strategy support the objectivity by the authors as they tried to identify patterns from the interviews.

The method is described in detail in the section "3. Method", to provide transparency for the reader.

By including information about the participants, it supports the transferability of the study. A limitation in this study is, that some information about the participants is left out to increase the confidentiality, since the P&O field is small in Denmark. However, the authors perceive, that it is still possible to transfer this study to other professions with the given information. The chosen purposive sampling strategy can limit the ability to generalise the findings to other populations (Holloway, 2005; Johnson & Christensen, 2016). Nevertheless, it is not relevant in this study since the authors do not aim to generalise it to all CPOs.

The number of the participants, which is also called the sampling size, is often questioned in qualitative studies. Due to the relatively low number of participants, it can be a limitation for the results by not having more different perspectives. But within qualitative research, it is not about the size but about the quality (Todres, 2005). There is a general rule in qualitative sampling, where the sample size should be large enough to obtain data-saturation, which means that no new or relevant information seems to emerge as more data are collected (Sandelowski, 1995, as cited in Johnson & Christensen, 2016). This study included five participants where the authors found the data-saturation obtained. Two of the participants were from the same clinic which can be seen as a disadvantage, in case the two participants talked about the study before they were interviewed which could influence their answers. Despite of this, the authors found it as an advantage because they can have different views on the phenomena even though they are from the same work environment.

The interview guide was used to make sure that specific topics related to the aim of the study were covered during the interview which increased the dependability to make similar studies. The interview guide was based upon the authors' literature search and their preunderstanding. Johnson and Christensen (2016) mention that a limitation to an interview guide is, that the interview can be less flexible due to the intention of making the participants answer correlated to the aim of the study. However, a strength of the interview guide is that it makes the data collection systematic for each participant (Johnson & Christensen, 2016). Two pilot interviews were performed with two P&O students who had some experience with the treatment of immigrants but did not meet the inclusion criteria. None of the authors had performed interviews before, and thereby they could practice the interviewing process in the pilot interviews. The authors gained more experience by doing more interviews, where they kept the same roles as interviewer and observer through all interviews. After the pilot interviews, the structure of the interview guide was adjusted, which created a better flow for the interviews.

The authors experienced, during the interviews, that the participants felt connected to the authors, due to the small P&O field in Denmark, which helped to achieve a confidential and secure atmosphere. The authors used the online interviews via Zoom instead of face-to-face interviews due to the Covid-19 pandemic. The limitation with online interviews is that sound and body language can be a problem for the conversation (Brinkmann & Kvale, 2018). The authors did not see it as a restriction, since a confidential and secure atmosphere was achieved, since the participants were placed at home or their workplace, and both the participants and the authors had turned on the webcam. Moreover, an advantage of the online interviews is the increased opportunity to interview people, who are geographically distant from the researchers (Brinkmann & Kvale, 2018).

Brinkmann and Kvale (2018) states that oral and written language contain different styles. Thus, the transcribed data may appear incoherent and repetitive in direct transcription. However, the authors used triangulation by transcribing separately with the same transcription key to increase the credibility. Thereafter they shared their transcriptions with each other where they read and listened to them, to make an agreement. The transcription key was a guideline for the authors to have the same structure of their transcriptions, but the authors had different transcribing styles despite of the transcription key. Thus, the comparison of the transcriptions was important and increases the confirmability.

The analysis process was conducted according to Brinkmann and Kvale (2018) and Gibbs (2018), which made the authors' analysis process equal. The authors analysed each interview separately and compared their findings together, meaning triangulation was also used in this process. An example of the authors' coding is included in the section "3. Method" to provide transparency in the study. The authors did all the analyses in Danish and then translated the quotations which were used in the "4. Findings". Wagner et al. (2014) mentioned that translating the findings is better for comparability than translating the original material. A consequence of the translation by the authors is that there is a possibility that some descriptions and meanings of the participants were lost, but the authors tried to make sure that the original meaning stayed intact.

The authenticity was a key factor for the entire process because the authors wanted the participants' voices to be clear by including some of their quotations, which also improved confirmability of the study (Cope, 2014).

The authors made use of member checking after they had analysed the data to increase the credibility and the participants' voice in the study (Johnson & Christensen, 2016). The member checking was to give the participants the opportunity to read and give feedback on the summary of what was found in their interviews. Four of the participants agreed on what was found in their interview, but the last participant did not report back even though it was requested from the authors through a follow-up e-mail.

There was a limited timeframe of approximately two months, and the authors had lack of research experience. By prolonging the study process, it might have been possible for the authors to gain more knowledge or even more accurate data. If the authors had more time, they would have used a strategy, where they would code the data, then leave the data for a while, and then code the data again within approximately 10-14 days (Schreier, 2014). This would provide the study with more stability of the findings due to the time, and thus, the dependability would be increased.

5.3 Future research

This study aimed to investigate Danish CPOs' experiences and perception of their intercultural competencies and to gain a deeper understanding within this phenomenon. However, future studies could include immigrants' perspectives who are treated by the CPOs. This would show another and quite important point of view and would provide a broader perspective of the Danish CPOs' intercultural competencies.

Furthermore, the authors perceive that it is possible to transfer the findings from this study to other professions, and thereby, future studies investigating intercultural competencies in other professions could be interesting.

The authors have not been able to find any previous literature about intercultural competencies within the P&O field, but several studies have been conducted within the general health care services. Thus, it can be

beneficial to perform more studies investigating the intercultural competencies specifically for the P&O field. Also, the authors will recommend future studies performing similar studies in other countries as well. Furthermore, it could be interesting to use both qualitative and quantitative methods to measure intercultural competencies, and to include more aspects within this topic. In addition, more participants in future studies could be desired to achieve more perspectives.

6. Conclusion

This study contributes with important knowledge within the intercultural competencies in the P&O field. The findings of the study give a broader perspective on Danish CPOs' experience and perception of their intercultural competencies in the treatment of immigrants.

The findings showed that the CPOs do not have any perception of themselves treating patients differently, because they aim to treat everyone from the same starting point, where they analyse the situation and act on it. In the treatment of any patient, a good chemistry, respect, open mindset, and the knowledge of the ambitions were seen as key factors. In the treatment of immigrants, the CPOs have experienced some challenges such as time, gender, appearance, and especially communication. To overcome these challenges, the CPOs uses specific tools and strategies, and they all mentioned the possibility of using a translator which they found to be a difficult process. If a translator is not an opportunity, they adjust their language, shows products to the patients, or make time in their work schedule. The CPOs felt that they have a great opportunity to cooperate with their colleagues in their daily work, and it would be an advantage with diversity in the CPOs' workplace. All the CPOs in the study experienced that their intercultural competencies and personal growth have improved over time, based on their experiences. The participants mainly wanted to further develop their cultural awareness even though they addressed the communication as the major challenge in the treatment of immigrants. None of them have undertaken any education within intercultural competencies, but most of them are willing to do so in relation to their work.

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Appendix A – Information Letter

Kære Bandagist,

Vi er to bandagiststuderende på Jönköping University, som er midt i vores bacheloropgave.

Formålet med vores opgave er at undersøge bandagister, der arbejder i Danmarks oplevelse med interkulturelle kompetencer i behandlingen af immigranter.

Interkulturelle kompetencer betegnes ved evnen til at kunne fungere på tværs af kulturer og interagere med mennesker fra en anderledes kulturel baggrund. Dette består af forskellige grene såsom kommunikation, kultur, evner, attitude og holdninger.

Det er et kvalitativt studie, som vi vil udføre på baggrund af interviews med autoriserede bandagister, som har minimum 1 års erfaring på en dansk klinik. Interviewene vil foregå på Zoom, som er en online kommunikationsplatform, som vi har adgang til gennem Jönköping University. For at deltage, kræver det en computer med mikrofon, og gerne et webcam – dette er dog ikke et krav. Vi forventer, at hvert interview vil tage omkring 30-60 minutter, men sæt gerne ekstra tid af til eventuelle uforudsete udfordringer.

Det er frivilligt at deltage i undersøgelsen, og det vil være muligt at trække sig eller undlade at besvare spørgsmål til hver en tid ved henvendelse enten mundtligt eller skriftligt til os. Deltagelsen, samt personoplysninger vil blive behandlet fortroligt, hvor det kun er de ansvarlige for opgaven, som har adgang til de indsamlede informationer. Deltagerne vil blive anonymiseret i opgaven, så det ikke vil være muligt at sammenkoble svarene til deltagerne. Alt indsamlet data vil blive administreret forsvarligt og ifølge universitetets gældende regler. Alt data vil desuden blive slettet efter endt eksamen.

Undersøgelsen vil blive udgivet på Jönköping University's database, DiVA, og hvis nogle ønsker at se resultatet af den endelige opgave, sender vi den gerne efter endt eksamen.

Interviewene kommer til at foregå i uge 12-13, og der vil blive sendt et zoom-link samt en samtykkeerklæring ud til deltagerne inden.

Efter vi har bearbejdet interviewene, vil vi sende det analyserede indhold til deltagerne, så de har mulighed for at give feedback.

Hvis du har lyst til at deltage i vores undersøgelse, kontakt os venligst på vores mail.

Venlig hilsen

Christina Louise Jørgensen &
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Appendix B – Statement of Consent

Samtykkeerklæring

Jeg giver samtykke til at deltage i dette bachelorprojekt, som undersøger danske bandagisters oplevelse af interkulturelle kompetencer i behandlingen af immigranter.

Jeg giver hermed samtykke til at:

- Jeg er indforstået med formålet og metoden i undersøgelsen.

- Jeg deltager frivilligt i undersøgelsen, og jeg kan til hver en tid trække mig fra undersøgelsen.

- Interviewet vil blive optaget på telefon, samt transskriberet.

- Interviewet vil udelukkende blive aflyttet af de involverede i undersøgelsen.

- Min deltagelse og oplysninger vil blive anonymiseret og behandlet fortroligt.

- Indsamlet data vil blive administreret ifølge universitetets regler, og det vil blive slettet efter endt eksamen.

- Jeg er indforstået med, at undersøgelsen vil blive udgivet på Jönköping University's database, DiVA.

- Jeg må blive kontaktet efter bearbejdning af interviewene for at have mulighed for at give feedback.

Med min underskrift godkender jeg denne samtykkeerklæring.

_____   _____

Deltagerens navn   Dato & Underskrift

_____   _____

Christina Louise Jørgensen   Nynne Harrishøj Schultz

Appendix C – Interview Guide

Briefing:

- Til info: Starter med at optage på telefoner nu

- Hvem er vi?
    - Bandagiststuderende
    - Christina – Interviewer
    - Nynne - Observatør + noter
- Formål med opgaven:
    - Undersøge bandagister, der arbejder i Danmarks oplevelse med interkulturelle kompetencer i behandlingen af immigranter.
- Interviewets struktur:
    - Samtykkeerklæring
        - Fortroligt og anonymiseret
        - Frivilligt
    - Vi er interesserede i dine oplevelser og subjektive meninger. Kom gerne med relevante eksempler og uddybende svar, og beskriv gerne så detaljeret som muligt
- Definitioner:
    - Kultur:
        - I vores opgave vil der være fokus på de kulturer, der optræder i forskellige lande, hvor man kan antage, at de forskellige lande har nogle generelle lignende overbevisninger, sæt af værdier, normer osv.

- Vil du starte med at fortælle lidt om dig selv?
    - Navn:
    - Alder:
    - Køn:
    - Erfaring på dansk bandageri (antal år):
    - Hvilken klinik er du primært på?
    - Størrelse på klinik (Antal bandagister):

Indledende spørgsmål:

- Når jeg siger "Interkulturelle kompetencer", hvad tænker du så?

- Hvordan vil du definere en immigrant?

- Hvor ofte møder du immigranter på en arbejdsuge eller måned?

Behandlingen:

- Hvordan er det for dig at behandle patienter med en anden kulturel baggrund end din egen?
- Kan du beskrive en specifik oplevelse, hvor du, som bandagist, er blevet behandlet anderledes på grund af jeres forskellige kulturelle baggrunde?
    - Har du haft andre oplevelser?
    - Føler du, at patienten oplevede situationen ligesom dig?

- Synes du, at det er vigtigt at lære om andre kulturer som en del af bandagistfaget? I så fald, hvorfor?

- Hvad synes du, at der skal til for at yde en god behandling for en patient?

- Har du nogen særlige værktøjer, du gør brug af i behandlingen af immigranter?
    - Har du adgang til nogen værktøjer fra din virksomhed?

Arbejdsmiljø:

- Tilbyder din arbejdsplads nogen specifikke værktøjer til behandling af immigranter, i så fald hvilke?
    - Forskellige nationaliteter på din arbejdsplads? Fordel eller ulempe ved det?

- Har du mulighed for at sparre med kollegaer, i tilfælde af at du oplever kulturelle udfordringer?

- Har du nogensinde oplevet at måtte overdrage eller selv overtage en patient til/fra en kollega på grund af vanskeligheder vedrørende kulturelle forskelle?
    - Uddyb
    - Hvorfor tror du?

Kompetencer:

- Føler du, at dine interkulturelle kompetencer har udviklet sig gennem tiden?

- Har du fået uddannelse eller kurser i interkulturelle kompetencer?
    - Kunne du have lyst til at lære om forskellige værktøjer inden for IK?
    - Hvordan har du fået kurser? (via arbejdspladsen, eller)

- Hvis vi lige gentager, at interkulturelle kompetencer betegnes ved at kunne fungere på tværs af kulturer og interagere med mennesker fra en anderledes kulturel baggrund. Her indgår kommunikation, kulturel bevidsthed, evner, attitude og holdninger.
  Er der nogen områder inden for interkulturelle kompetencer, du kunne ønske at forbedre?
    - Kan du gøre dig nogen tanker om, hvordan du kan opnå den forbedring?
    - Tror du, at det kunne fremme behandlingen at have den mulighed?

Debriefing:

- Har du nogen spørgsmål, eller er der andet, du gerne vil tilføje?

- Hvis der opstår spørgsmål, eller hvis du kommer i tanke om yderligere, er du velkommen til at kontakte os.

- Vi sender det sammenskrevne indhold, så du har mulighed for at give feedback.

Appendix D – Transcription Key

I: Interviewer

O: Observatør

D1-D4: Deltager 1 - Deltager 4

TEKST: særligt tryk på ord

(tekst): utydelig tale

{.}: ikke hørbar tale

(...): pause

=: øjeblikkelig tale

tekst: beskrivelse af "følelser"/lyde

(Firma/person): anonymisering

Appendix E – Danish Quotations

- ”Men i forhold til værdier og de her ting, synes jeg ikke, at jeg opfører mig meget anderledes end over for en indfødt dansker. Men selvfølgelig skal man overveje i forhold til humor og sarkasme og sådan nogle ting, som man måske ikke rigtig kan være sikker på, at de [immigranter] forstår, eller værdsætter.” (Q:1)

- ”… hvis man har en god kemi, er man også villig til at prøve flere forskellige ting. Der er en større tålmodighed og tiltro til, at man arbejder i samme retning…” (Q:2)

- ”Jeg synes, at det er meget vigtigt, at man er meget fordomsfri som bandagist, og at man er meget åben på den måde, at man ikke må være snæversynet i forhold til kultur, religion og så videre. Det handler rigtig meget om, det der med at læse folk.” (Q:3)

- “Nogle gange kan man godt, som bandagist, have nogle kæmpestore ambitioner for dem [patienter], men det er ikke altid sikkert, at det er det rigtige at gøre. Der tror jeg, at det er helt vildt vigtigt at lytte til borgerens behov.” (Q:4)

- ”Det er ikke noget problem [at behandle patienter med en anderledes kulturel baggrund]. (…) Der kan være lidt med at vide, om de forstår det. Hvis de kommer og snakker dansk, er det lige meget.” (Q:5)

- ”Jeg får oftere det der med, ‘Er du er en pige?’ ‘Ja, sådan rimelig’. ‘Nåh men vi troede det var en mand’.” (Q:6)

- “Det kan være et levn af det der autoritetstro osv., men det er altså typisk ved de ældre, og det er ekstremt sjældent. Men nogle gange kan man godt fornemme, at der er nogle ting, der går lettere igennem, hvis det bliver fortalt af en [mandlig] behandler, som de forventer.” (Q:7)

- ”… man synliggør et barns handicap ved for eksempel at give dem skinner på. Det er lidt et stigma i kulturen. Jeg har mange gange fået den kommentar, at ‘jamen bukserne kan jo ikke komme ud over [skinnerne]. Så kan de se, at mit barn har skinner på’.” (Q:8)

- “… det er eddermame en sej proces hvis man skal have en [professionel] tolk.” (Q:9)

- “Jeg taler langsomt, og jeg er meget klar og tydelig i mine udmeldinger. Jeg fylder ikke unødig snak på. Jeg forsøger at sikre mig, at de forstår, hvad jeg siger ved at få dem til at gentage det.” (Q:10)

- “I langt de fleste tilfælde, kan man jo klare sig med engelsk, gebrokkent tysk, eller et eller andet. Men det kan jo være en sjælden gang, hvis der er nogen, der kun kan snakke polsk for eksempel, så er det tegnsprog og fagter og sådan.” (Q:11)

- “Jeg tager produkterne med ind så de [patienter] kan pege på det [produktet] og vi er sikre på, hvad vi vælger. Dette gælder farver, snørebånd, Velcro osv.” (Q:12)

- *"… hvis man havde problemer med kommunikationen, så kunne man spørge, 'Har du 5 minutter? For jeg kunne godt bruge din hjælp'. Det ville også give en større indsigt i den opfattelse, som det kan blive taget imod med fra anden side [patienten]…" (Q:13)*

- *"… det kunne være meget rart at trække ind på banen. Men jeg mangler det ikke, for jeg synes jo ikke, at der er nogen af OS, der tænker, 'dem [immigranter] skal jeg behandle andenrangs'." (Q:14)*

- *"Vi bakker hinanden rigtig meget op, og det er uanset, hvad det er. Vi snakker om det, hvis der bliver noget. Det er også, når vi er to inde [i klinikrummet], så hvis der er noget, jeg ikke får med, så får den anden [behandler] spurgt ind til det." (Q:15)*

- *"Vi er gode til at få det til at gå op. Hvis kemien ikke passer, må man få hjælp eller overgive det til nogle andre." (Q:16)*

- *"De [interkulturelle kompetencer] udvikler sig jo hele tiden. Jo mere man har med det at gøre med folk med en anden baggrund, jo mere lærer man også, hvordan deres kultur er, og hvordan (…) de plejer at agere set ud fra et bredt perspektiv. Det bliver da bedre med tiden og det vil jo nok altid udvikle sig." (Q:17)*

- *"Selvfølgelig er det vigtigt også at lære om kulturerne, men jeg mener ikke at det skal være alt overskyggende. Behandlingen er altid første prioritet og så prøver man at finde (…) den gyldne middelvej…" (Q:18)*

- *"Det ville være 10 gange nemmere at hive sådan en [ordliste] frem og sige, 'Gør det ondt?', 'Er vi glade?', 'Hvad kan vi hjælpe med?'. Hvis de peger på foden, så er det nok der." (Q:19)*