Draping Education to Promote Patient Dignity: Canadian Physiotherapy Student and Instructor Perceptions

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ABSTRACT

Purpose: To determine the perceptions of educators and students in Canadian entry-level professional physiotherapy programmes with respect to the current draping curriculum and the methods of delivery of that content and to determine if there is a need for additional draping education time and resources in these programmes. **Methods:** Canadian university physiotherapy students ($n = 127$) and educators ($n = 183$) completed questionnaires designed by the authors. Data were collected via Survey Monkey, exported as Excel files, and analyzed using descriptive statistics and Pearson chi-square analysis. **Results:** Students and educators agreed that dignity as a concept and draping as a skill to protect patient dignity are both important and should be included in Canadian physiotherapy curricula. Respondents also agreed that students often have difficulty with draping. Educators identified barriers to teaching draping while students identified components of an effective educational resource on draping. **Conclusions:** To enhance the development of effective draping skills among entry-level physiotherapists, draping education should be included in Canadian physiotherapy curricula. An effective draping educational resource should be developed for educators and students.

Key Words: draping; human dignity; physical therapy; education, professional; questionnaires.

RÉSUMÉ

Objectif : Préciser les perceptions des éducateurs et des étudiants dans des programmes de niveau d'entrée en physiothérapie face au programme de cours en drapement et à la façon dont cette formation est enseignée afin de déterminer s'il serait nécessaire de consacrer plus de temps et plus de ressources à la formation en drapement des patients. **Méthode :** Des étudiants en physiothérapie canadiens ($n = 127$) et des enseignants ($n = 183$) ont rempli des questionnaires conçus par les auteurs. Les données ont été recueillies à l'aide de l'outil Survey Monkey, exportées sous forme de fichier Excel, puis ont fait l'objet d'une analyse en statistiques descriptives et d'une analyse du khi-carré de Pearson. **Résultats :** Les étudiants et les enseignants s'accordent pour dire que la notion de dignité et le drapement en tant que compétence ont tous deux leur importance et doivent être inclus dans les programmes de cours en physiothérapie au Canada. Les répondants se disent également d'accord sur le fait que les étudiants éprouvent souvent des difficultés avec le drapement. Les formateurs et les enseignants ont précisé les obstacles à l'enseignement du drapement et les étudiants ont identifié les composantes d'une ressource éducative efficace pour l'enseignement du drapement. **Conclusions :** Pour améliorer l'acquisition de techniques de drapement efficaces chez les étudiants débutants, une formation en drapement devrait être incluse dans les programmes de cours en physiothérapie au Canada. Une ressource éducative efficace sur ces techniques devrait également être produite à l'intention des éducateurs et des étudiants.

Human dignity is a concept that relates to many elements of patient care. Dignity is defined as an expression and interpretation of ideas about ethical propriety intuitively shared by a group.¹ Kant viewed dignity as an intrinsic, unconditional worth or worthiness, whereby humans should be considered as rational beings capable of making their own decisions.²

Patient dignity is a concept that has been discussed

and scrutinized for centuries.³ Dignity is associated with many elements of health care, and the term is used and understood by health care workers and patients. Dignity has been identified as an important factor in clinical care.⁴

In an attempt to understand how the term “dignity” is understood and used in the literature, a concept analysis of dignity was performed by Griffin-Heslin,⁵ who

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determined that dignity is complex and encompasses elements of respect, autonomy, empowerment, and communication. For a person to have dignity, multiple antecedents must exist: the person must have perceived dignity in himself/herself, must be in circumstances in which he/she feels competent, and must be autonomous. However, it is important to note that this concept of dignity may not apply to all cultures.

Jacobson⁶ conducted a grounded theory analysis to understand the violation of dignity in health care settings. Following an analytical review of the literature and interviews with nine experts in the theory and practice of health and human rights, Jacobson⁶ conducted interviews with 55 people concerning the lived experience of dignity. The author discovered that violations of dignity in health care can occur through rudeness, indifference, condescension, dismissal, disregard, dependence, intrusion (including threats to modesty and personal privacy), objectification, restriction, labelling, contempt, discrimination, revulsion, deprivation, assault, and abjection. This investigation of how dignity may be violated in health care settings provided a very strong analysis from a methodological perspective, but used a relatively small sample.

Whitehead and Wheeler⁷ conducted a literature review of patients' experiences of privacy and dignity. They concluded that privacy and dignity are fundamental human needs and that the two concepts are related. They also concluded that the dignity of elderly patients is affected by hospital designs and nursing interventions, and that older individuals value self-dignity and self-worth. Patients in rehabilitation settings value being respected as human beings, being involved in their own care, and staff who are sensitive to their needs and communicate meaningfully with them. The dignity of child-bearing women depends on clinicians' respecting the woman during clinical interactions. The authors concluded that dignity is a "sense of calm, serious awareness and style that shows suitable formality and worthiness. It is an experience of a high-ranking position... To help patients preserve their dignity is to accord them respect, e.g. their need for solace, confidentiality, personal space, and boundary."^{7(p.384)}

Baillie⁸ synthesized into a model of dignity the numerous factors that promote or threaten patient dignity. These findings were based on a qualitative study of a 22-bed surgical ward in an acute-care hospital in England that involved conducting patient ($n = 24$) and nurse ($n = 19$) interviews. Baillie's model places the patient as the central figure in a dynamic interplay among those factors that promote patient dignity and those that threaten that dignity, taking into account staff, patient, and environmental influences. Factors that threaten dignity include: curtness, authoritarianism, breaching confidentiality, impaired health, older age, the hospital system, and a lack of privacy. Components that promote dignity include: providing privacy, therapeutic inter-

actions, the ability to control the situation, attitudes, relationships with staff, relationships with other patients, culture/leadership, and a conducive physical environment. This model is a useful mental framework for considering the topic of patient dignity.

One component of dignity that has been recognized in the literature is draping.⁹ The literature on draping is sparse; most studies that address draping as a method of maintaining dignity were conducted with women,^{7,10–20} older populations,^{21–27} and hospital inpatients,^{9,12,19,26,28,29} although draping has also been addressed in connection with dignity for people receiving therapeutic massages, patients undergoing cardiorespiratory assessments,^{30,31} individuals of the Islamic faith,^{32,33} those with acquired brain injuries,³⁴ and those with spinal-cord injuries.³⁵ The concept of dignity for patients has been investigated primarily through descriptive studies and qualitative research.

Draping is an important component of maintaining patient dignity, and it is a practical skill that can be taught and objectively evaluated in the entry-level education of health care professionals, and reinforced with practicing health care providers. However, despite the clear importance of draping in clinical settings, patients report that healthcare providers do not always protect their dignity through appropriate draping techniques.²⁵

Numerous authors state that there is a need for education related to dignity and draping,^{25,29,36–41} but there is no consensus on the most appropriate method of providing this education. Moreover, the various draping directions to maintain patient dignity that are provided in the literature are vague and emphasize different aspects of draping procedures.^{11,14–16,22,25,28,30,31,42–44}

Although it is undoubtedly necessary for a clinician to be aware of individual patients' preferences related to draping, bodily exposure, and touch, it is also prudent for health practitioners to be aware of the impact of culture.⁴² The experience of health and illness is affected by culture and religion, and a misunderstanding of cultural difference may create obstacles to providing the best possible treatment.¹² Cultural differences related to draping and physical exposure among cultures such as Aboriginal,⁴⁵ Chinese,²⁰ South Asian,³² and Latino¹²; religions such as Islam,^{12,32,33} Christianity, and Orthodox Judaism³³; and elderly populations³² have been cited in various studies in the literature.

One might surmise from the above discussion that health care professionals assume they have been sufficiently educated in draping techniques during their entry-level education. However, the perceptions of the recipients of that care suggest that this may not be the case.

The aim of the present study was to add value to this body of knowledge to educational programmes and, by extension, to clinical practice, by investigating both current practices in entry-level draping education, and students' and educators' perceptions of that education.

The first step was a descriptive quantitative study, undertaken in entry-level Canadian physiotherapy programmes, to answer the following research questions:

1. What are the perceptions of the current draping content, and methods of delivery of that content, of educators and students in entry-level professional physiotherapy programmes?
2. Is there a need for additional time and resources to be devoted to draping education, and what components of a draping education resource are requested by entry-level physiotherapy students?

METHODS

Study design

Our study was a descriptive study incorporating questionnaires (see Appendix) with both closed- and open-ended questions.

Questionnaires

We designed two questionnaires to investigate how draping is taught and learned in the professional entry-level education of Canadian physiotherapy students (Appendix). These questionnaires were also designed to elicit respondents' perceptions related to draping, draping education needs, and current draping practices of students and clinicians in the clinical setting. In the absence of available tools to survey this body of information, we designed the questionnaires to comprehensively examine the research questions. Our author group included an inter-professional group of two health sciences academics and two health sciences students (one of each in medicine and physiotherapy).

To illustrate how culture may affect the specifics of educational curricula, two distinct cultures in Canadian society were selected at random, and the terms that these cultures associate with the concepts of dignity were used in queries on the questionnaires. One term provided to participants was *awrah*, a term used in Islam that denotes the intimate parts of the body (for both men and women) which must be covered with clothing. Exposing the *awrah* is unlawful in Islam and is regarded as sin. The exact definition of *awrah* varies, however, among different schools of Islamic thought. Participants were also asked about the term *tzniut*, a Hebrew term used in Judaism to describe both the character trait of modesty and humility, and a group of Jewish religious laws pertaining to conduct in general, and especially between the sexes. The notion of *tzniut* exerts its greatest influence within Orthodox Judaism; it is frequently used with regard to the rules of dress for women.

Participants and procedures

We selected a targeted sample of Canadian physiotherapy students and educators. Group 1 consisted of students currently enrolled in Canadian professional entry-level university physiotherapy programmes (PTS).

Group 2 consisted of educators (faculty members in physiotherapy departments as well as clinical instructors for student placements) from Canadian professional entry-level physiotherapy programs (PTE).

The student physiotherapy questionnaire was sent to a representative from each physiotherapy programme in Canada, with a request that it be distributed to students currently enrolled in the programme. Three months after the first round went out, a second round of requests was sent to each school that had not responded to the original request to distribute the questionnaire. The one exception to this recruitment protocol was the questionnaire mailed directly to Queen's University physiotherapy students by the investigators. The Queen's students who completed the questionnaire could be tracked in SurveyMonkey (<http://www.surveymonkey.com>), and so a second round of requests was sent to each student who had not responded to the original request. The physiotherapy educators' questionnaire was sent to the Academic Coordinator of Clinical Education of each physiotherapy programme in Canada, with a request that it be distributed to all clinical educators involved in the physiotherapy programme. All questionnaires were accessed through SurveyMonkey in August 2009.

Ethics approval to undertake the study was obtained from the Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board on May 28, 2009. Included in the request to participate in the study for each participant was a clear description of the purpose of the study and study procedure to ensure informed consent. Emphasis was placed on voluntary participation and confidentiality of information to protect the participants.

Data analysis

Data were collected via SurveyMonkey, meaning that respondents entered their own data. Because the SurveyMonkey tool only allows participants to select one of the available response options (i.e., incorrect or out-of-range responses could not be entered), further cleaning of the data was not necessary. Data were exported as a series of Excel files and imported into SPSS version 17.0 for Windows (SPSS Inc., Chicago, IL) for statistical analysis. We examined the questionnaires to identify items that were similar across respondent groups, and combined the databases to facilitate these comparisons. Following a descriptive analysis (using frequencies and percentages for the closed-ended questions, and print-outs of the open-ended questions), we compared the responses of the groups, where possible, using Pearson chi-square tests. Statistical significance was set at $p < 0.05$. Comparisons that fell short of statistical significance were also noted if they were deemed to be of clinical interest. The open-ended questions were not formally assessed using qualitative methods, as the quantitative work was extensive, but were reviewed to facilitate an understanding of the responses to the closed-ended items.

RESULTS

In total, 127 Canadian PTS and 183 Canadian PTE from a possible 13 different Canadian universities completed the respective questionnaires. We cannot calculate the definite response rate, as the respondents were contacted indirectly; however, four universities confirmed that they distributed the questionnaires to a total of 341 PTS, and six universities confirmed that they distributed the questionnaires to an unknown number of PTE.

The majority of the respondents were female (78.9% PTS, 86.3% PTE). Most PTS (96%) were born between 1980 and 1989. Other respondents were born in 1964 (0.8%), 1977 (0.8%), and 1979 (2.5%). Most of PTE reported that their physiotherapy education consisted of a Bachelor of Science degree. Some PTE reported that they also held a diploma, master's degree, or doctorate in physiotherapy. PTE reported working in outpatient clinics (17.4%), emergency departments (1.8%), intensive care units (4.9%), hospital wards (14.4%), home care (4.3%), long-term care (3.4%), and schools (1.2%). The remaining 52.6% of respondents did not specify a work location or did not provide employment information.

Importance of draping in Canadian physiotherapy curricula

Table 1 shows participants' responses to several items relating to the importance of draping in Canadian physiotherapy curricula. Both PTS and PTE said they believe it is important to learn proper draping (Item 1), and that draping has an impact on patient dignity (Item 2); PTE had stronger beliefs than PTS (80% of PTE, but only 62.2% of PTS, strongly agree). Both groups acknowledged that students often have difficulty with draping (Item 3); in this case PTS (68.5%) agreed more than PTE (52.2%).

Table 2 shows responses to items related to teaching draping. While most PTE (91.2%) agreed that specific draping skills should be taught within PT curricula (Item 1), only 60.4% of PTE reported explicitly teaching

proper draping techniques to students (Item 2). Similarly, 63.8% of PTE reported that they define the appropriate draping for each area being examined when teaching students (Item 3), but only 25.1% of students reported learning draping in a step-by-step fashion (Table 3, Item 3), and only 24.4% reported learning draping in the context of each physical exam (Table 3, Item 4).

Significant differences also emerged when respondents were asked if additional time in the physiotherapy curriculum should be spent on proper draping (Table 1, Item 4). Most PTS (60.6%) responded positively, whereas only 29.2% of PTE agreed and many (32.6%) said they have no opinion or do not know whether additional time should be spent on proper draping.

PTE and PTS were divided in their opinions on whether the draping techniques taught in PT curricula are the same as those used in clinical practice. Approximately half of PTE (47.9%) said they feel the draping techniques taught in school are often or always the same as those applied in clinical practice; 48.0% of PTS said they feel there is a discrepancy between the two (Table 3, Item 6). When those who did not have an opinion on the matter were eliminated, 64% of PTS said they feel there is a discrepancy between the two. Furthermore, 70.0% of PTS said that the expectations for draping during objective structured clinical examinations are not clearly defined (Table 3, Item 7).

When asked about exposure of the anterior thorax during precordium and cardiovascular examinations, most PTE (87.2%) and PTS (71.7%) said they feel it is never or rarely appropriate to perform an entire examination of a patient's anterior thorax with the thorax fully exposed (Table 1, Item 5). Similar numbers of PTE (87.2%) and PTS (64.4%) agreed that it is not appropriate to expose the entire anterior thorax for respiratory examinations (Table 1, Item 6). The students exhibited more uncertainty, however: many said they do not know

Table 1 Responses of Students and Instructors on the Importance of Draping in Canadian Physiotherapy Curricula

Item	No. of respondents and (%)		
	Students; <i>n</i> = 127	Instructors; <i>n</i> = 182	<i>p</i> -value
1. Important to learn proper draping	124 (97.6)	181 (99.4)	0.30
2. Draping has impact on patient dignity	124 (97.6)	175 (96.2)	0.007*
3. Students have difficulty with draping skills	87 (68.5)	95 (52.2)	0.012
4. Additional time should be spent on proper draping	77 (60.6)	52 (28.6)	<0.001
5. Disagree: when examining precordium and cardiovascular system, patient should expose entire anterior thorax at one time	82 (64.6)	129 (70.9)	<0.001
6. Disagree: when examining respiratory system, patient should expose entire anterior thorax	91 (71.7)	129 (70.9)	0.001
7. Disagree: when auscultating the precordium I leave patient exposed with drape removed from anterior thorax	96 (75.6)	140 (76.9)	<0.001

*Values represent frequencies for "agree" and "strongly agree" combined; or "often" and "always" combined, unless otherwise noted. Statistical significance (based on Pearson χ^2 tests) may therefore be attained even when frequencies appear similar, due to differing proportions in the agree/strongly agree categories.

Table 2 Responses of Instructors on Teaching Draping in Canadian Physiotherapy Curricula

Item	No. (%) of respondents; <i>n</i> = 182
1. Draping skills should be taught in the curricula	166 (1.2)
2. I explicitly teach proper draping techniques	93 (51.1)
3. I define appropriate draping for region examined	97 (53.3)
4. Draping techniques taught in school same as in clinical practice	89 (48.9)

Note: Values represent frequencies for “agree” and “strongly agree” combined; or “often” and “always” combined.

Table 3 Responses of Students on Learning Draping in Canadian Physiotherapy Curricula

Item	No. (%) of respondents; <i>n</i> = 127
1. Exposing key body parts is necessary	123 (96.9)
2. I often have difficulty knowing what is appropriate	57 (44.9)
3. I learned draping in clear step-by-step fashion	32 (25.1)
4. Learned in each physical examination	31 (24.4)
5. Draping is underemphasized in clinical education	57 (44.9)
6. Discrepancy between teaching and practice	61 (48.0)
7. Expectations in examinations are not clearly defined	89 (70)

Note: Values represent frequencies for “agree” and “strongly agree” combined; or “often” and “always” combined.

the correct response (Item 5: 17.3%; Item 6: 9.4%). The statistical significance of the differences on these two items arises from this uncertainty; when students who disagreed and those who said they are not sure are combined, the values are similar to the number of PTE who disagreed with these two statements.

Barriers to teaching draping

Physiotherapy educators reported various barriers to their ability to teach draping to PTS, including insufficient time, insufficient instructor knowledge, absence of draping from the curriculum, poor definition of draping in the curriculum, lack of draping materials, lack of educational resources, lack of willing volunteers, precedence accorded to other skills, draping skills not being important in actual clinical practice (as evidenced by colleagues not implementing effective draping skills consistently in clinical practice), and students' lack of enthusiasm for the subject matter (see Table 4).

The difficulty of draping

Physiotherapy students perceive different physical examinations as varying in level of draping difficulty. Draping for pelvic, hip, respiratory, cardiovascular, and

lumbo-sacral physical examinations is considered to be difficult; by contrast, draping for abdominal and central nervous system examinations is reported as neither easy nor difficult. Draping for wrist and elbow, knee and ankle, shoulder, and peripheral nervous system examinations is considered easy (see Table 5).

There are various aspects of draping that PTS reported as being difficult. The most difficult aspects included personally manipulating the draping materials, communicating with the patient, being aware of the patient's comfort level, maintaining the patient's modesty, physically touching the patient, and communicating with other health professionals (see Table 6).

Learning draping

The majority of PTS would appreciate more draping education for respiratory and cardiovascular examinations. However, the majority do not feel that additional education would be necessary for knee and ankle, hip, abdominal, wrist and elbow, head and neck, cranial nerve, shoulder, peripheral nervous system, central nervous system, or lumbosacral physical examinations (see Table 7).

Students indicated that the best methods for learning draping are demonstrations, volunteer patients, instructor led teaching, and videos. Textbooks and Internet-based resources were identified as the poorest methods for learning draping (see Table 8, Items 1–6).

Culture

With respect to cultural accommodations, 65.4% of PTS said they feel comfortable accommodating patients with specific cultural modesty concerns, and 79% of PTE feel comfortable teaching students how to accommodate such concerns (Table 9, Item 1). PTE reported feeling more comfortable with these accommodations. Only 7.9% of PTS and 5.7% of PTE reported being aware of the cultural concept of *awrah* (Table 9, Item 2), and only 3.1% of PTS and 4.0% of PTE said they are aware of the cultural concept of *tzniut* (Table 9, Item 3).

DISCUSSION

It has been suggested in the literature that draping is a component of dignity for a variety of patients.⁸ The results of our study support this view: almost 100% of Canadian PTS and PTE participating in this study also believe that draping has an impact on patient dignity (Table 1, Item 2). Draping is one component in a complex interplay of multiple factors that affect a patient's perception of dignified care. It is therefore important to recognize that skillful draping, in isolation from other components included in a dignified encounter, would not be sufficient to maintain a patient's dignity.

Although most of the Canadian PTS and PTE surveyed said they believe it is important for PTS to be taught how to drape appropriately (Table 1, Item 1), and PTE believe that draping skills should be included in the curriculum

Table 4 Instructor's Perceived Barriers to Teaching Draping ($n = 140\text{--}148$)

Barrier	No. (%) of respondents			
	No impact	Minor impact	Moderate impact	Major impact
1. Insufficient time	56 (37.8)	48 (32.4)	37 (25.0)	7 (4.7)
2. Insufficient instructor knowledge	37 (25.2)	59 (40.1)	37 (24.2)	14 (9.5)
3. Draping not included in the curriculum	46 (32.4)	39 (27.5)	46 (32.4)	11 (7.7)
4. Draping is poorly defined within the curriculum	34 (23.8)	39 (27.3)	54 (37.8)	16 (11.2)
5. Lack of draping materials	88 (59.5)	26 (17.6)	17 (11.5)	17 (11.5)
6. Lack of available draping educational resources	33 (22.9)	49 (34.0)	44 (30.6)	18 (12.5)
7. Lack of willing volunteers	70 (50.0)	45 (32.1)	16 (11.4)	9 (6.4)
8. Other skills take precedence	36 (25.4)	36 (25.4)	39 (27.5)	31 (21.8)
9. Draping is not important in actual clinical practice	76 (53.1)	25 (17.5)	26 (18.2)	16 (11.2)
10. Students lack enthusiasm for subject matter	60 (42.0)	53 (37.1)	19 (13.3)	11 (7.7)

Table 5 Student's Perceptions of Draping Difficulty during Physical Examinations ($n = 118\text{--}122$)

Examination	Degree of difficulty; no. (%) of respondents			
	Easy	Neither easy nor difficult	Difficult	N/A
1. Cranial nerve	78 (66.1)	2 (1.7)	1 (0.8)	37 (31.3)
2. Head and neck	112 (92.5)	3 (2.5)	2 (1.7)	4 (3.3)
3. Shoulder	90 (74.4)	14 (11.6)	14 (11.5)	3 (2.5)
4. Wrist and elbow	114 (95)	2 (1.7)	1 (0.8)	3 (2.5)
5. Respiratory	16 (13.2)	20 (16.4)	80 (65.6)	6 (4.9)
6. Cardiovascular	17 (14.1)	21 (17.4)	75 (61.9)	8 (6.7)
7. Peripheral neurological	74 (61.2)	16 (13.2)	13 (10.7)	18 (14.9)
8. Abdominal	42 (35.2)	29 (24.4)	29 (24.4)	19 (16.0)
9. Pelvic	9 (7.4)	12 (9.9)	85 (70.2)	15 (12.4)
10. Hip	20 (16.8)	15 (12.6)	81 (68.0)	3 (2.5)
11. Knee and ankle	111 (91.8)	6 (5.0)	1 (0.8)	3 (2.5)
12. Central neurological	28 (23.1)	31 (25.6)	16 (13.2)	46 (38.0)
13. Lumbo-sacral	30 (24.8)	25 (20.7)	54 (44.7)	12 (10.0)

(Table 2, Item 2), only one-quarter of students reported having learned draping techniques in each of the physical examinations they had been taught (Table 3, Item 4). It is not surprising, therefore, that both groups feel that PTS often have difficulty with draping skills (Table 1, Item 3).

Although nearly 100% of PTE said they believe it is important for PTS to learn how to properly drape (Table 1, Item 1), only about two-thirds said they "often" or "always" teach students draping techniques (Table 2, Item 2). There is a clear incongruity between these opinions and the PTEs' report that draping is not well defined or included within the curriculum (Table 4, Items 3–4). If PTE are unaware of where draping education is included in the curriculum, if they believe it is the responsibility of another educator or feel it is not expected in the curriculum, it will be lacking or under-emphasized in the course.

Interestingly, most PTS feel that draping is properly emphasized in clinical education (lab-based learning as well as clinical placements; see Table 3, Item 5), yet they believe more time and resources should be spent on draping (Table 1, Item 4). These findings are not incompatible, in light of the fact that 68.5% students reported difficulty with draping skills (Table 1, Item 3) and just under half reported difficulty knowing what draping skills are appropriate (Table 3, Item 2). Students may have low self-efficacy in their clinical skills even though the evaluation of their actual skills would suggest a higher level of competence.⁴⁶ More time and resources would address these concerns.

Like the PTS, nearly half of PTE respondents who expressed an opinion on the matter feel that there is a need for additional draping resources and education time (Table 1, Item 4). However, 70.2% reported that insufficient time has either "no impact" or "minor impact"

Table 6 Student Responses on the Difficult Aspects of Draping

Aspect	No. (%) of respondents <i>n</i> = 127
Personally manipulating the draping materials	63 (49.6)
Communicating with the patient	62 (48.8)
Being aware of patient's comfort level	59 (46.5)
Maintaining the modesty of the patient	43 (33.9)
Physically touching the patient	12 (9.4)
Communicating with other health professionals	4 (3.1)

Table 7 Student Responses on Physical Examinations in which Additional Draping Education Is Desired

Examination	Additional draping education desired; no. (%) of respondents; <i>n</i> = 127
1. Knee and ankle	2 (1.6)
2. Hip	54 (42.5)
3. Respiratory	69 (54.3)
4. Cardiovascular	70 (55.1)
5. Abdominal	39 (30.7)
6. Wrist and elbow	2 (1.6)
7. Head and neck	3 (2.4)
8. Cranial nerve	15 (5.1)
9. Shoulder	13 (10.2)
10. Peripheral neurological	(8.7)
11. Central neurological	33 (26.0)
12. Lumbo-sacral	69 (54.3)

(Table 4, Item 1) and 56.9% said a lack of resources has “no impact” or “minor impact” (Table 4, Item 6) as a barrier to teaching draping.

The barriers to teaching draping identified by PTE included: precedence accorded to other skills, poor definition of draping in the curriculum, a lack of available draping educational resources, and absence of explicit attention to draping in the curriculum (see Table 4). Additional exploration of these difficulties would aid in the development of educational materials for PTE.

The majority of PTS said they do not feel the draping expectations in objective structured clinical examinations are clear (Table 3, Item 7), and approximately half feel there is a discrepancy between in-class expectations and expectations in clinical practice with respect to draping (Table 3, Item 6). Given the absence of consensus on the most appropriate method of draping,^{25,29,39,41} and the fact that draping directions in the literature are vague and emphasize different aspects of draping procedures,^{11,14–16,22,25,28,30,31,42–44} it is understandable that PTS reported these incongruities.

Table 8 Student Responses on the Best Methods to Learn Draping

Method	No. (%) of respondents; <i>n</i> = 127
1. Demonstrations	116 (91.3)
2. Volunteer patients	73 (57.5)
3. Instructor-led teaching	66 (52.0)
4. Videos	58 (45.7)
5. Textbooks	12 (9.4)
6. Internet-based resources	9 (7.1)

There are various aspects of draping that can be considered difficult for PTS. In the data we found that personally manipulating the draping materials is a fundamental skill related to draping and is the draping skill that students find to be most difficult (Table 6, Item 1). Communicating with the patient has also been rated as a difficult aspect of the draping experience for students (Table 6, Item 2). Another aspect of draping that PTS perceive to be difficult is being aware of the patient's comfort level (Table 6, Item 3). Changing perceptions related to each individual's meaning of dignity leads to the acceptability of different levels of exposure. Students need to learn to interpret the comfort level of each individual patient.⁴⁷

The physical examinations that students perceive as difficult to drape for are of areas of the body located in close proximity to the sexual organs (pelvic, hip, respiratory, cardiovascular, and lumbosacral; see Table 5, Items 5, 6, 9, 10, and 13). These areas of the body are very rarely displayed in public situations. Draping for peripheral physical examinations, on the other hand, is not perceived to be difficult (Table 5, Items 1, 2, 3, 4, 11, 12). This is consistent with the fact that these areas are far from the sexual organs, are typically deemed acceptable for public exposure, and therefore have a higher threshold for the amount of exposure considered acceptable.

More PTS than PTE said they feel it is appropriate to expose a patient's anterior thorax during cardiovascular and respiratory examinations (Table 1, Items 5–6). This fits with the fact that PTS identified cardiovascular and respiratory draping as two of the four most difficult draping skills (61.9% and 65.5% respectively; see Table 5, Items 5–6), and more than 50% desire additional draping education in these areas (Table 7, Items 3–4). Despite similar low levels of awareness of two specific cultural concepts of modesty (*awrah* and *tzniut*) among both PTS and PTE (see Table 9, Items 2–3), students feel less comfortable about accommodating patients with culture-specific modesty concerns than PTE feel about teaching students how to accommodate such concerns (see Table 9, Item 1). Since PTS perceive greater difficulty with their draping skills in general than PTE perceive (Table 1, Item 3), it is feasible that their lack of

Table 9 Responses on Cultural Accommodations

Item	No. (%) of respondents		<i>p</i> -value
	Students; <i>n</i> = 127	Instructors; <i>n</i> = 182	
1. Comfortable accommodating patients with specific cultural modesty concerns	83 (65.4)	143 (79)	0.011
2. Aware of awrah	10 (7.9)	10 (5.5)	0.45
3. Aware of tznit	4 (3.1)	7 (3.8)	0.77

confidence around making cultural accommodations during draping is a result of their difficulty with draping in general, and does not indicate a lack of cultural sensitivity.

Our research has several limitations. First, although the design of the study was appropriate to address the research questions, it did not enable us to determine causal relationships, and there is consequently an absence of internal validity. The questionnaires, although based on an extensive systematic review of the literature, were not validated; they were created in the absence of a tool considered to be a gold standard in this area of investigation.

The results of the study are subject to limitations based on the configuration of the sample population and their interpretation of the survey questions. Although it is plausible that the population surveyed could have clinical backgrounds in other health care disciplines in addition to physiotherapy, the results of the survey cannot be generalized to other disciplines or geographical regions not represented in the data. Further, because participants were contacted indirectly through physiotherapy programme administrators, it is impossible to know with certainty how many PTS and PTE were invited to participate in the study. Although the study was intended to be a national analysis of draping education in physiotherapy programmes, the results represent only 7 out of 13 schools and 10 out of 13 Canadian provinces and territories.

Another limitation of our study is that because the student population surveyed had not yet completed their academic studies, it is possible that they had not acquired all the draping education provided in their respective curricula. It may be that students at programme graduation would have acquired additional draping education that would have affected their responses to the survey.

Lastly, the composition of the two responder groups (PTS vs. PTE) required that we include questions not posed to both groups, so as to examine their unique perspectives of draping education. Consequently, the questionnaire content between groups was different.

Application of Results

Questionnaire findings indicate that physiotherapy programmes should include and define draping edu-

cation and skills within the physiotherapy curricula in Canada. Our study results could be used to guide this curricular planning.

Recommendations

Our survey confirms the need to develop appropriate educational resources for both physiotherapy students and educators in Canada. These resources would then need to be formally evaluated to determine whether improved confidence and performance in draping resulted. Given that the majority of PTS surveyed indicated that they consider instructor demonstrations the ideal method of learning draping, a more thorough exploration of the difficulties that limit instructors' abilities to teach draping would be indicated. An effective tool would benefit both educators and learners. Volunteer or standardized patients specifically trained to offer advice and feedback on draping might prove to be an effective method of training for this skill.

An educational module for pelvic, respiratory, hip, cardiovascular, and lumbosacral examinations, with a focus on how to manipulate draping materials, how to communicate with the patient, and how to instill an awareness of patient comfort, should be developed. Guided by physiotherapy students' preferences, the educational module could be delivered through any combination of instructor-led teaching and demonstration, practice with volunteer patients, or videos. In addition, physiotherapy programmes could revise clinical education sessions and clinical placement experiences to provide students with education and practice in draping.

CONCLUSIONS

Our study shows that, although both PTS and PTE believe that draping education is important and that draping affects patient dignity, sufficient draping education is not being provided in entry-level curricula. Lack of emphasis on (or poor definition of) draping in physiotherapy curricula and a lack of sufficient resources for draping education are likely important factors affecting the confidence and skill of PTS and future clinical professionals in performing effective patient draping.

If students (future clinicians) are expected to protect the dignity of patients to the greatest extent, they must be aware of patients' needs and perceptions and be proficient in draping skills. When evaluating the efficacy of

any educational interventions related to draping, it is also imperative to investigate whether or not the draping education contributes to the maintenance of patient dignity.

Finally, because there are different cultural expectations and doctrines around issues of dignity and its links to draping, physiotherapy curricula must address cultural sensitivity as applied to draping and, when relevant, introduce clinical skills to meet the needs of Canada's culturally diverse population.

KEY MESSAGES

What is already known on this topic

Dignity is important to patients, and many patients and healthcare workers consider draping to be one component of this concept. Healthcare workers do not always use proper draping techniques. There is a need for education related to dignity, but no intervention has been shown to be effective at improving the amount of dignity provided in care.

What this study adds

This study identifies the perceptions of Canadian physiotherapy educators and students related to dignity and draping. It identifies barriers to teaching draping for clinicians, the physical examinations for which students desire additional draping education, and the methods expected to be most beneficial for students in learning draping skills. The concept of the cultural aspects of dignity and draping in physiotherapy education is introduced.

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APPENDIX: QUESTIONNAIRES

1. Draping during the physical exam: Physiotherapy students

	Strongly disagree 1	Disagree 2	Agree 4	Strongly agree 5
It is important for physiotherapy students to learn how to properly drape patients during a physical exam.				
Students often have difficulty with draping skills.				
Female patients are more difficult to drape than male patients.				
Male patients are more difficult to drape than female patients.				
I often have difficulty knowing what draping is appropriate in a given physical examination.				
Draping is underemphasized in clinical skills education.				
I learned draping in a clear step-by-step fashion.				
I have learned how to handle draping in each of the physical examinations that I have learned.				
The expectations for draping in the Objective, Structured, Clinical Evaluations throughout the curriculum are clearly defined.				
The expectations for draping in clinical practice (e.g. in outpatient clinic, in the emergency department, etc.) are clear.				
I am comfortable accommodating patients with specific cultural modesty concerns during the physical exam.				
There is a discrepancy between proper draping techniques taught in classes and those that are used in clinical practice.				
Additional educational time should be spent on proper draping.				
Draping has an impact on patient dignity.				

Please answer yes or no.		
I am aware of the concept of awrah	Yes	No
Please comment on your understanding of awrah		
I am aware of the concept of tzniut	Yes	No
Please comment on your understanding of tzniut		

The best way for me to learn proper draping techniques is through (Check all that apply):	Videos Text Books Demonstrations Volunteer Patients Other (please specify)
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What elements of draping do you consider to be difficult during a physical exam? (Please check all that apply)	<ul style="list-style-type: none"> • Personally manipulating gown/ sheets, etc. • Communicating with the patient how to manipulate materials/ body parts • Communicating with other health professionals • Being aware of patient's comfort level with exposure/ non-verbal cues • Physically touching the patient • Maintaining modesty of the patient • Other . . . (explain)
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Please rate the difficulty of the draping associated with the following exams using the 5 point scale provided.						
	Relative draping difficulty					
	Very easy 1	Somewhat easy 2	Neither easy or difficult 3	Somewhat difficult 4	Very difficult 5	I have not been taught how to perform this physical examination. N/A
Knee and ankle						
Hip						
Respiratory						
Cardiovascular						
Pelvic						
Abdominal						
Wrist and Elbow						
Head and Neck						
Cranial nerve						
Shoulder						
Peripheral neurological						
Central neurological						
Thoracic						
Lumbar-sacral						

<p>In which physical examinations would you appreciate further draping education? Please check all that apply.</p>	<ul style="list-style-type: none"> • Knee and ankle • Hip • Respiratory • Cardiovascular • pelvic • Abdominal • Wrist and elbow • Head and neck • Cranial nerve • Shoulder • Peripheral neurological • Central neurological • Thoracic • Lumbar-sacral
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<p>Please provide any suggestions useful to enhance student learning of proper draping techniques.</p>
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<p>Please add any comments you have about draping, and how it is taught.</p>
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2. Draping during the physical exam: Physiotherapy clinical educators

Please select the answer that most closely matches your feelings about each statement below.					
	Totally disagree 1	Somewhat disagree 2	Agree 3	Strongly agree 4	No opinion N/A
It is important for physical students to learn how to properly drape patients during the physical exam.					
Students often have difficulty with draping skills.					
Specific draping skills should be taught in the physiotherapy curriculum.					
I am comfortable teaching students how to accommodate patients with specific culturally based modesty concerns during the physical exam.					
There are sufficient educational resources to teach draping skills.					
Comments					

Many cultures have specific concepts that encompass the idea of physical modesty. These next two questions examine your familiarity with these concepts.		
Are you aware of the concept of awrah?	Yes	No
Please explain your understanding of this concept very briefly.		
Are you aware of the concept of tzniut?	Yes	No
Please explain your understanding of this concept very briefly.		

Please choose the answer that most closely resembles your feelings				
	Never 1	Rarely 2	Often 3	Always 4
When I teach physiotherapy students clinical skills, I explicitly teach them proper draping techniques.				
When I teach a particular physical examination (e.g. the respiratory or hip exam) I explicitly define the appropriate draping for the region being examined.				
The draping techniques used in clinical practice are the same as the techniques taught in physiotherapy programs (i.e., for Objective Structured Clinical Examination).				
It is necessary to perform the entire examination of the anterior thorax with the patient's anterior thorax fully exposed.				
Please briefly explain your answer above:				

During examination of the precordium and cardiovascular system it is appropriate for a patient to lower his/her gown to expose the entire anterior thorax for inspection at one time.	Yes	No
Please briefly explain your answer above:		

During examination of the respiratory system, it is appropriate for the patient to lower his/her gown to expose the entire anterior thorax for inspection.	Yes	No
Please briefly explain your answer above:		

When auscultating the precordium I teach students to expose the area being auscultated (whether the patient is male or female).	Yes	No
Please briefly explain your answer above:		

When auscultating the anterior thorax, it is most appropriate for the patient to expose their entire anterior thorax (whether the patient is male or female)	Yes	No
Please briefly explain your answer above:		

Please indicate the impact that each element below has on your ability to teach draping to students.				
	No impact 1	Minor impact 2	Moderate impact 3	Major impact 4
Insufficient time				
Insufficient instructor knowledge about draping				
Draping is not included in the curriculum				
Draping technique is poorly defined within the curriculum				
Lack of draping material (e.g. sheets and gowns)				
Lack of available draping educational resources				
Lack of willing volunteers to practice draping skills on				
Other skills take precedence				
Draping techniques are not important in actual clinical practice				
Students lack enthusiasm for draping subject matter				
Comments				

Please provide some suggestions about ways to enhance teaching of proper draping technique: