

Interprofessional Simulation (IPS) as an Educational Tool to Address Cultural Competence in Working with Muslim Patients in West Texas

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Abstract:

To deliver high quality health care to Muslim patients requires providers have a basic awareness of the Islamic faith and beliefs. This paper reports on how five academic programs from two universities in Rural West Texas have developed, implemented, assessed, and continue to develop an interprofessional simulation (IPS) program that incorporates challenges specifically related to the medical assessment of Muslim patients. It is through this process that social work, nursing, pharmacy, occupational therapy, and speech and language pathologists will be better prepared to assess and treat Muslim patients in a culturally competent manner, in an attempt to address discrimination and improve medical results.

Introduction

We live in a world that is increasingly diverse. It is expected that by 2050, one in three of the US population will be persons of color. This is largely due to increased differential birth rates and changing demographics of immigrants (Rutledge, Garzon, Scott, & Karlowicz, 2004). One of the peoples that has grown dramatically over the course of the past three decades is the Muslim population (Hodge & Nadir, 2008). However, despite this fact, relatively little information exists about the capability of healthcare professionals to provide culturally competent services to Muslims. In fact, most health professional providers appear to have been exposed to relatively little content on Islam during their education and professional training (Hodge & Nadir, 2008). The need to address cultural and ethnic diversity issues in medical education as a means of elevating the quality of patient care for all has been highly encouraged. In this paper, we aim to describe a simulation-based interprofessional simulation educational program that incorporated challenges specifically related to the medical assessment and treatment of Muslim patients. It is through this process that social work, nursing, pharmacy, occupational therapy, and speech and language pathologists will be better prepared to assess and treat their future Muslim patients.

Cultural Competence

Cultural competence models in healthcare organizations began in western nations with a goal of addressing discrimination and inequities being directed towards various ethnic and cultural groups (Thomson, 2005). Cultural competence has been defined as,

A set of behaviors and attitudes and a culture within business or operation of a system that respects and takes into account the person's cultural background, cultural beliefs, and their values and incorporates them in the way healthcare is delivered to that individual. (Betancourt et al., 2002, p. 3).

Cultural competence training focuses on learned behaviors and action, and can be applied both at individual or organizational levels (Betancourt et al., 2002). The key to cultural competency and culturally

congruent care lies in the ability of individuals to “craft respectful, reciprocal and responsive effective interactions across diverse cultural parameters” (Barrera et al., 2002, p.103).

Teaching future health care professionals about specific cultures has been unsatisfactory because it does not allow for the development of an understanding of cultural competence for use in practice. In several countries, educational objectives that address cultural or ethnic diversity in one way or another have been outlined for medical faculties (e.g. in the UK, Sweden, and the Netherlands). However, the practical application of these objectives appears to be challenging. In particular, it seems to be difficult to ensure that cultural competency is fully integrated into the curriculum. Teaching about this subject is fragmented, and teachers and curriculum developers are often unfamiliar with the subject (Dogra et al., 2005). It is not always clear what should be taught especially when it comes to a complicated, diverse minority group such as Muslims.

Diversity and homogeneity within Islam

The number of Muslims in the United States has increased dramatically over the course of the past three decades (Selvman, 2013; Hodge & Nadir, 2008). Although estimates vary significantly, somewhere in the range of 2 to 8 million Muslims now live in the United States. Despite the size of the Islamic community, most health care providers have been exposed to very little content on Islam during their educational years (Hodge & Nadir, 2008). Moreover, little material exists in the academic literature that would help prepare health care providers to engage in culturally competent practices with Muslims (Sheridan & North, 2004).

For many Muslims, Islamic practices dominate every aspect of their lives and behaviors, but there are also acculturated Western-oriented Muslims who may or may not follow firmly to the practices of Islam. There is a confusion in Eurocentric literature about Islamic culture and Muslim culture. According to Philips (2007),

Islamic culture represents the traditions and customs which evolve from day-to-day practice of people following the authentic teachings of Islam. In general, when various cultures of Muslims around the world are compared, the common features found in all countries and regions represent the core of Islamic culture, and the variations represent the basic features of Muslim cultures (p.63).

Indeed, Muslims are not a homogeneous group, and different groups from different regions of the world will have different cultures even though they share the same religious values and practices. However, their behavior is often shaped by cultural practices that may not be consistent with basic religious practices. Some of the cultural or pre-Islamic practices observed by Muslims are given an Islamic dimension even though they are not Islamic practices (Rassool, 2014). Generally, religious or Islamic practices have roots in the Qur'an and traditions - or Sunnah, the life and teachings of the

Prophet Muhammad (Peace be Upon Him). The diversity within this population means that caring for Muslim patients presents constant challenges to health-care providers (Rassool, 2014).

In order to deliver a high-quality care to Muslim patients, health care providers need to have a basic awareness of the Islamic faith and Islamic beliefs. Having such understanding should inform health professionals' efforts to achieve cultural competence and deliver care that is culturally sensitive (Rassool, 2014). Many U.S. medical schools have accreditation requirements for interprofessional education and training in cultural competency, yet few programs have developed programs to meet both of these requirements simultaneously. Furthermore, most training programs to address these requirements are broad in nature and do not focus on addressing health inequalities. Thus, the lack of integration may reduce the students' ability to apply the knowledge learned. Innovative programs that combine these two learning objectives and focus on marginalized communities are needed to train the next generation of health professionals.

Interprofessional Simulation (IPS)

The literature recognizes several methods or approaches that instructors have used to help students learn how to provide culturally competent care. However, there is a lack of agreement on how to incorporate these into a curriculum (Larsen & Reif, 2011). Evidence-based guidelines and strategies have been used to support medical and nursing students to enhance cross-cultural skills. These include community service learning projects, readings, objective structured clinical examinations, case studies, role-play, self-reflection, and immersion in another country (Axtell, Avery, & Westra, 2010). Since 2000, interprofessional simulation (IPS) strategy has become a main point in the United Kingdom (Chief Medical Officer, 2009; General Medical Council, 2009). In addition, IPS has been proposed by multiple organizations as a suitable and innovative educational approach to address global health care challenges in the 21st century (WHO, 2010; HCC, 2005).

IPS is becoming an increasingly popular and recommended feature of health professional curricula (Halupa, 2015). In addition to imparting content knowledge, it introduces the concept of teamwork and, for students, contributes to the development of professional identity and interprofessional respect. Simulation is a component of IPE programs (Palaganas, Epps, & Raemer, 2014). Learning clinical skills in a simulated environment can drive engagement of learners by providing clinically relevant or valid tasks. For IPS to be beneficial, simulation-based education must be relevant to all professions of the participating students. The simulation task can then be tailored towards the learning needs of the participants to optimize their learning (Palaganas, Epps, & Raemer, 2014).

Current Study

The institution where this study was conducted introduced a compulsory IPS module to enable students to experience multi-professional teamwork by working alongside their peers from other disciplines in scenarios facilitated in a safe and controlled environment. The aims of the project were to promote the use of clinical simulation to enhance the students' learning opportunities and ensure a high level of activity in the new clinical simulation facilities by developing a program to facilitate interprofessional scenario-based simulation training for health care students. It also provided an opportunity for students to observe aspects of the work carried out by other professionals and to interact with them when it was appropriate during a scenario and the debriefing. It explored whether simulation improved trainees' perception about working with patients from different race and religious backgrounds.

Methods

The cross-sectional study was designed to evaluate healthcare student's basic knowledge, skills, and professional identity from five departments at two universities in a rural Midwestern state in the U.S. In addition to their professional knowledge, the exercise sought to explore the students ability to address gender, ethnic, cultural, or religious concerns presented by standardized patients (SPs).

After human subject approval of the research protocol, a simulation center was transformed into an outpatient clinic and medical/surgical unit. The student participants (n=141) were asked to assess and treat SPs on the basis of twenty-six evidence based case scenarios that were created to address chronic medical conditions, as well as gender, ethnic, religious, and cultural competence issues. All SPs had undergone a prior training program to become familiar with the symptoms of their assigned medical diagnosis and the specific gender, ethnic, religious, or cultural competence issues they were to exhibit.

After randomization into one of the two sessions (AM and PM) and the specific treatment areas, nursing, social work, pharmacy, occupational therapy and speech and language pathology students were asked to provide care for the twenty-six different patient diagnoses. All students in both the AM and PM sessions met for an initial informational session and were provided with an informed consent document to participate in the exercise. They were also informed of the purposes of the study and that the information was to be used by the faculty for educational and research purposes. Most importantly, they were informed that they would not be graded on the simulation exercise and that it was for educational and learning purposes.

The current work presents the information and rationale for only one of the twenty-six evidence based scenarios. The scenario involved the presentation of a 56 yo Muslim female with a fractured right hip who was

awaiting a right hip replacement. She was to be evaluated from a medical standpoint by use of appropriate sensitivity to her cultural and theological needs.

The training instructions for the SP from the 2017 exercise had consisted of the following information: (i) You are a Syrian refugee and immigrated to the US approximately two years ago and presented with a fractured right hip that will require surgery. (ii) You are a Muslim and pray on your knees on a prayer rug five times a day facing Mecca. The evaluation of that exercise had shown the SP's training to be inadequate to address the complexity and sensitivity necessary to prepare healthcare students to adequately work with Muslim patients.

Because of the initial findings, two additional individuals were recruited to help evaluate and make recommendations for the 2018 exercise. One of the students was a Master's level Muslim psychology student, and the other an undergraduate Christian social work student who had expressed an interest in the study of and working with Muslim patients.

After completion of their initial assessment of the 2017 results, they made the following recommendations for the SPs training (see Table 1). The training itself was conducted by the simulation clinic nursing staff, the two students, and took place as part of the SP training session the week before IPS exercise.

Table 1: SP 2018 Training Recommendations

It is difficult to distinguish between religion and culture as far as male-female interaction
You will wear a Burqa (will be provided).
If there is a male staff present, you need to request a female.
There will be no difference in behavior if the practitioners are female.
You are allowed to refuse the surgery if there is no female surgeon available.
The bed coverings must be up to your neck.
All examination or touching must be done over the clothing
To prepare for prayers, hands and face must be washed with water
You do not make eye contact with the male staff.
Dietary: you do not eat pork or drink alcohol- cannot even have it in surgery

Given the small number of students that would be working with the Muslim patient, faculty opted for a qualitative assessment of the student's interaction with the SP. The interaction between the students and the SP was qualitatively evaluated by two individuals, one a masters level Muslim female, and undergraduate level social work student. They were the same students who had been actively involved in helping to develop the scenario protocols and SP training. Quantitative evaluation was not possible due to the limited number of students directly involved with the case (n=5). The amount of attention given to this specific scenario was necessary due to the

problems encountered in the prior year's exercise, when it had been observed that the SP was inadequately prepared to fully exhibit cultural and theological requirements for the scenario.

Results

After randomization, 11 different students were observed interacting with the SP through a one-way mirror and the observations were broken down into two categories: positive and negative culturally appropriate student interaction (see Table 2 and 3, respectively). As encouraging and positive as some of the student's responses were (see Table 2); not all of the interactions reflected understanding of Muslim patient needs (see Table 3).

Table 2: 2018 Observed Culturally Appropriate Student Interaction

Evaluated properly for language barrier
Explained step-by-step head to toe examination and why they were doing it
Explained the meds to the SP properly
Started head to toe examination with cultural discussion
Asked permission to touch her
Students responded appropriately to request for information about alcohol based antiseptics and blood transfusions
Evaluated and informed SP on praying within physical limitations
Much of the interaction was done in appropriate detail and in language to easily understand.
Male student initially made eye contact, but realized it and made the extra effort to avoid her eyes out of respect.

Table 3: 2018 Observed Culturally Inappropriate Student Interaction

Student asked if 'Syrian' was the SP's religion.
Students did not ask to examine patient underneath clothing.
Students did not understand what 'Muslim' meant.
SP asked students to slow their speech, but they did not
Students did not ask about dietary needs
Students did not address prayer position limitations resulting from injury.
Students talked too fast for SP's language barrier
Students sat SP up in bed at an angle that caused her pain
Students were unresponsive to prompting to talk slower
Student guaranteed a female surgeon would be available, when they were not
Some of the language used was insensitive

Discussion

The overall faculty assessment of the student's learning from the 2018 IPS exercise could best be described as ambiguous. While many of the observed interactions were appropriate between the students and the SP seeking treatment (see Table 2), there were serious concerns about the problems seen in an equal number of the student communications, that left the faculty questioning whether the students actions were based on lack of knowledge or questionable attitudes towards the Muslim patient (Table 3).

With the 2017 IPS exercise, the primary problem had been inadequate SP preparation and her lack of comprehensive understanding of a female Muslim patients needs. This had been addressed with more thorough SP training (See Table 1). This year, the SP exhibited more appropriate Muslim care needs, and it was encouraging to observe the positive student interaction as seen in Table 2. However, the problems reported in Table 3 are troubling, given faculty's previous efforts to stress cultural understanding.

There is no way to fully evaluate the underlying issues as observed through the inappropriate student communication and behavior with the 2018 exercise. Do they represent a lack of knowledge, indifference to the needs of a Muslim patient, or open hostility for one of another faith or culture? For faculty, each of these considerations is problematic, and need to be addressed. But, in the absence of fully understanding exactly what they represent, what should be done? After meeting to review the findings the faculty determined that there were three things that needed to occur: (i) continue to enhance the SPs training; (ii) augment the student's curriculum through enhanced instruction about Muslim beliefs and practices; and (iii) that professional consultation was needed before faculty could fully accomplish items i and ii.

To seek theological and cultural consultation the faculty has asked Dr Hesham Sayed, Editor, Egyptian Journal of Social Work, and Professor of Social Work at Helwan University, Cairo, Egypt to evaluate and comment on what we, as faculty need to do to enhance our IPS scenario to be able to better prepare future students in their work with Muslim patients and families. We recognize that we cannot adequately prepare our students if we ourselves are lacking in our theological and cultural understanding.

Dr Hesham Sayed's Assessment and Educational Recommendations

How Health Professionals deal with Islamic Female Patients

Despite the agreement of some religions on the principles and values associated with faith in God, there are many different values and behaviors among religions that are challenges to achieving the goals different professions may have in caring for a human being. One of the most challenging for healthcare professionals in the United States is to deal with patients from different cultures, especially the Islamic culture. These challenges can be summarized within two main dimensions. The first is the

nature of the problems and difficulties experienced by patients related to their Islamic culture. The second dimension relates to the way that healthcare professionals care for these patients in the light of the Islamic values they embrace—the basic principles of their dealings with others. Therefore, if these healthcare providers do not consider the nature of Islamic culture when dealing with women patients, it should be expected that the chances of success of the treatment programs provided to them are less likely.

The nature of the relationship between men and women is one of the most important challenges that face the effective provision of services within health care institutions. One of the most important results of the present study is the existence of difficulties faced by students in health care institutions when dealing with Muslim women patients. Some of these difficulties include 1) students did not ask to examine patient underneath clothing (all examinations or touching must be performed over the clothing), 2) students did not understand what 'Muslim' meant, 3) students did not ask about dietary needs especially if regarding pork or alcohol, 4) students did not slow their speech, and 5) students did not address prayer position limitations resulting from the injury. All these and other difficulties may be due to the lack of understanding of students in the field of healthcare about the nature of Islamic culture, and the associated values regulating the relationship between men and women, as well as the Islamic values of clothing, food and drinking.

There is no doubt that the success of dealing with Muslim patients, especially female Muslim women, is based on the extent to which healthcare professionals understand the nature of Islamic culture and the importance of respecting the values and behaviors that are associated with them. In order for healthcare professionals to understand the different cultures, especially the Islamic culture, as well as to acquire the necessary skills to deal with them, educational programs must include courses that contribute to the development of cultural awareness and humility of health professions students in Islamic culture. It is important to develop the professional skills of those students through the field training programs and simulation experiences in dealing with those patients.

Educational Program:

The preparation of members of the medical team to manage clients belonging to the Islamic culture require a theoretical framework that includes the most important Islamic values for Muslim behaviors, especially in the context of interactions with other cultures or religions. Therefore, the program of education at the level of bachelor or master must include a course that addresses the important Islamic values and behaviors that medical professionals need to deal with patients. The basic contents in this course should include (see Table 4):

Table 4: Needed Muslim Educational Course Content

1. The core values of Islamic culture.
2. The importance of religious rituals in the life of Muslims, especially prayer and fasting, and the extent of respect for others.
3. How to deal with sensitive issues in Muslims, such as sexual problems.
4. The issue of the relationship between men and women, and the extent to which women accept dealing with a man who is not her husband or family member.
5. Respect the Islamic dress of women, especially the veil as a fundamental value in Islamic culture
6. Acceptance of the disease, however dangerous, that may be in Islamic culture is a test of God.

In addition, the focus on the study of code of ethics for professions with regard to non-discrimination between clients who need care based on gender, religion, or color is the key to students' understanding of Islamic culture and acceptance to study its course as a tangible start to deal effectively with patients belonging to Islamic culture.

Training programs:

There are two kinds of training programs; field practicum for students during bachelor or master programs, and healthcare practitioners' training through their work. Field training helps students apply health and social care programs in respect to their understanding of the Islamic culture they have studied in their coursework. First, these programs may start with visits to health care institutions that treat Muslim patients. These visits allow them to observe patterns of patients' behavior that reflect their Islamic values and principles, as well as observing how healthcare professionals manage those patients according to their culture. Second, students can accompany professionals while providing services to Muslim patients. They record, analyze, and discuss interviews with supervisors or professionals in order to answer their questions and inform them of the reality of how to deal with these patients. Finally, students can be assigned to provide simple services to Muslim patients and interview them through follow-up by supervisors. Then supervisors can discuss with the students what obstacles they have encountered and how to avoid them in the future.

On the other hand, training programs for practitioners in healthcare institutions aim to provide information and knowledge about the Islamic culture, especially new practitioners or those who do not know much about this culture—in addition to training them in the skills of dealing with Muslim patients in the light of the principles and values of this culture. These skills include communication skills and talking with patients, especially in subjects that have special sensitivity in Islamic culture, taking into account the Islamic limitations in the types of food they eat, and the skills of discussion and persuasion about some of the remedial procedures,

which the patients believe, are contrary to their Islamic values. Most importantly, practitioners must respect practices based on Islamic culture such as worship, clothing, and accepting the patient's willingness to deal with same sex practitioners.

Summary

The results of this IPS exercise suggests that this experiential opportunity provides not only for practical skills application and furthering student knowledge of engagement and assessment of clients, but also provides the unique opportunity to increase multiple disciplines' cultural competence. We believe that this simulation is so crucial that faculty involved are working to develop additional scenarios for future exercises to give students increased opportunity for interaction with other cultures as described in this paper. Additionally, the continued assessment of practices that increase this competence is essential as this project moves forward. Not only is it imperative for us to continue to engage students in dynamic experiences with other cultures, it is crucial that faculty stay abreast of best-practices and emerging literature on this topic as well. This is why all of those involved in the planning and delivery of this simulation are dedicated to furthering their knowledge about each aspect of this project. We are constantly reviewing our own data and comparing it with available resources in the area of interdisciplinary practice, particularly with consultation and guidance from experts who have contributed to the current and future work in this area. The challenge lies in finding accurate, current, and credible sources that help both faculty and students grasp the skills needed to carry out culturally competent practice. While there are resources that currently exist in this area, we are careful to not take one singular, primary source as our guide. Each source, as well as all of our data (including anecdotal data) is reviewed by multiple experts in the field for accuracy. Careful curation and scrutiny of each potential resource in this area aims to ensure quality and positive intended outcomes as this simulation moves forward.

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