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Reflecting on Pediatric Physical Therapy in the International Community

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Abstract: Physical therapists and physical therapist assistants are a subset of health care providers taking on new roles in global health through international clinical experiences (ICE). During ICE, clinicians and students often work with patients and families. Each party brings with them health beliefs and interaction styles obtained from their families and communities. The revised code of ethics for physical therapists and the standards of practice for physical therapist assistants challenge us to be respectful of all patients we work with and to identify our own biases with regard to those we serve. Strategies used by clinicians have potential to greatly help or harm patients and families depending on the interaction approach used. It is important to be attentive to patients, families, family dynamics, and the expectations of the patient and family if the physical therapy interventions are to be optimally effective. An understanding of one's own culture and personal values as well as the ability to detach oneself from personal views are essential to providing appropriate family-centered health care that empowers families rather than diminishes their ability to care for their children. This article discusses strategies of moving from not-knowing into knowing as we engage and empower the patients and families we encounter in the ICE setting through a reflective "I CAN DO" model to promote sustainable care. Several case examples are provided which illustrate engaging families and communities in a culturally respectful manner which empowers families long after we leave the ICE setting.

Keywords: International Clinical Experiences, Pediatrics, Culture, Family-centered Care, Not-knowing

Physical therapists and physical therapist assistants are a subset of health care providers taking on new roles in the international setting and becoming involved in global health initiatives. International roles in the global setting include that of clinician, educator, administrator, consultant, and researcher. The American Physical Therapy Association (APTA) revised the Code of Ethics and Standards of Practice to address the broadened roles played by clinicians. These new documents challenge clinicians to reflect upon their own values and beliefs when providing care (APTA 2009a; 2009b). Every patient encounter involves the intersection of several cultures including that of the clinician, the patient, and the culture of health care. International clinical experiences (ICE) are becoming popular for clinicians and students alike. These experiences consist of performing physical therapy duties in a country that is different than the one in which the clinician typically practices or was trained. In crossing borders, whether actual or figurative, the role of culture in practice must be considered whether in the United States or abroad. Often the new international environment and the mood of a given situation may cloud the ability to think clearly and see appropriate possibilities (Klappa 2010). Clinicians often experience the phenomenon of not-knowing when practicing in an international setting. Not-knowing involves four phases progressing toward knowing which include facing limitations, strategizing and improvising, self-doubt, followed by illumination and clarity (Klappa 2010). A model to assist clinicians in self-reflective skills may help

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ease the transition from not-knowing to knowing how to best serve clients and families. Teaching and practice in the United States may not prepare health care clinicians or students to be helpful for the clients and families when serving in a pediatric ICE setting.

Do current pediatric approaches used in the United States benefit or harm those served in an ICE setting? Is the need to self-reflect an important skill in pediatric physical therapy practice in local and international settings? The purpose of this article is to illustrate the need for health care clinicians to stop, reflect, and consider their own values and beliefs as they seek to provide services in the United States or a new international community. We will also present a model for reflection upon rehabilitation roles in the international pediatric setting, integrating the APTA Core Values (APTA 2003) the revised Code of Ethics and Standards of Practice with strategies for recognizing one's own values and biases (APTA 2009 a, b). Finally, we believe the integration of a reflective model will improve client-centered pediatric care within both international settings and our local practices.

A Case of Confusion

A new graduate was presented an opportunity to go to XXXX as part of an international clinical experience. A local health worker requested help with a family who was struggling with their child's disability. The family wanted help from this new graduate physical therapist. The therapist visited the home with a health worker and requested that the mother leave the area as the child began crying and would not cooperate. The therapist began a 'hands on' treatment to address the disability. During this treatment session, another local health worker arrived at the home with a team consisting of an instructor and three physical therapy students from the United States as part of another international clinical experience. The US instructor observed the therapist-child interaction and wondered where the family was at this time. The health workers were confused, the child was distressed, and the new graduate therapist was alarmed at so many visitors interfering with her treatment session. This therapist, the instructor, and the health workers have just encountered the phenomenon of 'not knowing.' Each of these parties may be assisted by reflecting on health beliefs, values and behaviors while considering current best practice for involving families in partnerships.

This case illustrates several difficulties inherent in transferring training from a well-staffed health care setting to working with children of rural, developing countries with less resources and expertise. Each therapist in the case example needs to consider his/her limitations in 'not-knowing' what to do next to facilitate successful interactions for all parties within this situation. Implementing an "I CAN DO" model in this international setting can assist the reflective process when situated in a setting with decreased community health care providers (Meade 2010). Clinicians in the global community may find this mnemonic helpful in delivering best pediatric practice within stressful, unfamiliar environments.

Developing an International Pediatric Service Delivery Model

Clinicians may use the following three components to assist reflection during an ICE and facilitate making a transition from 'not-knowing' to knowing how to best assist families in the care of their child. Presented in Figure 1, this model is composed of the following steps:

1. Preparing for a primary role of reflective clinician as teacher to create sustainable, transferable care.
2. Recognizing the contextual perspectives of culture, health beliefs, and behaviors.
3. Applying best clinical practice (pediatric) frameworks to practice in the international venue.

The Role of Reflective Clinician

Many medical and allied health care educational programs speak of producing graduates who are highly competent, ethical, evidenced-based clinicians who are able to address health needs of society. These statements also hold strong professional practice implications for engaging in the international arena. Physical therapists have developed a newly revised APTA Code of Ethics. Principle one states, "Physical therapists shall respect the inherent dignity of and rights of all individuals" (APTA 2009a). Principle 1B furthermore states, "Physical therapists shall recognize their personal biases and shall not discriminate against others in physical therapy practice, consultation, education, research, and administration" (APTA 2009a). The Standards of Ethical Conduct delineates similar ethical standards for physical therapist assistants (APTA 2009b). Finally, the APTA Core Values Document suggests that physical therapist and physical therapist assistants shall embody these core values in all interactions (APTA 2003). Physician, nursing, occupational therapy, speech therapy, and pharmacy professionals hold similar values (AMA; ANA; AOTA; ASLHA; APA). Although these documents are noble, each clinician is left to determine their own self-reflective strategy for identifying biases and beliefs.

It is important to prepare clinicians and students for the challenges of working with different resources and valuing diverse cultures while developing advanced clinical reasoning skill. The Physical Therapy profession values self-reflection skills based on our Code of Ethics (APTA 2009a). Interestingly, how one thinks determines what one thinks. Benner (2001) noted the differences of clinical reasoning process between experts and novice clinicians. Inherent biases are built into clinical thought processes and are influenced by observer and recall bias, previous experiences and expectations, and quite possibly, by favorite treatment techniques (Wainwright 2010). Since clinical reasoning is influenced by perceptions of the world, it is important to discover what those perceptions are.

Is it right to assume that a clinician's values, beliefs, and ways of doing are not without harm when engaging in a local or international community? How do we foster reflective skills as clinicians and for our students? What steps might help us determine if our medical and allied health care culture blends well and resonates with that of patients, clients, and families no matter where they live?

Recognizing the Role of Culture, Health Beliefs and Behaviors

Royeen and Crabtree (2006, 3) define culture as "the sum of the experiences, values, beliefs, ideals, judgments, and attitudes that shape and give continuous form to each individual." Storti (1999) suggests that culture includes the shared assumptions, values, and beliefs of a group of people which result in characteristic behaviors. Culture may be explained by the model of an iceberg (Peace Corps; Lattanzi 2006). Interacting with someone from another culture, one often notes words and behaviors, similar to experiencing the tip of the iceberg. There is much more below the surface. A person's cultural values and attitudes affect what he or she says and does (Royeen 2006; Storti 1999; Peace Corps; Lattanzi 2006; Spector 2004; Fortes 2008). Those values and attitudes are affected by history, religion, and geography of a given people or country. Communicating effectively with people from other cultures requires looking below the surface at the base of the iceberg.

A mirror analysis assists clinicians experiencing a new culture to make sense of deeply held beliefs and biases. Identifying the how and why of one's feelings helps a clinician understand how these may influence the beliefs and values of the client and family, facilitating effective and respectful treatment. A mirror analysis can help the reflection process by asking: 1) *What may be expected to occur?* 2) *What can change?* 3) *What needs to be asked?* See Table 1. Wondering about the unknown and seeking answers from others on their world views and health beliefs assists the transition to 'knowing.'

If the therapist, the instructor, and students in the above scenario can reflect on the situation they have just encountered, they could create a learning environment of reciprocity. Each person steps back from the situation and uses the mirror analysis to ask themselves what they expected to occur, share these expectations and ask how they feel and why. The mirror model helps the clinician, the instructor, and the students view things differently in a non-threatening environment. Realizing each wants the best situation for the child and family, the group discusses what might change the situation and strategize on what may be needed to proceed in a sustainable manner.

Creating a learning environment which fosters reciprocity allows each person to discuss individual perceptions. Each person shares their own health beliefs and biases. A discussion on the possibility of ethnocentrism and a lack of family partnership in the rehabilitation process ensues. Ethnocentrism is described as "the universal tendency of human beings to think that their ways of thinking, acting, and believing are the only right, proper, and natural ways" to be (Spector 2004, 23). As the group realizes they have common goals, they become comfortable trying to work together and include the family in the interview. Everyone notes each has learned something not considered before the discussion, and that the family provided some interesting and helpful ideas.

Health beliefs are another area under the tip of the iceberg (Fontes 2008). One's personal health beliefs are often assumed to be the same as those held by others. When there is a lack of resonance with the beliefs of patients or clients, problems will occur in providing appropriate care. Recognizing ethnocentric behavior is very important when working across cultures. Fontes (2008, 7) states:

> We need to be especially cautious when working with a person from a culture that is different from our own, where we are less apt to understand the full implications of what we say and do. The risk of accidentally stumbling into an ethical minefield is greater in cross-cultural encounters.

We must consider our perception of the world as we recognize our own health beliefs and values. Beliefs are often so deeply held that it is difficult to understand how or why others might think differently. This skewed view of a situation can result in ethnocentric behaviors. Understanding how clients and family define health and illness is important in interpreting and understanding what patients share about their situation. It also dictates the response to the interventions proposed.

Kleinman's Explanatory Model is useful in determining which health beliefs and system a patient, client, or family may be willing to access and practice (Kleinman 1988). This model involves inquiring into a health problem and allowing the patient or client and family to share health beliefs. Understanding one's values and beliefs helps avoid the idea that clients and their families are being non-compliant in the treatment plan. Valuable insight can be gained on the life context of clients and their families through the use of questions.

The Ladder of Inference is a model proposed by Ross (1994). According to this model, a personal ladder sits in a puddle of data. Each rung on a ladder is labeled as perceptions, beliefs, and truth. As one ascends the ladder, perceptions influence beliefs and beliefs determine truth (Ross 1994). A clinician's beliefs are influenced by the data that makes sense as each ascends the ladder model toward truth. A clinician's perspective of the world is then based on the data selected and beliefs become truth. It then becomes difficult to consider other world views. When utilizing the Ladder of Inference in clinical decision making, clinicians may use erroneous inductive reasoning. Data chosen fits a favored hypothesis. Assumptions are made and too few questions are asked. Too few hypotheses may be considered, leading to inappropriate tests and irrelevant conclusions. Understanding values and beliefs helps avoid the idea that patients, clients, and families are being non-compliant with a treatment plan established without collaboration.

In the opening scenario, each person brought their own ideas and perceptions to the situation. Without providing an opportunity to self-reflect with the group, the situation holds the potential to become competitive rather than collaborative in nature. Within a given realm of physical therapy practice there are always several approaches which provide optimal care. What is helpful in one health care system may not be useful in another. In health care systems where there are limited health care providers or access to care, clinicians must consider their role as teacher and coach in order to create care sustainable and transferable care. Recently, researchers studied how clinicians spend their time in a typical pediatric treatment session, particularly in family-centered practices. Study clinicians expressed surprise that only 4% of each session was spent teaching or coaching parents on applying treatment ideas to daily activities and home environments (Blauw-Hospers 2010). During coaching, ideas are shared, negotiations are made, teaching occurs, and all stakeholders are empowered to carry on once the ICE team leaves the community.

Clinicians may use 'asset-based thinking' to make sense of others' health beliefs and values. Is it possible to view clients, customers, and communities as having strengths? Physical therapy clinicians need to be service providers, not helpers. A *helper* implies a power differential between providers, the patients, clients, or families. A helper, feeling good, will place those being helped in a position of lower power within the therapeutic relationship (Remen 1996). The Andean concept of *Ayni* or reciprocity proposed by Porter and Monard (2001) builds reciprocity into relationships, moving from an attitude of helping to serving and from problem-based vision to asset-based thinking. It provides a concerted effort to move from charity to justice and from service to the elimination of need. *Ayni* concepts allow us "to collaborate with others and to contribute our special talents to the wider society" (Porter 2001, 141). When using *Ayni* concepts in practice, we empower others to become co-collaborators with us in the rehabilitation process. In doing so, we become open to other ways of thinking and understand our own biases and beliefs better.

Returning to the opening scenario, consider how asset-based thinking and the *Ayni* principles may be applied to the case. As the individuals involved in the scenario realize that everyone has come with good intentions, the angst in the situation will be diminished. By creating a safe place to discuss ideas, values, beliefs and philosophy of care, the clinicians will see the good intentions of others. *Ayni* principles highlight that increasing stakeholders in a given situation strengthen the possible outcomes. Clinicians influenced by *Ayni* principles consider parents' and caregivers' wisdom as legitimate sources of knowledge. Clinicians do not hold all the answers. Including family members in the interview, brainstorming, and planning process will contribute to a care plan that is sustainable. In some cultures, the teacher or clinician is seen as the person possessing all knowledge. A foreign health care provider is often highly respected and sought out for help (Klappa 2010). A paradigm shift occurs when considering the *Ayni* model because increasing stakeholders (the parents and/or caregivers) and reciprocity are included in the evaluation and care planning process.

Reflection on one's personal values and beliefs may improve the delivery of pediatric services. During ICE, students and clinicians must prepare themselves to understand how their biases and beliefs may conflict with the health beliefs and values of the culture visited. Applying the Code of Ethics (APTA 2009a) and Standards of Practice (APTA 2009b) in local and international settings allows all cultures to be valued. The next section reviews current evidence for providing pediatric care and partnering with families as part of a reflective practice that will resonate with the family's culture and environment.

Applying Best Pediatric Practice in ICE Settings

Clinicians may consider four evidence-based elements in clinical decision making. The first element is recognizing that *maturation* is only one determinant in child development and this

factor highlights individuality (Mulder 1991). Second, *motor control*, reflects a dynamic systems approach to understanding the complex interactions occurring during development (Heriza 1991). The third element, *the child as the active learner*, highlights that practice is necessary for change to occur (Larin, 2006). And finally, *the parents and family* are the critical environmental supports needed for creating opportunities to learn and practice (Mahoney 2005; Spagnola 2007).

Dynamic system theorists hypothesize that cognitive and motor development occurs as a result of the interplay between multiple systems, not just maturation, which includes the child, the task they are attempting to do or learn, and the environmental context available (Kamm 1991; Pohl 1998). Change in motor skill is related but not determined by age, highlighting that there are other individual and environmental factors that produce change, such as motivation, physical size, and opportunities to practice (Perry 1998). Therapists must consider that both the motor system and the family system are dynamic, view the development of a child within a complex family model, and appreciate that intervention opportunities will come from within this complex system (Perry 1998; Mahoney 2004).

The physical therapy profession has shifted in practice frameworks from the Nagi (1965) model of disability, to the World Health Organization (WHO) International Classification of Function (ICF). The ICF model is an excellent example of asset based thinking. It has three levels, Body Structure and Function, Abilities, and Participation. Practitioners are challenged to plan interventions that will not just affect the first level impairments, or a person's body functions, but look at what an individual's is *able to do*, a person's strengths, with the goal of increasing *participation* in community activities in which peers without a disability participate. This model encourages looking with a more holistic view while learning about the context of patients' and families' lives, in order to plan treatment opportunities which enable each person to actively participate alongside other community members.

Engaging Families

One of the most challenging components of clinical practice is engaging parents in the selection and carryover of treatment plans. Researchers suggest that it is the process of changing parent behaviors that is most critical to changing early child motor skills (Mahoney 2004). Opportunities to engage families can occur through asking questions during the first contact and again when services begin (Meade 2008).

Screening is an excellent opportunity for the first engagement. Screening using a professional's clinical judgment without a standardized test is only about 50% accurate in determining who may have a disability (Glascoe 1993). Evaluating only one system, such as motor milestones, doesn't focus on child and family strengths (Taanla 2005). Opportunities for whom and what to practice to enable abilities or determine in what activities a child may wish to participate are then lost. In contrast, tests which gather information from parents can assist with determining what parents think and want. Glascoe (2002) lists five possible ways of gaining information from parents (parent estimations, concerns, history, predictions, and surveys). Glascoe's findings suggest that only three of the five methods are valid, illustrated by acceptable levels of sensitivity and specificity (Glascoe 2002). These three, parent estimations, comparing their child to others of the same age; parent concerns, answering 10 questions on the Parent Evaluation of Development (PEDS); and gathering data from a survey of current time, as in the ages and stages questionnaires (Squire 1999), are all valid methods. The specific structure of these methods standardizes parent information, and increases validity, confidence, and entry into services (Glascoe 2002).

Using Parent Concerns: An International Example

The PEDS test, one of the valid methods for gathering parent information, was selected as a first contact for parents during an 'all island' screening clinic for ages birth through five, held once each year in all five villages on the island of Kosrae, in Micronesia. The PEDS test was translated into Kosraean (with the authors' permission) to determine if parents had any concerns about their child's development. However, the ability of the PEDS to accurately predict which of the children with parent concerns would actually have a disability (termed the positive predictive value (PPV), is too low, 37%, if it is the only test used. An optimal 70% PPV is recommended by Glascoe (1992). Adding a second test was needed to increase validity.

Parents filled in the PEDS form as they registered for the clinic, filling in their concerns and observations. Clinic staff reviewed concerns and then added a second test to look at other expected age level skills. For children aged between 4–6 months, they added the Meade Movement Checklist (Meade 2009) and for other ages, a screening form developed by David Werner for use in the developing world (Werner 1987).

Concerned families were then asked if they would like a follow-up home visit. At the first home visit, staff members were coached in a reflective, I CAN DO process, so families could be able to assist their children (Meade 2005). Three easy to remember steps guide busy clinicians, particularly in stressful or unfamiliar environments. The steps include I for interviewing, C for collaborative selection of the intervention strategy, and D for Do, closing your session with parents saying, "Yes, I can do this," ensuring that the agreed upon solution can be practiced during the family's daily routine.

Step 1: The Family Interview

Asking questions is an important first step in the transition from not-knowing to knowing. The therapist first gathers information to begin to answer, 'who is this child?' Information from many sources may be needed and the evaluation is a process of discovery. Three questions, what does your child do best, do you believe in practice, and what is most difficult for your child at this time, form the foundation for joint planning with the family (Meade 2008).

A final interview question, how do parents and their child spend a typical day, helps frame concerns and routines within each cultural environment (McWilliams 2001). This information assists coaching families to put practice into their day as part of step 3 of the I CAN DO model, 'Doing'. Once the information has been assembled, the therapist, together with the parents/team will discuss what the information may mean for this child in this family, in this country, in their particular part of the world.

Step 2: Collaborative Problem Solving

The second step in the 'I Can Do' process helps the team organize information from the screening, evaluation, and the interview. Observations of the child in their natural environment may be linked to the subjective interview and objective evaluation data. An example would be a conversation discussing evaluation results:

> I noticed that your primary concern was that your child is not able to stand, and he is 12 months old. You commented in the interview that all the other cousins and the neighbor children are able to stand at this age. When we did the evaluation to learn more, together we noticed that he is very weak in his trunk or middle of the body. This seems to make it difficult for him to hold his body and take weight on his legs when you stand him. Do you think that that is an accurate statement from listening to you, and observing and testing your son?

Parental answers help current thinking and what parents might be ready to do and practice at home. This approach helps discover common misperceptions. In this example, the main concern was standing, until the parents clarified they wanted their son to be off their dirt floor and move independently to a caregiver. Each view results in very different treatment solutions; the first to practice standing, and the second to offer different mobility strategies. Students and clinicians, during the ICE experience, can use this strategy to reflect and then suggest interventions which integrate the parents' attitudes and cultural beliefs toward rehabilitation.

Collaboration requires that both the therapist and family see the child through the same lenses. Comparing a child's ability with their current age helps families understand how difficult change may be for their child (Meade 2008). Discussing the major area of difficulty which the family mentioned in the interview will assist in starting a focused plan. Starting at the point parents are most concerned will ensure their willingness to address this area at home (Glascoe 2002).

Step 3: 'Doing' Through Practice in Everyday Routines

Practice is considered the critical component in early acquisition of a new motor skill (Adolph 2003). Families have the greatest opportunity to influence the amount of practice that an individual will have in an environment, in whatever country they are situated (Mahoney 2004). The interview and collaborative discussion will allow the therapist to link evaluation results to the step parents have described as most important for their child (Erhardt 2005). Parents' information on daily routines will highlight opportunities for movements to be dovetailed into existing activities throughout each day, using local resources which are readily available. If the therapist does all the movements directly with the child, sustaining any changes that may have occurred with the therapist's hands will be nonexistent once the therapist leaves the village. The family will not feel that they have the skills to continue giving the child opportunities to practice what they may have learned, and, wishing to do the best for their child, will spend all their resources pursuing other ways to find another therapist to do the exercises. Families who help determine what will be practiced and when given a chance to learn exactly what to do with the therapist present, using available resources, will respond, "Yes, I can do this."

Selecting the right task for each family is an important consideration of 'DO.' Discovering daily tasks in which parents are already helping their children, provides an excellent starting place to blend movement into daily life. Observe for transitions between positions, particularly lying-to-sit and sitting-to-stand. Teach family members to notice and then coach the child to become independent with each transition. On the island of Kosrae, all adults in the large, extended family help carry new infants, as infant seats are unavailable. This strategy provides an early opportunity to adapt upright positions. Early head control and limited misshaping of the head result from these practices, illustrating the value of building treatment ideas around traditional methods which are already in use. (See Figure 2.) Authors van der Dussen et al (2001) describe mobility, communication, and activities of daily living (ADLs) as areas in which rehabilitation personnel have had a positive influence on client function and focus treatment at the ICF level of participation. However, they also challenge clinicians to focus on the unsuccessful areas of educational achievement, employment, and *participation* for community members with a disability (van der Dussen 2001).

Transitioning to a Primary Role as Teacher

Reflecting on thinking and decision making is an important strategy in improving clinical reasoning and in the transition to expert practice and a teaching role (Benner 2001; Wainwright 2010). Transitioning to a teaching role requires clinicians to willingly inquire into the thinking and reasoning of others in a non-threatening, collaborative manner (Kleinman 1988; Blauw-

Hospers 2010). Valuable treatment time is spent in discussion as a critical element in service delivery. Reflecting on the case using the mirror model strategy allows the team to develop sustainable strategies which empowers families. See Table 1 for this process.

The Introductory Case Revisited … Confusion Cleared

The therapist, the instructor, and students from the US in the opening scenario all reflect on the situation they have just encountered. They step back from the situation and ask themselves how they are feeling and why. This strategy allows each person to begin a discussion on their perceptions of what they have witnessed. Each person shares the expectations of what they believe was supposed to occur. They also share their own health beliefs and biases using the mirror analysis model. A discussion on the possibility of ethnocentrism occurs. The lack of family partnership in the rehabilitation process is also discussed. As the group realizes they have common goals, they become comfortable trying to work together and decide to include the family in the interview. When the mother of the child returns, the entire team begins a family interview. What are the family's views of the child? What does the child do best? What is the biggest difficulty facing this child in this family at the moment? (**INTERVIEW**) *As the interview is progressing, another health visitor arrives with an ICE group. The therapist asks the family if the group could be part of the planning for a home program. The family agrees and the group listens to the interview and then breaks into small groups to discuss possible solutions with the instructor's coaching. The therapist continues to discuss how the family sees opportunities for practice in their environment considering their concerns. After 15 minutes, the instructor and class regroup. The instructor offers three suggestions which were developed by the student groups. The family, health visitors, therapist, and instructor all discuss pros and cons of each idea.* (**COLLABORATION**) *The family finally selects the idea they think will work best in their home. The therapist models teaching the family members the specific handling skills needed as the child tries the activity. Once the family says 'Yes, we can do this at home', everyone is thanked for their input and the therapist closes the visit with pictures of the family and child doing the activity with thanks to all the students for their creative assistance.* (**DO**)

Summary and Conclusions

Practitioners must reflect on their work in the United States and in the international setting by asking difficult questions. What is the focus of our interventions? Are we ensuring that families are the decision makers? Are we promoting sustainability? Does our input impact quality of life (QOL)? Is there participation and by whom?

This article has presented clinical, reflective practice models for engaging clients and families in international practice settings. Moving from a position of not-knowing to knowing includes recognizing one's cultural beliefs and biases. Background information on recognizing health beliefs, behaviors, and ethics allows therapists to successfully transform their pediatric approach into a sustainable effort. Several models of clinical self-reflection are presented to facilitate optimal engagement of all parties in pediatric ICE environments. Using a reflective process, such as an I CAN DO model when working with children and families provides one strategy for insuring sustainable interventions. Recognizing that poor care may result from a lack or reflection, possible ethnocentrism, miscommunication or reinforcement of stereotypes encourages clinicians to reflect and engage stakeholders, from assessment through to practice, moving toward community participation for all.

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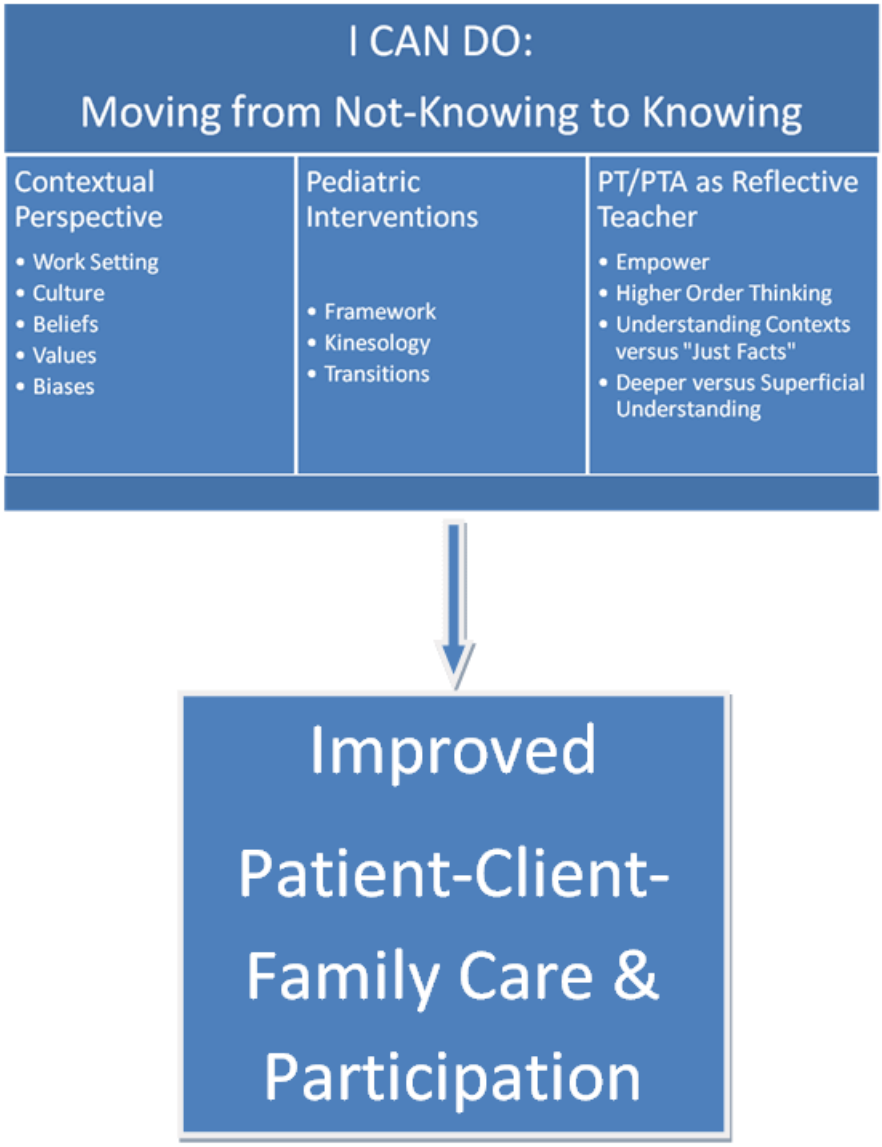

Figure 1: I CAN DO Model for Sustainable Pediatrics Practice in the International Setting

Figure 2: Photograph of Two-month Old Kosraean Baby in Traditional Holding Position

Table 1: The Mirror Model Strategy

• **What can we accept?**   • Health workers are very limited in numbers in the developing world, so focus on teaching others to promote sustainable changes for community members with a disability in poor resource areas.

• **What can we change?**
  • Recognize that a medical expert model can be harmful if a transition to sustainable care does not occur.
  • Engage families from first screening assessment through planning.
  • Promote sustainable change using strategies such as a reflective 'I CAN DO' approach with families

• **What do we need to ask?**
  • How do different cultures influence opportunity to practice every day?
  • How can clinicians deliver sustainable changes through students and families?

ABOUT THE AUTHORS

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