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Recommended Citation

Williamson, Moira and Harrison, Lindsey: Dealing with diversity: incorporating cultural sensitivity into professional midwifery practice 2001, 22-25.
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Abstract

In the Australian College of Midwives, Code of Ethics, Section 11. Practice of Midwifery, the following is stated "A. Midwives provide care for women and childbearing families with respect for cultural diversity while also working to eliminate harmful practices within those same cultures." However, it is difficult to know what is meant by "respect for cultural diversity". This paper presents the results of a critical review of the health literature. There is surprisingly little consensus about the meaning of terms such as cultural sensitivity and cultural appropriate care. Nor are there reflections on incorporating these concepts into practice. It could be argued that until there is greater clarity about these concepts and more discussion of how they may be used in practice, midwives would have to continue to rely on their individual knowledge and experience.

Keywords

midwifery, professional, into, practice, sensitivity, dealing, cultural, incorporating, diversity

Disciplines

Arts and Humanities | Life Sciences | Medicine and Health Sciences | Social and Behavioral Sciences

Publication Details

Williamson, MJ and Harrison, L, Dealing with diversity: incorporating cultural sensitivity into professional midwifery practice, Australian Journal of Midwifery, 14(2), 2001, p 22-25.

DEALING WITH DIVERSITY: INCORPORATING CULTURAL SENSITIVITY INTO PROFESSIONAL MIDWIFERY PRACTICE

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ABSTRACT

In the Australian College of Midwives, Code of Ethics, Section 11. Practice of Midwifery, the following is stated "A. Midwives provide care for women and childbearing families with respect for cultural diversity while also working to eliminate harmful practices within those same cultures."

However, it is difficult to know what is meant by "respect for cultural diversity". This paper presents the results of a critical review of the health literature. There is surprisingly little consensus about the meaning of terms such as cultural sensitivity and cultural appropriate care. Nor are there reflections on incorporating these concepts into practice. It could be argued that until there is greater clarity about these concepts and more discussion of how they may be used in practice, midwives would have to continue to rely on their individual knowledge and experience.

INTRODUCTION

Although dealing with people from different cultural backgrounds is a daily reality for Australian midwives, there is limited evidence as to how they manage cultural diversity and how they incorporate cultural sensitivity into their practice. This paper presents some of the preliminary findings from a study, which is exploring these issues by asking midwives practising in different locations about their strategies, their experiences and their difficulties. Some of the participants work with Aboriginal women and their families, as it was felt to be particularly important to include the perspective of these midwives. Since colonisation, the Aboriginal population has experienced discrimination and oppression, and this has also been evident in the provision of health care (Jackson et al. 1999). Investigating how midwives now ensure culturally sensitive practice for this group is thus especially useful.

The paper begins with some background literature about culture and cultural sensitivity. It is concluded

that there is little clarity about definitions or about how these amorphous concepts might be incorporated into practice. Following a brief description of the study design, the paper sketches some preliminary findings. In general, the participants have not been able to articulate clearly how they incorporate cultural sensitivity into their practice. The midwives so far have discussed instead what appear to be the related concepts of control and flexibility. They have been concerned to explain how the context of care (community or hospital) effects their ability to relinquish control and be flexible with their practice.

BACKGROUND LITERATURE

The Australian College of Midwives (ACMI) in its 1981 Philosophy and Position Statements states that:

It is the right of every woman and baby to be recognised as individuals regardless of age, race, religion, political belief, economic status and social position. (ACMI, 1989, 1.1.0.)

In the ACMI Code of Ethics is the following:

Midwives provide care for women and childbearing families with respect for cultural diversity while also working to eliminate harmful practices within those same cultures. (1995, Section 11)

Although the philosophy and code of ethics are clearly stated, there is no evidence in the literature to show how cultural sensitivity is or may be incorporated into the daily activities of midwives, or how they deal with cultural diversity, when providing care to individual women and their families.

So what do culture and cultural sensitivity mean? Current definitions of culture tend to be all encompassing, such as the following from Yearwood (2000, p179). It is difficult to see the utility, in a practice sense, of such wide ranging definitions.

We can view culture as pervasive, dynamic and complex. It is not simply bound by age, gender,

race, religion, socioeconomic class, educational level, geographic origin, personal, and group values. Culture is an abstract concept, which at times can be contextually bound and viewed.

The literature tends to refer to 'recognition' in relation to these matters. Homer (2000), for example, suggests that cultural diversity refers to the recognition of different cultural groups and their needs. Different cultural groups from this perspective, are those whose first language is other than the dominant language of the country they live in. How their 'needs' may differ in a cultural sense is unclear. However, Homer points out that traditional practices may be important for some women and not for others, that there are diversities within cultural groups as well as between groups. She agrees with Waldenstrom (1995) that cultural diversity includes 'recognition' of a person's social and economic background. Again, we see the concept of recognition, an act of cognition, which does not necessarily point to particular behaviours or provide guidelines for action.

The midwifery literature is not helpful either and, while there is a growing amount of literature about how women perceive midwifery care, it is sparse in relation to how midwives provide care (Hunter 2001). Instead, there is a common theme of viewing midwifery as one in which holistic care is provided to the woman and her family. This involves taking culture into account. Denman-Vitale and Murillo (1999) argue that health care workers need to be culturally competent to meet the needs of their clients. Cultural competency will allow for the development of an understanding of cultural diversity and facilitate the incorporation of cultural sensitivity into clinical practice. These authors state that health professionals need to have an understanding of their own culture, in particular their own 'values and beliefs', in order to understand their personal responses to people from other cultures. They recognise that health care workers cannot know all there is to know about every cultural group, but assert that they should have an understanding of the culture of every person that they are providing care for.

There are a number of difficulties with the approach of Denman-Vitale and Murillo. Having a broad understanding of different cultures may lead to stereotyping. Individuals are labeled as belonging to a particular culture and are viewed as having the same characteristics as everyone else in that group. As a result, the individual needs of women are not taken into account (Bowler 1993). Further, Denman-Vitale and Murillo fail to define cultural needs and their faith in 'cultural competency' leading to an understanding

of cultural diversity is unexamined. Writing from an American perspective, they state that the use of 'cultural interpreters', (who are people from the same cultural background as the client and are used to provide interpretation and insight into cultural practices) may need to be utilised to effectively meet the needs of clients. On the one hand, this could be helpful to both the client and the health professional, but on the other hand, this suggestions fails to recognise that people within cultural groups differ in significant ways, for example, socioeconomic status, educational background and life experience. None the less, in Australia, the health care interpreter's service can be an important ingredient in providing good care and Indigenous health workers have proved to be indispensable in many situations.

Within New South Wales, there are a limited number of midwives who can speak a language other than English, and even fewer who are Aboriginal. There have been a number of studies, which criticise the 'dominant Anglo-Australian monocultural perspective' of the Australian health care system (Caley 1998). According to Caley (1998), this perspective views illness and health from a rigid scientific approach and may be detrimental for those whose cultural backgrounds do not fit this mould. Midwifery has not been immune from these sorts of criticisms. It has been suggested, for example, that as the majority of maternity services are provided by 'Anglo' health workers, there may be inherent discrimination and lack of understanding of people from other cultures (Pheonix 1990, Caley 1998 and Baxter 1996). Fahy (1998) also asserts that 'Anglo-Celtic Australians', who share similar cultural beliefs with those in other Western cultures, have endorsed the medicalisation of birth. This may lead to the non-acceptance by midwives of alternative birthing practices, which may be viewed as 'incorrect' (Caley 1998). As Caley (1998) points out, this view conflicts with Australian multicultural policy that endorses the recognition of different cultural traditions and ethnic identities. But plainly, these are areas of debate and in urgent need of exploration.

METHODOLOGY

This research is informed by feminist theories. There are numerous feminist approaches, liberal, Marxist, radical, socialist and now poststructural. All of these have a common theme in which they are concerned about woman and the inequality of the social system. In particular, the patriachal system which allows men power. The feminist movement whatever the approach has encouraged women to have a voice and to challenge oppressive social systems (Cheek et al. 1996).

researcher 'to investigate the meaning of particular representations: to understand how they came to be as they are, and what they communicate about their specific cultural and historical contexts' (Squier 1993, p.30 as cited in Cheek 2000, p.6). A poststructural feminist perspective 'values plurality, fragmentation and multivocality' (Cheek 2000, p.40).

A grounded theory approach has been adopted for the data collection and analysis. The aim of this approach is to construct an explanatory framework or theory 'where no theory exists' (Beanland et al. 1999, p.248). Grounded theory was developed by Glaser and Straus in 1967, as a way of describing how data could be analysed and interpreted to generate theory. Originally developed in sociology (Locke 2001), it has been well utilised by the nursing and midwifery professions (Keddy et al. 1996).

Individual in-depth audiotaped interviews are being undertaken with a variety of midwives from the mainstream clinical setting, as well as with midwives whose dedicated midwifery practice is specifically with Aboriginal women. This involves accessing midwives from three different geographical locations (urban, regional and rural) within New South Wales. The transcribed interviews are being analysed with the aid of NVivo, a qualitative software package that allows the researcher to code the transcripts, explore the data visually and to sort and store the relevant information (Bazeley & Richards 2000).

ETHICAL ISSUES

Approval to carry out this research was obtained from the relevant ethics committees and from the health service managers of each facility where midwives have been interviewed. An information sheet is provided to the participants and written consent obtained prior to interview. Confidentiality of information and the anonymity of participants are being scrupulously maintained.

EMERGING FINDINGS

Few midwives so far have given a definition of cultural sensitivity. However, when asked to discuss this concept in relation to their practice, a number of related concepts emerge. Midwives talk about the need to be flexible and the degree to which they are able to give control to their clients. Being prepared to recognise the values of others and being aware of their own value system allows them to let go of control. Another important influencing factor in the provision of care appears to be the context of care. Hospital

based midwives discuss the context of care in terms of workloads and the impact of the busy clinical environment on practice. This hinders their ability to treat every woman as unique. Midwives working in community practice tend to contrast hospital practice to their own, stressing their ability to be more flexible.

Midwives who are involved in community practice or a community service to provide education and/or care to Aboriginal women have discussed how they have had to adjust their practice. Where the administration of care is by definition far from routine, and where the woman is in her normal environment, the midwife has a close encounter on a daily basis with the factors which affect access to health care. While many of these factors, such as unemployment, also affect some sections of the non-Aboriginal population, Aboriginal people continue to experience everyday discrimination in a way others do not and interaction with non-Aboriginal people responsible for providing services is not always positive.

As a result, community based midwives need to have a flexible approach to their practice. Appointment times are at the woman's convenience and if she isn't home at the required time, another visit is carried out. This may mean that the midwife calls on the woman several times until she is actually seen. When these midwives discuss this issue with ward based midwives, they are often told that they are 'wasting their time', because it seems obvious that the clients don't want the service.

'As I said, some other midwives say, oh well I wouldn't bother after 3 visits, if they are not there they don't want the service. They do want the service, but it mightn't be their priority on the day. It's got to be flexible, it's really got to be flexible and I'm happy to do it.'

MIDWIFE, REGIONAL ABORIGINAL COMMUNITY PRACTICE

From the point of view of the hospital midwife, this attitude appears sensible. In a busy environment, where they are dealing with a 'captive' population and care becomes routinised as a survival mechanism, they could not afford to provide the flexibility of community practice.

Midwives provide care based on generic hospital policies and procedures. These are written specifically to provide guidance or steps for practice, which can become 'recipes' for providing care. Following hospital policy closely ensures that all bases are covered, but flexibility is not a concept that can be valued in this

context. It can therefore be difficult for midwives to provide individualised care unless they are prepared to go beyond hospital policy.

Some of the Aboriginal women I looked after (in Arnhem Land) ... they didn't know how to speak English and it was difficult too because the hospital had a certain set standard protocol and there's no way you could of worked within that so you had to actually go outside of that to actually be able to be functional in a positive way.

MIDWIFE, REGIONAL PRACTICE (DISCUSSING PREVIOUS EXPERIENCE)

Control is another issue that has emerged from the data and is obviously closely related to flexibility. Midwives have discussed situations where they are able to allow the women to control their own situation rather than control the situation themselves. This is interesting as midwives believe they are working in partnership with women to advocate choice for them, but in reality it depends on the working environment as to whether this takes place or not. It is also difficult for some midwives in the community to relinquish control if they have been used to having it in the hospital environment. In some cases this causes stress for midwives as they learn to adapt to the difference in their role.

'I think the difference between care in the hospital and care at home is that once people are at home they are on their own grounds and you are not an intruder but you're no longer the controlling body, they are'. (Midwife, regional community practice).

Midwives often have an ideology relating to the care that they perceive women should be receiving from them or providing for their baby. They want women to have choices but, inevitably, these may not be what the midwife would choose. For this to work, midwives have to let go of their own values when providing care to women whose values may differ from their own, if the women's choice is to be upheld. This may be more feasible for experienced midwives than for new practitioners, no matter how well educated.

'That these people actually have a choice and regardless really of perhaps what your ideal for them was, theirs was different'. (Midwife, regional community practice).

CONCLUSION

Although at this stage these results are only

preliminary, the midwives who have been interviewed have provided an important insight into how midwives deal with diversity in their daily practice. The study is beginning to identify the importance of being flexible, the ability to let go of control, letting go of personal values, recognising other peoples' values and accepting difference when providing care. The context of practice (hospital or community) appears to have a direct impact upon midwives approach to care.

Based on the findings so far, however, it seems unlikely that the concepts of culture and cultural sensitivity in relation to practice will be illuminated. It may be that the terms are not useful for practice and that midwives, implicitly recognising this, have broken the concepts into what they see as their constituent parts, as discussed above. Should we abandon the search for clarification of these terms and their application to practice? Perhaps the time has come to recognise that using them may hinder rather than help and, in the absence of clarity, midwives have been going about their business providing, as best they may, appropriate care for all their clients. Perhaps we should instead identify those factors which constrain their practice, and transform them.

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