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Dealing with diversity: incorporating cultural sensitivity into professional midwifery practice

Moira Jane Williamson

University of Wollongong

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DEALING WITH DIVERSITY: INCORPORATING CULTURAL SENSITIVITY INTO PROFESSIONAL MIDWIFERY PRACTICE

A thesis submitted in fulfilment of the requirements for the award of the degree

DOCTOR OF PHILOSOPHY

from

UNIVERSITY OF WOLLONGONG

by

MOIRA JANE WILLIAMSON, RN, RM, RMN, BNursing, MHlthAdmin, GCertHiEd

SCHOOL OF NURSING, MIDWIFERY & INDIGENOUS HEALTH

2008
I, Moira J. Williamson, declare that this thesis, submitted in fulfilment of the
requirements for the award of Doctor of Philosophy, in the School of Nursing, Midwifery
& Indigenous Health, University of Wollongong, is wholly my own work unless
otherwise referenced or acknowledged. The document has not been submitted for
qualifications at any other academic institution.

Moira J. Williamson

31 May 2008
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ACM</td>
<td>Australian College of Midwives</td>
</tr>
<tr>
<td>ACMI</td>
<td>Australian College of Midwives Incorporated</td>
</tr>
<tr>
<td>ABW</td>
<td>Aboriginal Health Worker</td>
</tr>
<tr>
<td>AMIHS</td>
<td>Aboriginal Maternal and Infant Health Strategy</td>
</tr>
<tr>
<td>AMS</td>
<td>Aboriginal Medical Services</td>
</tr>
<tr>
<td>ANMC</td>
<td>Australian Nursing and Midwifery Council</td>
</tr>
<tr>
<td>ATSIC</td>
<td>Aboriginal and Torres Strait Islander Commission</td>
</tr>
<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse</td>
</tr>
<tr>
<td>CATSIN</td>
<td>Congress of Aboriginal and Torres Strait Island Nurses</td>
</tr>
<tr>
<td>DOCS</td>
<td>Department of Community Services</td>
</tr>
<tr>
<td>FCAA</td>
<td>Federal Council for Aboriginal Advancement</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>NAC</td>
<td>National Aboriginal Conference</td>
</tr>
<tr>
<td>NACC</td>
<td>National Aboriginal Consultative Committee</td>
</tr>
<tr>
<td>NACHO</td>
<td>National Aboriginal Controlled Health Organisation</td>
</tr>
<tr>
<td>NIC</td>
<td>National Indigenous Council</td>
</tr>
<tr>
<td>NMB</td>
<td>Nurses and Midwives Board</td>
</tr>
</tbody>
</table>
NSW  New South Wales

TAFE  Technical and Further Education

WBSMAHS  Women’s Business Service at the Mildura Aboriginal Health Service

The Commonwealth of Australia Style Manual (John Wiley & Sons, Australia 2002:56) says: Always capitalise ‘Indigenous’ when it refers to the original inhabitants of Australia – as in ‘Indigenous Australians’ and ‘Indigenous Communities’. It doesn’t need a capital when used in general sense to refer to the original inhabitants of other countries or other native things (eg indigenous plants).
ABSTRACT

Caring for women from culturally and linguistically diverse (CALD) backgrounds is a daily occurrence for Australian midwives. It is an expectation of professional bodies such as the Australian College of Midwives and health care services that all midwives will provide culturally appropriate care. However it is not clear how cultural sensitivity is used in practice when caring for CALD women and there is even less information on how this is achieved when midwives are caring for Indigenous women. This is especially important as the Indigenous population has experienced oppression and discrimination and this has been evident in their health provision and care.

The aim of this research was to explore:

- How midwives define culture and incorporate cultural sensitivity into their practice;
- The strategies midwives use when providing care for Indigenous women;
- The factors which impact on how midwives provide care to women from different cultural backgrounds.

Semi-structured interviews were conducted with thirty two midwives in three different geographical locations within New South Wales (NSW). A modified grounded theory approach was used for the data collection and preliminary analysis. The intention was not to produce theory but to ensure a systematic process. As the study proceeded, the emerging findings were explored with and compared to relevant theoretical perspectives and the work of theorists which best supported the investigation of the topic. In this case,
an analysis of discourse and the work of theorists such as Foucault were identified as the most fruitful approach.

The findings showed that the participants used a number of discourses about the ‘other’ when describing their practice with women from CALD backgrounds, including Indigenous women. I have called these discourses: the discourse of cultural difference, the discourse of social justice and the discourse of denying difference.

When discussing the concept of ‘culture’, most participants referred to customs and traditions, a perspective which tends to see culture as static and unchanging. They had been encouraged to view culture in this way by their educational preparation, reinforced by much of the nursing and midwifery literature. As a result, participants tended to expect CALD and Indigenous women to conform to what they themselves believed were cultural norms. Some were challenged in this view during their practice but, for many, the routines of busy hospitals allowed little time for reflection. More recent approaches in the literature have emphasised ‘cultural safety’, which advocates being aware of the social, political and economic factors which impact on clients, but it is still unclear how this concept may be operationalised in practice.

The study findings also identified that the context of care has a significant impact on the way in which midwives provide care, as issues of power and control circulate within health care services. The thesis concludes by discussing the utility of using the concept of culture in midwifery education and practice.
ACKNOWLEDGMENTS

This has been a journey of personal learning and along the way I been given support by many colleagues, friends and family. This support enabled me to stay focused and achieve my goal. In particular I would like to acknowledge the support of my supervisor Dr Lindsey Harrison - firstly for believing in me and secondly for her patient guidance and the time that she committed to my development – words can not express my gratitude.

I would also like to acknowledge the midwives who volunteered their time to be part of this study – thank you. I also wish to acknowledge the encouragement and support of The University of Wollongong, School of Nursing, Midwifery and Indigenous Health, under the leadership of Professor Patrick Crookes and the University of Wollongong library staff for their ongoing assistance, in particular Chris Brewer, Alison Pepper and Lucia Tome. I would also like to thank Kumiyo Inoue for her technical support.

To colleagues and friends, Mercy Baafi, Ann Grieve, Maria Moran, Robin Peters (Lanham), Julie Shaw, Vicki Williams, Pam Strong and her daughter Kody–Leigh Brown all of who have provided support and encouragement, and to my extended family, the Forsyth clan, my mother Valerie, my brothers Michael and John and in particular, my sisters Judith Smith and Kaye Cox, my sisters-in-law Julie Bass and Karen Forsyth - who have all been on this journey with me, and to my nephew Matthew Cox (for the loan of your Foucault textbooks) - thank you.

Finally to my husband Alex and son Sean, who have endured the highs and lows of this journey, thank you for your love, understanding and support, I would not have reached my goal without you both.

This thesis is dedicated to my father Alan Ellwood Forsyth (1926-1993) always positive - who encouraged his children to fulfill their dreams.
CHAPTER ONE: INTRODUCTION

1.1. Introduction

Dealing with people from different cultural backgrounds is a daily reality for Australian midwives. However there is limited evidence as to how midwives manage cultural diversity and how they incorporate cultural sensitivity into their practice. There is even less evidence on how midwives provide culturally appropriate care to Indigenous women and their families. This is especially important as, 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, p.162). What is known is that the maternal and perinatal mortality and morbidity rate for the Indigenous (Aboriginal and Torres Strait Islander) population of Australia is greater than that of the non-Indigenous population (Powell & Dugdale 1999). Investigating how midwives ensure culturally sensitive practice for this group is thus especially useful. Exploring factors that impact on the provision of appropriate care is also beneficial. This is what this study set out to achieve.

Thirty two midwives in three different geographical locations within New South Wales (NSW) were interviewed about how they provide care for Indigenous women. When asked how they provide culturally sensitivity care to women, the majority of the midwives discussed how they provide care to women from culturally and linguistically diverse (CALD) backgrounds, as well as the care they provide for Indigenous women and this is reflected in this thesis.
This is not surprising as Australia is a multicultural society (Australian Bureau of Statistics 2007). Since World War II there have been over six million migrants to Australia. The majority of the migrants (3.3 million) live within major urban cities, for example, Sydney and Wollongong (Australian Bureau of Statistics 2004). In comparison the Indigenous population comprises 2.5% (517,200) of the total Australian population and NSW has the largest Indigenous population of 148,200 (Australian Bureau of Statistics 2007).

It became clear, as the study progressed, that structural factors such as where the midwives provided the care, for example within hospitals settings, also influenced how midwives cared for women and so this became one of the areas of investigation.

Midwives in the main are employed by state health care services. These services are governed by a bureaucracy which determines the policies and procedures that govern how midwives practice. Other midwives are employed by non-government bodies such as Aboriginal Community health services and follow their procedures.

The study identified that discourse (the way in which individuals view the world) has a critical role in the way the participants view individuals and provide care for women. Discourse requires the use of language (Danaher et al. 2000) and has effects due to the elements of truth, power and knowledge (Foucault 1980). Discourse is used in the

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1 In some cases these midwives are employed by the state area health services rather than directly by the Aboriginal health service. However, they are based in the Aboriginal community health service (see methodology chapter).
Western world to describe difference. It has enabled the use of discursive practices to produce psychological and social realities and these practices have been used to label people who appear different as ‘the other’ (Davies 2000). Pivotal to the use of discourse is the concept of power. The way in which discourse is used to describe people and how power is dispersed throughout society by the use of discourse provided a very effective way of analysing the data.

This chapter is arranged in the following sequence. Firstly the aims, objectives and significance of the study are detailed. As the context of care has an influence on how midwives provide care, information about the health care system in NSW, focusing on maternity services and the role of midwives are provided next. Then, to enhance the significance of the study, some background information is provided about the history of contact since Australia was colonised in 1788. The methodology and theoretical framework are then introduced. Lastly, the structure of the thesis is outlined.

1.2. Aims and Specific Research Questions

The aims of the study were to gain an understanding of midwives’ concepts of culture and cultural diversity and to explore their strategies to incorporate cultural sensitivity into professional practice, especially in relation to Indigenous women. The study also explored factors that impact on the provision of culturally appropriate care.
An important outcome is to provide recommendations for the educational preparation of midwives, so that they are able to maximise positive experiences for all their clients and, in the case of Indigenous women, not to inadvertently repeat past injustices.

1.2.1. Specific research questions

1. How do midwives define culture and how do they provide culturally appropriate care?
2. What strategies do midwives use when caring for Indigenous women?
3. What factors impact on how midwives provide care to women from different cultural backgrounds?

1.3. Significance of the Study

There is little empirical evidence on how midwives provide culturally appropriate care for women from CALD backgrounds. There is even less information available on how midwives incorporate cultural sensitivity into their practice when providing care for Indigenous women. The results from this research will add to and enhance the limited body of knowledge on this subject.

This study is significant because professional bodies such as the Australian College of Midwives (ACM) have in the past had position statements that directed the development
of professional and educational standards. The Australian College of Midwives Incorporated (ACMI)\(^2\) ‘Philosophy and Position Statements’\(^3\) stated 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 (Australian College of Midwives Incorporated 1989, 1.1.0).

The ACMI Code of Ethics stated 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 (Australian College of Midwives Incorporated 1995).

Recently the Australian Nursing and Midwifery Council (ANMC) have released the National Competency Standards for the Midwife which state that:

The competency standards have an overarching framework – woman – centred care is a concept that implies that midwifery care:

- is focused on the woman’s individual, unique needs, expectations and aspirations

\(^2\) The Australian College of Midwives Incorporated (ACMI) has recently removed ‘incorporated’ from their title and is now known as the Australian College of Midwives (ACM).

\(^3\) The ACMI Code of Ethics and other position statements have been replaced by the ANMC National Competency Standards for the Midwife. However the above statements were the initial catalyst for undertaking this study. I am aware that the ACM currently supports the concept of cultural safety.
• recognises the woman’s right to self determination in terms of choice, control, and continuity of care

• follows the woman between institutions and the community, through all phases of pregnancy, birth and the postnatal period

• is ‘holistic’- addresses the woman’s social, emotional, physical, psychological, spiritual and cultural needs and expectations


Although the philosophy, code of ethics and ANMC framework are clearly stated, there is limited 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.

This study, as previously stated, will provide recommendations to enhance educational programs for midwives, including those undertaking their initial midwifery education and those undertaking further tertiary qualifications, to improve the care for all women, and in particular, not to repeat past injustices when providing care for Aboriginal women.
1.4. Context of Care and Midwifery Practice

This section provides a review of the maternity services available for women within NSW. There has been a change from traditional hospital based maternity care to the various options of maternity care that have been recently implemented in some maternity services in NSW.

Midwifery practice has historically been undertaken in NSW in maternity wards of general hospitals or within large, designated obstetric and gynaecology hospitals. Until recently the care provided to women within hospital settings was fragmented into antenatal, intrapartum and postnatal care (Pairman and Donellan-Fernandez 2006). This fragmentation of care was reviewed in New South Wales in the late 1980s, when the NSW Department of Health commissioned the Ministerial Task Force on Obstetric Services in New South Wales (1989), referred to by health professionals as the ‘Shearman Report’ (NHMRC 1996). Ongoing state and federal reports, such as the NSW Framework for Maternity Services (2000) and the National Maternity Action Plan (2002) have continued to highlight the benefit of continuity of care for women.

Midwives have advocated for the primary health care approach to be the philosophy underpinning midwifery care (Guillard, Tracy and Thorogood 2006). Models of primary health care include continuity of carer models, where women are seen by the same midwife or a small group of midwives for their pregnancy, birth and postnatal care (Homer et al. 2001).
Changes to the way midwives are educated have also occurred over the last two decades. Originally midwifery education was hospital based, with registered nurses undertaking their midwifery training over a 12 month period (Australian Health Care Advisory Committee 2002). This form of education was greatly influenced by the nursing and medical professions (Barclay 1995). However midwifery education is now tertiary based and is offered as a Bachelor of Midwifery, or as a postgraduate qualification for registered nurses (Australian Health Care Advisory Committee 2002). The differences in philosophy underpinning midwifery practice and the medical model of care are discussed in more detail in chapter 3 and again in chapter 7.

As a result of the Shearman Report (1989), community based practice where midwives provide postnatal care to women and their babies in the women’s homes was only introduced in NSW in the late 1980s. Community midwifery or early discharge programs have now become the ‘norm’. This has reduced the length of hospital in-patient stay for women and their babies dramatically. The average length of stay for women and their newborns in 2002, was 2.6 to 3.8 days for urban facilities, 2.3 to 2.6 days for regional locations and 2.9 to 3.8 days for rural facilities (NSW Department of Health 2003). However not all maternity services rotate all of the midwives (employed within the hospital) into the early discharge programs, some hospitals have designated midwives for

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4 Since the introduction of early discharge programs in Australia in the 1980s the postnatal length of stay in hospitals for mothers and babies has decreased progressively. Prior to the introduction of early discharge programs the average length of stay was five to seven days (Brown & Lumley 1997). From personal experience as a former manager of a maternity service, early discharge programs enabled postnatal bed numbers to be reduced.
this role. This means that some midwives have had little experience of providing community based midwifery practice. The significance of this can be appreciated as the current trend in maternity services is for an increase in community based or more diverse models of care. These models require some midwives to work outside the traditional hospital based system of care. This can be a challenge for midwives who have had little exposure to different models of care.

Women in NSW (depending on their geographical location) may choose from a variety of pregnancy and birth care options. The options and choices for women within the public health system are also expanding. The options consist of:

- **Private health care** - if a woman has private health insurance she may choose an obstetrician for her pregnancy care and birth. The birth may be in a private or public hospital depending on the choice of the woman and the hospital visiting rights (accreditation) of the obstetrician.

- **Public hospital based antenatal, intrapartum and postnatal care** - where the women will be seen by a variety of different doctors and /or midwives within the hospital setting.

- **Public community based outreach clinics** (these clinics are provided in community health settings) - the doctors and midwives providing this service are employed by the local area health service and the majority of their work is performed within a hospital setting.

- **General practice shared care programs** - where women are assessed by their local general practitioner until they are 36 weeks pregnant. They are then seen
by doctors or midwives in the antenatal clinic at the hospital until the birth of their baby.

- **Birth centre** - where the women desire a natural childbirth with little intervention. The antenatal and intrapartum care is usually provided by midwives. A small number of hospitals within NSW offer this service.

The most recent models of care are:

- **Continuity of carer models** - where women receive care from a known midwife or a small number of midwives. These midwives provide care throughout the antepartum, intrapartum and postpartum periods. Some of this care can be provided within the community setting (Homer et al. 2001).

- **Maternity- Public Homebirth Services** (NSW Department of Health 2006).

The last two choices for women in NSW are fairly new initiatives, especially maternity public homebirth services. The majority of women still birth within designated maternity units. A large proportion of the care (intrapartum and postpartum) for childbearing women is provided within a hospital setting.

As NSW has a large multicultural population, there are interpreter services available within NSW Health services, such as hospitals, to assist health care professionals to provide services to people from different CALD backgrounds.
1.5. Services for Indigenous Women

In 2001, the NSW Department of Health funded the ‘Aboriginal Maternal and Infant Health Strategy (AMIHS)’\(^5\). This was initiated to improve the pregnancy outcomes for Aboriginal women and to reduce perinatal morbidity and mortality (NSW Department of Health 2006). The strategy consisted of introducing seven specific antenatal and postnatal services for Aboriginal women in 20 different local government areas (NSW Health Department 2006, p.7). As well, education and training were provided for the midwives and Aboriginal health workers who provided the services (NSW Health Department 2006).

There is no official report by the NSW Health Department on the outcomes of this strategy. However, I contacted Sue Hendy, Special Midwifery Project Officer, NSW Aboriginal Maternal and Infant Health Strategy, to enquiry if the above strategy had been initiated and I was informed that an ‘Aboriginal peer education program’ had been initiated in the Mid-western Area Health Service in 2005. This was a joint initiative with the Technical and Further Education (TAFE) provider based in Orange (a rural city in NSW). Participants who successfully have completed or will complete the program are awarded an ‘Attainment in Aboriginal Women’s Peer Education’ (Forrester & Kenna 2005). At this stage there is no formal evaluation available on the outcomes of this initiative in regards to health improvement for Indigenous women involved in the program. However plans were developed in 2005 to undertake a formal evaluation of the

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\(^5\) This initiative was introduced after I had completed the data collection for this study, so no midwife who took part had been involved in this program.
program (Forrester & Kenna 2005). Sue Hendy (2007, pers. comm., 5 September) has indicated that the above program is about to commence in other area health services in NSW.

‘Aboriginal community controlled health services’ are available in different areas within Australia (National Aboriginal and Torres Strait Islander Health Council 2003, p.9). Aboriginal Medical Services (AMS) are operated as part of these services to provide primary health care to Aboriginal communities. There are 103 AMS which operate across Australia. These services are represented at the national level by the National Aboriginal Controlled Health Organisation (NACHO) to enhance greater access for Aboriginal people to appropriate health care (National Aboriginal Controlled Health Organisation).

1.6. Historical Background

It is important to understand the historical background of the colonisation of Australia because it has had an impact on both the Indigenous and non-Indigenous population. In particular it has had a negative impact on the Indigenous population. The history of contact has left the Indigenous population with two legacies. The first is that the Indigenous population has a marginal position within contemporary Australian society. The second legacy is that this marginalisation has created poor material circumstances for the majority of the Indigenous population (Anderson 2007). In this section of this chapter,
I will provide a brief history of the history of contact and how this has affected the health of the Indigenous population.

In 1788, when the British colonised Australia, the Indigenous inhabitants were said by the colonisers to be uncivilised (Bourke 1998; Jamrozik 2004). Colonial discourse portrayed the Indigenous Australians as ‘inferior savage beings’. Social Darwinism permeated the discourses of the day, inferring that the ‘less fit, fail to survive’ (Bourke 1998, p.2). Social Darwinism focused on the biological development of humans. The ‘norm’ for biological development was based on physical characteristics (for example skull size and the colour of the skin) of Europeans. ‘Others’, the non Europeans, were seen to be primitive and believed to be savage and therefore belonged at the bottom of the hierarchy (Jupp 2002). Indigenous Australians were portrayed as having traits and behaviours which were seen as primitive and childlike (Eckerman et al. 1992) and therefore were described as unfit and deemed unable to survive (Miles 1989; Bourke 1998).

At first the British colonisers had hoped that the Indigenous population could be used to provide manual labour for the economic development of Australia (Miles 1989; Loomba 1998). The colonisation of Australia by the British was related to economic development and material gain (Eckerman et al. 1992), which are important for industrialized societies (Altman 2000). It was only when the Indigenous population refused to submit to being manual labourers that the discourse of the colonisers altered from describing the Indigenous population as ‘meek’ to the use of discourses which portrayed the Indigenous population as ‘savages’ (Loomba 1998, p.113). The colonisers did not value or appreciate
the Indigenous traditional way of life which focused on kinship (Altman 2000) rather than economic growth. This legitimised the destruction of the Indigenous way of life by the colonisers (Bourke & Edwards 1998). It also allowed for the Indigenous population to be marginalised and not considered to be part of main stream society, as described below:

…the prevalent image of the Aborigine amongst the European population remained a racist one. A combination of marginalisation and extermination placed the vast bulk of the Aboriginal population both materially and conceptually at or beyond the fringe of the social relations accompanying the development of commodity production in the Australian colonies. Thus, the debate about the nature of the imagined community of Australia rarely considered the original inhabitants of the continent (Miles 1989, p.92).

When it became obvious that the Indigenous populations were not going to become extinct, the government introduced ‘Aboriginal protection’ (Eckerman et al. 1992). The Indigenous populations were segregated from the non – Indigenous population and a number of government policies ensured that the Indigenous populations became dependent on government or missionary organisations for survival. By the 1930s a policy of assimilation for those of mixed descent was initiated. Government policies were directed at merging the Indigenous population into the non - Indigenous population way of life. This was based on the premise that some of the Indigenous population (those with white ‘blood’) would abandon their way of life and adopt the values of the non – Indigenous community (Altman 2000). The degree of difference, which was judged by
physical appearance and blood lines, was used to justify the forced removal of children from their Indigenous mothers (Jamrozik 2004).

The 1960s and 1970s saw increasing pressure from both internal and international bodies for the improvement of the well being of the Indigenous population (Eckerman et al. 1992). The lack of rights for Indigenous Australians became an embarrassment to many non-Indigenous Australians (Castles & Vasta 1996). The Indigenous population, with the aid of Aboriginal agencies such as the Federal Council for Aboriginal Advancement (FCAA), requested that the Australian Federal government be given the power to legislate for the Indigenous population, which the constitution at the time forbade (Brady 2004). It was felt that this would unify policy in relation to the Indigenous population. The Federal government also had the funding to support Indigenous initiatives. The referendum to alter the constitution which gave the Federal government this power was enacted on May 27th, 1967. The referendum also allowed the counting of the Indigenous population in the census for the first time (Hemming 1998; Brady 2004).

As a result of the changes to the constitution the thinking in relation to the Australian Indigenous population began to change. Indigenous people were still seen as ‘different’ (Brady 2004, p.19) but they now had social and political rights. In 1972, self determination and later self management (Altman 2000) became the policy endorsed by the majority of the Indigenous population and the Australian government. More of the Indigenous population were demanding that they be able to ‘self manage’ their well being (Eckerman et al. 1992). To be able to determine their own self governance and as argued
by Dodson (2003) to be free to alter the negative stereotypical image of the Indigenous population created by ‘others’.

Recognition of a people’s fundamental right to self-determination must include the right to self-definition, and to be free from the control and manipulation of an alien people. It must include the right to inherit the collective identity of one’s people, and to transform that identity creatively according to the self-defined aspirations of one’s people and one’s own generation. It must include the freedom to live outside the cage created by other peoples’ images and projections (Dodson 2003, p.342).

Different Indigenous bodies have been formed over time to advise the government, such as the National Aboriginal Consultative Committee (NACC), which was later changed to the National Aboriginal Conference (NAC), but they have no direct power. In 1990, the Aboriginal and Torres Strait Islander Commission (ATSIC) was formed at a federal level to formulate policy (Eckermann et al. 2006). A board of directors, voted in by regional Indigenous councils, was responsible for the management of ATSIC (Federal Race Discrimination Commissioner 2001). However, over time there had been a growing mistrust by the government and the public, of the way in which ASTIC managed some of the funds provided for different projects (Eckermann et al. 2006). In 2004, the Coalition government (March 1996 to November 2007) abolished ATSIC. The government then set up and appointed the members of the National Indigenous Council (NIC) to provide advice for the ongoing management of Indigenous issues. This move was seen as taking
the control back from the Aboriginal people and giving the power to a select few who were controlled by their government appointment to the NIC (Eckermann et al. 2006).

1.6.1. Health policies and health care

Currently the Federal government has the formal role of administrating Indigenous affairs and directs funds to Aboriginal controlled health services. However, state and territory governments are responsible for health care provision for their populations including Indigenous populations. This has led to a lack of coordination in regard to Indigenous health care services;

…there seemed to be a mosaic pattern of approaches to Aboriginal health across Australia. There was little coordination between Commonwealth and state governments. While there had been a number of attempts to develop strategies to improve Aboriginal participation in Aboriginal health service and policy development, the strength of these mechanisms varied. Further, at a national level there was no mechanism for drawing together key stakeholders so that strategic directions could be developed and maintained (Anderson 1997, pp.124-125).

This uncoordinated approach to the provision of health care and the continued lack of resources allocated by federal, state and territory governments have also contributed to the poor health outcomes for Indigenous communities (Anderson 1997). Currently there are 517,200 Indigenous people and their life expectancy (calculated for the period 1996
to 2001) is 65 years for females and 59 years for males (Australian Bureau of Statistics 2007). This is considerably lower than the average life expectancy of the non-Indigenous population, calculated to be 82 years for females and 77 years for males (Australian Bureau of Statistics 2007).

The policy of self determination has to some degree also affected Indigenous population health outcomes. The discourse of difference, which endorses the uniqueness of the Indigenous population and their need for specific health care policies, has impacted negatively on some health and education issues as policies are not in place or lag behind in comparison to the non-Indigenous population (Banks 2003; Brady 2004). For example, while the non-Indigenous population had policies in place to deal with health issues such as drug and alcohol use, the Indigenous population were not included due to their perceived ‘difference’ (Brady 2004).

This section has provided a brief history of the colonisation of Australia and the impact this process continues to have on the health and wellbeing of the Indigenous population. Further discussion on the impact of colonisation and the use of discourse is provided in the theoretical chapter of this thesis.
1.7. Methodology and Research Methods

An inductive approach was undertaken as a literature review on the topic revealed that there was minimal information on the cultural needs of Indigenous women during pregnancy, birth and the postnatal period. The nursing and midwifery literature also revealed ambiguity around definitions of cultural diversity and cultural sensitivity. There is also limited evidence on how these concepts are incorporated into practice.

Thirty two study participants (midwives) were recruited from three different geographical areas - urban, regional and rural locations within NSW. The locations were chosen for their identified Indigenous population.

A modified grounded theory approach was utilised for the data collection and analysis. This approach provided clearly defined steps to follow for the collection of the data and analysis (Seale 1999). A modified grounded theory approach also allowed for the constant comparison of the data with existing theoretical frameworks (Grbich 1999).

In-depth interviews were undertaken. These interviews were semi-structured, allowing the researcher to gain the required information about the research topic. However the participants were able to freely tell their stories and provide as much information and detail as necessary to illustrate different points (Polit & Tatano Beck 2004). Data analysis was performed by using constant comparative analysis identifying themes until data
saturation was reached. The theoretical framework for this study was directed by the theoretical sensitivity of the analysis.

1.8. Theoretical Framework

If we look at how the Aboriginal people have been talked about, thought about or imagined in popular culture and the political arena, a number of different ways of thinking and talking about them are discernible. These discourses or ways of talking about the Aboriginal population have been embedded in power relations. This insight led to the review of the concept of discourse and power relationships for this study. Examining discourse and how it is used provides a very useful framework for the analysis of how midwives view culture and how they incorporate cultural sensitivity into practice.

For discourse theorists such as Foucault, discourse can constitute ‘the other’ in powerful ways and this insight is important. Discourse has effects because of the elements of truth, power and knowledge (Mills 1997). Power is a key element (Mills 1997). Foucault considered that power is dispersed ‘throughout social relations, that it produces possible forms of behaviour as well as restricting behaviour’ (Mills 1997, p.17).

Not only does Foucault’s notions of power provide a way of looking at how the Australian Indigenous population is viewed, it also provides a very useful way of looking at how power dispersion within environments such as hospitals impacts on midwifery
practice and the women who receive midwifery care. Pivotal to the factors that impact on
the provision of health care by midwives are the ‘macro powers’ in the form of
government policies, and the ‘micro powers’ in the form of the hospital administration,
including policies and procedures.

1.9. Structure of the Thesis

Chapter 1 has introduced the aims and specific research questions, followed by a brief
history of the colonisation of Australia. Information about the methodology and research
methods used and a discussion on the theoretical framework of this study has also been
provided.

Chapter 2 reviews the nursing and midwifery literature in relation to how the concept of
culture is defined and incorporated into practice. There are two main approaches to
culture; the first tends to focus on the cognitive aspects of culture, the ‘values, beliefs and
traditions’ of a particular group of CALD women. The second approach is broader and
considers the effect of the individual’s social position within society, factors such as their
economic status and educational levels.

While Chapter 2 is the main review of the literature, relevant literature has been referred
to throughout the thesis to illustrate particular points and to strengthen the analysis of the
data.
Chapter 3 describes the theoretical framework, the use of discourse and power and in particular the work of Foucault which was used for the analysis of this study.

Chapter 4 describes the methodology used and the research steps undertaken in collecting and analysing the data.

Chapters 5, 6 and 7 are the data chapters. Chapter 5 presents the analysis on how midwives provide care to women from CALD backgrounds. Chapter 6 presents the analysis of the strategies midwives use when providing care to Aboriginal women. Chapter 7 presents the analysis on the factors that impact in care provision.

Chapter 8 provides a discussion and summary of the findings as well as presenting the significance of the study, the implications, limitations and areas of future research.

There are also Appendices:

A. University of Wollongong Ethics Committee approval.

B. Participants’ Information sheet.

C. Consent form.

D. Interview questions.

E. Study participants’ age, gender, location and ethnic background.
F. Memo – Colonisation.

G. Published journal article.

H: Conference abstracts.
CHAPTER TWO: EXPLORING CULTURE AND PRACTICE

2.1. Introduction

This chapter reviews the nursing and midwifery literature in relation to culture and practice. The chapter argues that distinct approaches to culture and nursing and midwifery practice may be discerned in the literature. One tends to focus on the cognitive aspects of culture, discussing ‘traditions’, ‘values’ and ‘beliefs’, assumed to be shared by all with the same cultural background. Those working in this perspective support learning about other (specific) cultural groups, in particular about their health beliefs and (apparently) traditional behaviours, which will sensitise the nurse or midwife and allow him/her to provide appropriate care to people from Culturally and Linguistically Diverse (CALD) backgrounds. Scholars also often refer to the need for nurses and midwives to be aware of their own culture (again, seen as values and beliefs) in order to facilitate their understanding and acceptance of ‘difference’ (Duffy 2001; Benkert et al. 2005).

There are a number of criticisms which may be made about this perspective and the assumptions that it makes. One is it assumes culture is static and unchanging but, even within the same culture, the experience of the individual changes over time and with it their practices, beliefs and views. It also fails to take into account diversity within cultural groups and between generations. This may lead to stereotypical images of particular groups, with the assumptions regarding their nursing and midwifery needs being made by care providers based on these stereotypical images. This approach has led to the development of generic care plans for people from CALD backgrounds and the use of
these care plans have been labelled as a ‘cookbook’ approach to care (Duffy 2001). Discussion on this issue is provided in this chapter.

The other perspective incorporates culture within a wider, structural framework, focusing on social position, education and socioeconomic status to explain health status rather than on individual behaviours and beliefs. Within this latter perspective is included a small group of postcolonial scholars who are interested in the impacts of the colonial process on the ongoing relationships of Indigenous and non-Indigenous people and how this affects health and health care. This approach has been particularly evident in New Zealand and Canada (Kirkham et al. 2002; Ramsden 2002; Anderson et al. 2003).

In Australia, it is noteworthy that issues of culture and cultural identity are seen in the literature to be more the province of CALD (i.e. non – Anglo-Australian and non – Indigenous) groups. However, as stated in Chapter 1, the concept of cultural safety has been introduced recently in Australia. Cultural safety was developed in New Zealand by Irihapeti Ramsden, who stated that:

Cultural Safety has been developed almost entirely from the interactive experience of the indigenous [Maori] people with a nursing and midwifery service largely derived from a migrant ethic group thus making it unique to this

\[\text{6 As for the majority, or ‘mainstream’, I prefer the term ‘Anglo-Australian’ in a cultural rather than a racial or ethnic sense. The bare majority who are of third or earlier generations is overwhelming derived from the British Isles and speaks only English (Jupp 2002, p.3)}\]
country [New Zealand] although there are elements of international comparison (Ramsden 2002, p.180).

Ramsden (2002) explained in her thesis that the concept was derived from the need for the impact of colonisation to be acknowledged and for an understanding of the effect of colonisation on the Maori population to be taken into account when providing health care for this population. The concept of cultural safety according to Anderson et al. (2003) can be written within a critical postcolonial discourse. The meaning of discourse and how it is used is explored in Chapter 3. However, the concept of cultural safety and its application in Australia will be discussed in this chapter.

Different approaches are also apparent in Australia. Some of the health, nursing and midwifery literature focuses on the ‘empowerment’ of Indigenous people and their participation in health care (Williams 1999; Pyett 2002; NSW Department of Health 2003; Dahlen 2006; Eckermann et al. 2006). This increasing emphasis on empowering the Indigenous population is in direct response to the unsatisfactory morbidity and mortality rates of the Indigenous population in comparison to the non-Indigenous population (O'Donoghue 1998). Alongside this empowerment literature, however, is another literature which continues to focus on traditional practice (Gaff-Smith 2001; Sarzin 2003). There is an assumption, for example, that all Indigenous women follow the same birthing practices (Carter et al. 1987; Gaff-Smith 2001; Sarzin 2003), this will be further discussed in this chapter.
The chapter begins with the search strategy utilised for the study followed by a description of the different approaches to incorporating culturally appropriate care into practice which were identified within the literature.

### 2.2. The Search Strategy.

The literature was obtained using the following search strategy. Electronic databases including Medline, Cinahl, Socio-file and Expanded Academic Index were accessed. A variety of key search terms were used for example, midwi#7 (midwife, midwives or midwifery), nurs# (nurse, nurses or nursing), cultur# (culture or cultural), diversity, sensitivity, competency and empowerment. The results relating to midwifery practice were few, therefore the term ‘nursing’ was included within the entire search strategy which increased the amount of material considerably.

Any references that were deemed useful from the reference index of relevant texts and journal articles were also included in the review. The inclusion criterion for the review was any article that provided information on culture which was based on the care of individuals from Indigenous and/or CALD backgrounds. This included articles on transcultural nursing, cultural diversity, cultural competence and cultural safety.

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7 Truncation (#) of a key word finds variations from the stem of the key word.
A manual review of the journals and textbooks in libraries was performed on an ongoing basis for relevant articles. Regular electronic auto alerts were also received from the University of Wollongong Library databases which provided updates on any new literature relating to my key terms for the duration of this study.

The next section of the chapter examines the literature on culture and practice.

2.3. Culture and Practice

There is a significant amount of literature which apparently addresses how culturally appropriate care may be carried out. Terms used include transcultural nursing (the oldest approach to the issue) and more recently cultural diversity, cultural sensitivity and cultural competency. The concept of cultural safety, which has recently been endorsed by the Australian Nursing and Midwifery Council, within the National Standards for the Midwife, will also be discussed. Finally a description will be provided of how the above concepts have been used within the literature to describe Indigenous traditional practices (cognitive aspects), as well as, the broader approach to practice which incorporates the history of contact and the marginalisation of the Indigenous population within Australian society.

It can be argued that the nursing and midwifery professions first became interested in the topic of culture and the implications for practice in the 1950s, when the anthropologist
Margaret Mead, was employed as a lecturer in the School of Nursing at Cornell University, in the United States (Baker 1997). The growing interest in culture and health care can be directly related to the concept of transcultural nursing as first depicted by Leininger (1988). However, although transcultural nursing has been endorsed by many in the nursing and midwifery profession, it has also been criticised. This criticism is based on the view that transcultural nursing provides a vehicle that allows individuals to be stereotyped and also fails to look at the effect of structural factors (such as colonisation) on individual behaviours (Bruni 1988; Smye & Browne 2002). None the less, transcultural nursing has been extremely influential and hence this chapter begins with a discussion of Leininger’s work.

Leininger states that in the 1950s she became aware that ‘care is the essence of nursing and the central, dominant, and unifying feature of nursing’ (Leininger 1988, p.152). She believed that people from a different cultural background to the care giver had different expectations, therefore nursing required a theoretical framework in which to provide suitable care. Leininger explains how the aspect of culture was not considered at this time, as the main focus of nursing was on clinical procedures and she completed a doctorate in anthropology to develop a theory to address this issue (Leininger 1988).

Leininger’s research concentrated on the development of the ‘new field of transcultural nursing with a focus on cultural care theory’ (Leininger 1988, p.153). This research led her to introduce transcultural and cultural care nursing theory into nursing curricula, particularly in the United States, which in her view impacted positively, on the care
nurses provide within the clinical setting (Leininger 1988). Leininger also asserts that since she first introduced the discussion on care the amount of research, published articles and textbooks on the subject has increased dramatically (Leininger 1988). She states that her:

…theory of Culture Care is not static, but rather a dynamic theory that is being used worldwide by many knowledgeable nurses as the most meaningful, timely and relevant theory in nursing (Leininger 2001, p.37).

Leininger argues that transcultural nursing is a:

… a formal area of study and practice focussed on comparative holistic cultural care, health, and illness patterns of people with respect to differences and similarities in their cultural values, beliefs, and lifeways with the goal to provide culturally congruent, competent, and compassionate care [original in italics] (Leininger 1997, p.342).

Leininger (1997, p.342) states that to provide appropriate transcultural nursing care, nurses must have an understanding of other cultures and look for culture specific ‘symbols, expressions, and meaning of specific and diverse cultures’. It is evident from the literature that there are many nurses internationally who support the theory of transcultural nursing. Midwives and nurses are able to enrol in transcultural nursing programs or seminars in the USA and Australia. In the past, the University of Sydney has offered transcultural nursing courses and The Royal College of Nursing, Australia has
endorsed and published the text ‘Transcultural Nursing in Multicultural Australia’ (Omeri & Cameron-Traub 1996) as part of their professional development series. The concept of transcultural nursing has also gained recognition within the United Kingdom, as this approach has allowed for nurses to draw on specific care plans for people from CALD backgrounds (Mason 1990).

Not only does Leininger assert her role in introducing transcultural nursing, she believes that she also introduced a new way of undertaking research to the nursing profession by building her theory from qualitative research methods rather than from quantitative methods. She states that it was with the use of ethnography that she was to develop an understanding of the needs of people from other cultures (to that of the care provider) in relation to nursing care. Leininger is explicit in her belief that the concept of cultural care focuses on the views of the patients. These views, according to Leininger, provide the ‘meanings, symbols, patterns and expressions of cultural care and nursing from a wholistic perspective’ (Leininger 1988, p.153). This view of culture espouses its cognitive aspects without taking into consideration the individual patient’s life experiences, such as their status within their social environment, socioeconomic factors and education level, which are known to affect an individual’s well-being (Hart et al. 2003).

Leininger has been publishing on the topic of culture care for over forty years and she has provided different interpretations or definitions of the concept of culture during that time. In her earlier publications Leininger defined culture as:
... the learned and transmitted knowledge about a particular culture with its values, beliefs, rules and behavior, and lifestyle practices that guides a designated group in their thinking and actions in patterned ways (1978, p.491).

Subsequentially, she has not defined culture per se but she has instead focused on what ‘culture care’ is:

The theory is a holistic, culturally based care theory that incorporates broad humanistic dimensions about people in their cultural life context. It is also unique in its incorporation of social structure factors, such as religion, politics, economics, cultural history, life span values, kinship, and philosophy of living; and geo-environmental factors, as potential influencers of culture care phenomena (Leininger 2007, p.9).

The first definition is one which appears to view culture as static and unchanging (Price & Cortis 2000). It does not address the issue of agency in relation to how people choose to act, as some individuals choose not to follow their ascribed cultural customs. This interpretation of culture does not allow for diversity (difference) within labelled ‘cultural groups’ to be recognised and it also fails to take into account the effect of migration on individuals and the subsequent merging or loss of different practices. This is why transcultural nursing has been criticised for stereotyping (viewing all individuals within a perceived group as being the same) (Bruni 1988).
As identified in the second quote Leininger is now incorporating social structural factors into care provision, such as the individual’s economic position and their social environment. However, her emphasis is still on the nurse being able to recognise the cognitive aspects of culture by using an ‘ethnonursing research’ approach to care;

...that enables the researcher to enter the world of the participant and tease out the largely unknown and covert care beliefs, values, and lifeways. The method includes five enabler guides to facilitate discoveries of specific care phenomena. These enablers have been extremely relevant and most helpful to enter the cultural world of informants and discover their covert culture care beliefs, values, and practices (Leininger 2007 p.11).

Since Leininger began her work, the increasing changes brought about by globalisation and the growing migration of people (Duffy 2001) have influenced the continuing interest of the nursing and midwifery professions in providing care that is ‘culturally appropriate’. The vocabulary used to describe caring for people from different cultural backgrounds has also increased, including terms such as ‘cultural diversity’, ‘cultural sensitivity’, ‘cultural competency’, ‘cultural safety’ and ‘empowerment’ which are now discussed.

‘Cultural diversity’ is the term used by several authors (Henkle & Kennerly 1990; Erlen 1998; Kirkham 1998; Homer 2000; Callister 2001) to describe the changing population of the world through migration. These authors are referring to the United States, Canada and Australia, however many other countries are experiencing or have experienced changes to
their population through immigration. Callister (2001) refers to the world becoming a ‘global village’ and therefore health care professionals are dealing with individuals from a multitude of different cultural backgrounds to their own on a daily basis. Erlen (1998) and Henkle and Kennerly (1990) expand on the concept of cultural diversity to include not only immigration as the cause of the diversity but they also include those people who were born in the same country who have different values or approaches to life to that of the health care provider.

It is suggested that cultural diversity refers to the recognition of different cultural groups and their needs (Homer 2000). Homer is particularly concerned with the lack of representation within midwifery research studies of CALD women. She argues that many Australian studies in the past have excluded women whose first language is not English. Different cultural groups, from Homer’s perspective, are those whose first language is other than the dominant language of the country they live in.

A definition of culture is not provided by Homer (2000), however, she seems to mean ‘tradition and custom’. She points out that traditional practice may be important for some women and not for others and she states that this may be because the women choose not to follow ‘their customs’ because of the effect of their new living and social conditions (Homer 2000, p.253). Homer refers to the cognitive aspects of culture, such as traditions and customs but does not provide examples. This term ‘traditional’ is problematic. It appears to assume that there is set of distinct unchanging practices which are, or should be, performed by all people from the same cultural backgrounds.
The emphasis in a large proportion of the literature is on recognition of a consistent set of values exhibited by individuals who are labelled as belonging to specific CALD groups, such as Asian women (Matthey et al. 2002; Liamputtong & Naksook 2003). When health care professionals attempt to broaden their awareness of ‘difference’ by attending cultural training sessions that discuss cultural difference and subsequently adjust their practice to meet the needs of these individuals, they are said to be ‘culturally sensitive’ as they appreciate ‘the richness and the complexity that diversity brings to a situation’ (Erlen 1998, p.3).

However, it is argued by Erlen (1998) that to respect other cultures, the health professional must first recognise their own culture and any biases that may impact on their practice. As the literature on cultural sensitivity increases (Henkle & Kennerly 1990; Erlen 1998; Yearwood 1998; Scholes & Moore 2000; Omeri & Malcolm 2004; Benkert et al. 2005) there is a growing consensus that health care professionals need to be aware of their own ‘cultural beliefs, attitudes and feelings’ (Duffy 2001, p.498) to facilitate their understanding of people who may be from a different background. There are numerous methods/teaching strategies, according to these scholars, to assist health professionals to recognise their own values, for example, ‘value clarification exercises’ (Erlen 1998, p.3), ‘self assessment tool’ (Benkert et al. 2005, p.225) and ‘continuing education’ including ‘case conferences’ (Omeri & Malcolm 2004, p.187). However there is little evidence to show if the above are effective. It has been argued that when the focus of education is on cultural difference, there is a danger of reinforcing an ethnocentric approach to care and,
in some cases, a paternalistic approach to health care provision (Bruni 1988; Blackford 2003), as Bruni (1988) asserts is the case in Australia.

Endorsement of their ‘culturally sensitive’ practice is achieved for the nurse or midwife when they are rewarded by health care organisations or professional bodies by being called ‘culturally competent’. Robinson defines cultural competence as:

…a sensitivity to issues of culture, race, gender, sexual orientation, social class and economics. Cultural competence involves more than knowledge acquisition: it involves skills, awareness, encounters, desire and knowledge (2000, p.131).

This definition goes beyond Leininger and transcultural nursing to include attributes such as, awareness, skills and knowledge. However there is no mention of how these attributes are measured in the context of the nurse or midwife’s workplace.

In an Australian context the Australian Nursing and Midwifery Council has developed ‘Principles for the Assessment of National Competency Standards for Nurses and Midwives’. However, in NSW there is no mechanism to mandate competency assessments for registered nurses or midwives. The NSW Nurses and Midwives Board (NMB) currently mandate that registered nurses and midwives are registered annually. However, this consists of the registered nurse or midwife paying an annual fee to the NMB and the registered nurse or midwife is not required to provide any evidence of ongoing competency assessment or education. Therefore there is no formal mechanism to
evaluate ongoing competency, including cultural competency, unless the institution
where the registered nurse or registered midwife currently is employed does so.

2.4. Avoiding the Generic Approach to Care

Duffy (2001, p. 489) argues that nursing education continues to espouse ‘distinct cultural
components (local particularities)’ without taking into account the interaction of the
individual with global influences such as media and the increasing use of technology. The
individual gets lost in an education that, focusing on cultural characteristics and customs,
provides a ‘cookbook’ approach to care (Duffy 2001, p.498).

This ‘cookbook’ approach refers to generalised information that has been formulated
about different specific CALD groups. As argued by Duffy (2001) transcultural literature
and texts are full of these generic ‘cookbook’ approaches. An example is the text,
‘Culture Care Diversity and Universality, A Worldwide Nursing Theory’ edited by
Leininger and McFarland (2006). The text endorses ‘culture specific clinical nursing
care’ which is a care plan that has been formulated specifically ‘to make nursing care
decisions and take actions that are culturally congruent with the beliefs, practices, values

This approach in the majority of cases is used to provide generic information about
people from specific CALD backgrounds. Some authors do warn the readers that this
approach can lead to ‘stereotyping’ as it is impossible to cover the diversity within CALD groups such as those from South Asia (St. Hill et al. 2003). However despite the advice to not stereotype individuals, generic cultural information is often provided for specific CALD individuals (who are labelled as belonging to a group or having the same characteristics as a group).

We respectfully ask you to avoid using this book as a cookbook or to stereotype the women described in each chapter. Please use it as a starting point from which to think about and ask whether this particular family, client, or student is similar to or different from what the chapter describes on the topic of interest (St. Hill et al. 2003, p. xviii).

The problem is that although the warning has been provided in the preface by St. Hill et al (2003), it may not be read by those health care providers or students who are seeking to enhance their knowledge of people from specific CALD backgrounds. It is likely that individuals seeking information will turn to the chapter that provides their required information. For example, in St. Hill et al. (2003) text book entitled ‘Caring for Women Cross-Culturally’, chapters are labelled to provide generic information such as Chapter 4 ‘Arab Americans’, Chapter Six ‘Cambodians’ and Chapter 7 ‘Chinese’ women.

Educational strategies tend to focus on learning about particular ‘cultures’, as indicated above. Students may do this, according to the literature, by spending time overseas or by interviewing other nurses who are from diverse backgrounds (Henkle & Kennerly 1990;
Robinson 2000; Scholes & Moore 2000). This practice is believed to enhance cultural competency. However these approaches to cultural competency have rarely been critically evaluated (Suh 2004). They suggest that an individual can ‘embody’ culture in some way or that individuals from similar backgrounds, either similar linguistic backgrounds, for example ‘Chinese speaking’, or similar national backgrounds, for example ‘Greeks’ are all alike in some way. Lock (1990) suggests that this approach ignores differences such as age, gender, class, education and sexual orientation which shape each person’s perspectives. This can make health professionals who are apparently from similar cultural backgrounds unsympathetic to health care recipients with a perceived traditional outlook and they are often devalued because of their adherence to outdated traditional beliefs.

A final criticism of the approach to practice that focuses on the cognitive aspects of culture, traditions, customs and values, is that it fails to take into account broader social, political and economic factors which affect health and access to health care. As a result, and given the emphasis on the individual and individual responsibility within Western societies, this perspective can lead to ‘victim blaming’ based on ‘lifestyles, cultural differences or biological predisposition’ rather than focusing on people’s ‘social and economic circumstances, marginalisation and oppressive internal colonial politics’ (Browne & Smye 2002, p.29).

By ‘oppressive internal colonial politics’ Browne and Smye (2002) mean that when the impact of colonisation on an Indigenous population is not taken into account by the
relevant government, this is reflected by the whole non-Indigenous community. There is a lack of understanding of the impact of colonisation on the well-being of Indigenous populations worldwide and an expectation in Australia that the Indigenous and non-Indigenous population should ‘move on’ and forget the past. The result is that legitimate demands of the Indigenous population are not met (Jamrozik 2004, p.83). The discourse of colonisation and the way power is filtered throughout the social environment of individuals will be discussed in detail in Chapter 3, the theoretical chapter.

2.5. Culture and Power

The idea that learning about the customs and beliefs of particular groups is beneficial for the appropriate care of the individual and their families from Indigenous and CALD groups, ignores more critical analyses of the culture concept. In particular, how it may be used in power relationships, which are usually detrimental to minority groups, such as the Australian Indigenous population. This critical analysis leads to an approach which is more explicitly theoretical, utilising the insights from postcolonial discourse theory. Proponents of ‘cultural safety’ tend to come from this perspective.

Cultural safety originated in New Zealand (Jeffs 2001) but has been taken up by scholars in other countries such as Canada (Kirkham et al. 2002). Not all agree that it is transportable. As it is concerned with ‘biculturalism’ in New Zealand (the Maori and Pakeha), some suggest that there are difficulties in utilising the concept of cultural safety
in countries where there are multiple Indigenous groups (for example many different First Nation peoples, Inuit etc), and many different immigrant groups, as is the case in Canada (Kirkham et al. 2002; Smye & Browne 2002). However, these same authors (Kirkham et al. 2002; Smye and Browne 2002) argue that by using the concept of cultural safety (even though it is recognised to be a bicultural approach) the benefits outweigh the negatives, and there are many similarities between New Zealand and Canada in the way colonisation affected their respective Indigenous populations.

When discussing the concept of cultural safety Kirkham et al. (2002, p.227) describe it as requiring ‘a reconsideration of the disparate power relations within and beyond health care and the historical and social processes that organize these relationships’.

These Canadian authors state that by taking a postcolonial viewpoint of the concept of cultural safety as developed in New Zealand, they are able to examine the extended history of the role of economic, political and social subordination of Aboriginal groups and other ethnic minorities in Canada, and the direct negative impact this has had on their health outcomes. Kirkham et al. (2002) argue that it is important to understand that the concept of culture, defined by some health care professionals as being a balanced system of communal practices, beliefs and meanings, does not exist. On the contrary, when viewing culture from a postcolonial discourse perspective, it is seen as not being unitary or neutral. Kirkham et al. (2002, p.224) argue:
…the concept of culture must be interrogated to unmask the relations of the ruling and domination that have shaped the constructions of the “other”, even as attempts are made to bridge the gap between the Western self and the “colonized other” in the appeal to ideas such as cultural sensitivity.

The underpinning philosophy of cultural safety was derived from the work of Ramsden who completed a doctorate on cultural safety and nursing in New Zealand in 2002 and who is internationally known for ‘developing an educational framework for the analysis of power relationships between health professionals and those they serve’ (Ellison-Loschman and CPHR 2005). Ramsden defined cultural safety as ‘an outcome of nursing and midwifery education that enables safe service to be defined by those that receive the service’ (Ramsden 2002, p.117). She stated that the process of cultural safety requires ‘a critical analysis of existing social, political, and cultural structures and the physical, mental, spiritual and social outcomes for people who are different’ (Ramsden 2002, p.180).

Ramsden stated that the non-Indigenous population of New Zealand did not consider the impact of colonisation on the Maori population. She argued that:

For patients to be considered in terms of their political status and historical circumstances requires an understanding and knowledge of history which continues to be uncommon in New Zealand currently (Ramsden 2002, p.180).
Using the concept of cultural safety nurses and midwives are encouraged to reflect and analyse how power relationships and history have impacted on the health of individuals (Spence 2003; Kruske et al. 2006). Part of this reflection includes how ‘personal and institutional cultures impact on the delivery of health care’ (Spence 2003, p.224). The goal of cultural safety is to provide care that is ‘effective’ and ‘determined’ by the individual (Spence 2003, p.224).

Cultural safety has also been endorsed by the Nursing Council of New Zealand, and their definition of the concept of cultural safety is:

The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability.

The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual (Nursing Council of New Zealand 2005, p.7).
However, Williams (1999) cautions that for cultural safety to be utilised (as intended by Ramsden and by the New Zealand Council of Nursing) within an Australian context, the Indigenous population need to be empowered to be able to direct appropriate care. It is acknowledged that cultural safety was developed in New Zealand, and although there are similarities in the history of colonisation of Australia and New Zealand, there are also primary differences in the way in which colonisation was enacted (Kruske et al. 2006).

Under the Treaty of Waitangi enacted in 1840, the Maori people were guaranteed to have their way of life protected and at the same time were granted full citizenship rights (New Zealand Government 2005). The Australian Indigenous people were not treated in the same manner, and full citizenship rights were not given until the 1967 referendum (Hemming 1998), one hundred and seventy nine years after Australia was colonised by the British. As outlined in Chapter 1, the Australian Indigenous population was excluded and marginalised and, as a result, the Indigenous people’s role in determining their well-being has been quite different to the Maori population in New Zealand. That is why it has been recommended by Williams (1999) that the Australian Indigenous population needs to be empowered to direct the care that they wish to receive under the banner of cultural safety.

However, as argued by Hunt (2001), the present health care system is not conducive to allowing Indigenous women to be empowered, as health care providers control pregnancy care. Hunt (2001) argues that many Indigenous women experience increased surveillance, as more assessments, tests or increased hospitalisation takes place to monitor the health of the woman and her foetus. Indigenous women will not be empowered until health
professionals and the health system recognize and relinquish ‘some of the control they currently exert over women’ (Hunt 2006, p.53). This is reiterated by Kildea (2006) who argues that Indigenous women’s voices need to be heard for cultural safety to be truly enacted and that the current dominant Western medical system needs to be challenged to improve the health outcomes for Indigenous women and children. Indigenous women are being removed from remote and rural communities to birth in hospitals in city or major town centres with little thought given to the impact this has on their and their families’ social well-being. The removal of women from their communities has not improved their birth outcomes (Kildea 2006).

In the past there has been little education on Indigenous health issues it is therefore difficult to envisage how all Australian nurses and midwives will have a full comprehension of what cultural safety encompasses. An audit by the Congress of Aboriginal and Torres Strait Island Nurses (CATSIN) of Australian nursing programs found that only 22 out of 33 provided a distinct subject on Indigenous Health (Australian Nursing and Midwifery Council 2007). The Australian Nursing and Midwifery Council (ANMC) is now calling on all providers of nursing and midwifery programs leading to registration or enrolment to include a distinct subject/module on Indigenous health, culture and history (Australian Nursing and Midwifery Council 2007).

However, there is limited evaluation on how the concept of ‘cultural safety’ and the inclusion of this concept in nursing and midwifery curricula have worked in reality (Richardson 2004). Johnstone and Kanitsaki (2007) argue that although cultural safety is
a part of all nursing and midwifery curricula in New Zealand, there is limited evidence (if any) on how this concept has impacted on the health outcomes of the Maori population. These authors undertook an Australian study to determine how the concept of cultural safety was understood and applied in an Australian context. They interviewed a total of 145 participants, including patients and their families. Their results showed that the concept of cultural safety is not readily understood by health professionals and therefore it is not applied as intended in the clinical setting (Johnstone & Kanitsaki 2007).

Despite not being familiar with the term, health service provider participants had a sense that cultural safety was a complex process primarily concerned with health care providers “doing things safely” and ensuring that patients from diverse racial, ethnocentric, and language backgrounds got “safe care” and did not suffer mishaps and harms because “communication was not effective” or because “staff lacked cultural knowledge and awareness” (Johnstone & Kanitsaki 2007, p.251).

When cultural safety is viewed in this way there is no recognition of the social determinants that may affect an individual’s well-being. The focus of the health professionals in this study was on providing safe clinical practice. The meaning of cultural safety has been totally misinterpreted.

Most importantly Johnstone and Kanitsaki’s (2007) research identifies that consumers (patients) of health care were unable to define cultural safety or to express what they
thought it may be. It should be noted that although consumers were included in the study, it is not clearly identified by the authors the exact number of participants who were Indigenous. This study undertook a broader approach to the concept of cultural safety by seeking to ascertain whether it was suitable in a multicultural context. This was not the original intention of the concept of cultural safety as defined by Ramsden. The use of the concept for the provision of care to all individuals devalues the original concept of recognising the impact of colonisation on Indigenous populations. Immigration is a different issue, although immigrants face many challenges, they have not experienced the oppression or injustices that many Indigenous populations have faced and continue to face.

However, it can be argued that the concept of cultural safety has at least provided a focus for nursing and midwifery education that has moved beyond providing a ‘cookbook’ approach to care (as discussed previously):

The purpose of cultural safety in nursing education extends beyond the description of practices, beliefs and values of ethnic groups. Confining learning to rituals, customs and practices of a group assumes that by learning about one aspect gives insight into the complexity of human behaviours and social realities. This assumption that cultures are simplistic in nature can lead to a checklist approach by service providers, which negates diversity and individual consideration (Nursing Council of New Zealand 2005, p.7).
2.6. Indigenous Australians and the Nursing and Midwifery Literature

There is an increasing amount of literature that discusses Indigenous traditional birthing practices (Carter et al. 1987; Callaghan 2001; Sarzin 2003). Callaghan (2001) argues that there is a wide variance in traditional practices depending on geographical location and groups, but she found there remain key commonalities. There is an assumption by some that all Indigenous women follow the same birthing practices such as ‘smoking the baby’ (Carter et al. 1987; Gaff-Smith 2001) or the ‘use of warm sand to settle the baby’ (Sarzin 2003, p.22). This adherence to traditional practices may then be expected by midwives caring for Indigenous women.

In some of the literature that discusses the importance of traditional practices for Indigenous women there is reference to what has been labelled as ‘shame’ for these women (Watson et al. 2002a; Minniecon et al. 2003; Kruske et al. 2006). ‘Shame’ has been defined as the feelings of guilt Indigenous people experience if they have been singled out if they take part in an activity that has not been approved by their group or the activity does not meet their cultural or social requirements (Morgan et al. 1997; Watson et al. 2002a; Kruske et al. 2006). For Indigenous women, ‘shame’ may occur if they are cared for by a male health professional during pregnancy, birth and the postnatal period (Kruske et al. 2006).
However the amount of literature that reports on research into how Indigenous women find their maternity care within the context of a hospital or community health setting is small (Fitzpatrick 1995; Watson et al. 2002a; Campbell & Brown 2004). There is a focus by these writers on the importance of communication, education and Aboriginal community health services.

A study was undertaken by Campbell and Brown (2004) to compare the experiences of a group of Indigenous women who were attending ‘the Women’s Business Service at the Mildura Aboriginal Health Service’ (WBSMAHS). The results of this study were compared with the results of a study undertaken on women across the whole of Victoria, who were attending public antenatal services. The authors identified that the 25 women attending the WBSMAHS were more satisfied with their care than women attending other rural public maternity services in Victoria. The results attributed to the 25 women are as follows:

…having options in labour and an active say in decisions about care (11/25). knowing their care givers (9/25), sensitivity, kindness, reassurance and respect shown by care givers (8/25), and feeling informed about what was happening (6/25)’ (Campbell & Brown 2004, p.379).

It is important to note that the Indigenous women who were participants in the study by Campbell and Brown were involved in the decisions about their care. As argued by Hunt (2001), health outcomes for Indigenous women will not improve unless they are involved
in their health care decisions. Hunt (2001), states that a number of key factors impede the
ability of Indigenous women to be included or to make decisions about their health care
management. These factors are:

…communication difficulties, lack of time, lack of continuity of carer,
prescriptive protocols, and provider concern about the possible negative health
or, other impacts of women making decisions different from those recommended
by providers or protocols (Hunt 2001, p.52).

Watson et al. (2002a) conducted a project at a Northern Territory hospital to develop
educational material from interviews they did with both Indigenous women and health
professionals. This project was carried out over three stages. The first consisted of focus
interviews with ten professional Indigenous women to seek information about the best
approach for interviewing Indigenous women about their birthing experiences, either in
hospital or unplanned within the community. A Delphi technique was undertaken and the
results identified various themes. These themes consisted of traditional and cultural
understanding, the most appropriate way to perform interviews such as story telling, the
preparation for birth, experiences in the hospital setting, support for Indigenous mothers
when they are hospitalised or away from their homes, and lastly communication and
relationships with health care providers (Watson et al. 2002a).

The discussion about tradition and culture focused on the need for Indigenous women to
be supported by their grandmothers or aunties, who understand their needs. Although
‘women’s business’ was discussed, Watson et al. (2002a) point out that this is changing in some cases, as women may prefer to have their male partners present at birth. The research identified that Indigenous women who are moved away from their communities to give birth often feel isolated and do not know what to expect, especially if they are staying in a hostel with the added cost of finding money for food. The authors (Watson et al. 2002a) stated that their research project confirmed issues that had been previously identified for Indigenous women attending this particular hospital in the Northern Territory, such as communication difficulties between health care professionals and Indigenous women.

The second component of the research project conducted by Watson et al. (2002b) consisted of interviewing twelve Indigenous women about their maternity care experiences whilst inpatients in a Darwin hospital. They were interviewed by an Aboriginal Health Worker (AHW). This component of the study had several limitations; the AHW approached only women who she thought would take part in the study, and they were mainly aged over 30, which is not representative of the Indigenous population admitted to this hospital. Nevertheless, the interviews did highlight that each of the twelve women had individual experiences. However there were common issues relating to the following; ‘there were overwhelming expressions of miscommunication, lack of empathy, and misunderstanding of cultural and spiritual beliefs’ (Watson et al. 2002b, p.159).
The majority of these women, although removed from their communities for the birth of their baby, understood the reason for this and were happy to go to the referral hospital as they were concerned for the safety of the baby. However their discomfort in different surroundings was exacerbated by the fact that English was often not their first language, they did not understand the medical system and ‘Western bureaucracies and their cultures’ (Watson et al. 2002b, p.159).

The third part of the project conducted by Watson et al. (2002c) consisted of interviewing nineteen health professionals, non Indigenous and Indigenous about their experiences of providing caring for Indigenous women. The participants consisted of midwives and doctors, whose first language was English. The majority of the midwives were over thirty five years of age (88% of the sample size), which is representative of the Australian midwifery workforce. The surveys showed that all the participants believed that Indigenous mothers did not receive adequate antenatal education about what to expect when admitted to a hospital setting. They also indicated that communication was the biggest issue in providing care for Indigenous women. Some stated that they had difficulty building a rapport with Indigenous women due to their perceived shyness. Others had no difficulties building a rapport with Indigenous women.

Suggestions to improve care for Indigenous women were sought in the surveys. One suggestion made by a participant was ‘that each community should put together a ‘birthing plan’ for their mothers’ (Watson et al. 2002c, p.164). This again highlights the desire of health professionals to have a generic approach to care for CALD women,
including Indigenous women. This approach to care does not recognise a person’s individual needs, and could result in an individual approach to care being replaced by a generic approach, with little thought given to the variance within communities and populations.

The concept of cultural safety and caring for Indigenous women has been addressed by Kruske et al (2006) and although these authors are very explicit in their view that historical factors and power relationships need to be taken into account, they also state the importance of taking traditional cultural practices into account when providing care for Indigenous women, to avoid ‘shame’ from occurring. The danger of including details of cultural traditional practices is that the reader may focus on these rather than on underlying reasons for the disparity between health outcomes for the Indigenous population and the non-Indigenous population. On the other hand Morgan et al. (1997) argue that when health care professionals only focus on the social factors that have caused the disparity in health outcomes for the Indigenous population, three fundamental aspects of Indigenous culture are ignored. These according to Morgan et al. (1997, p.597) are:

- a generally poor understanding of the way Aboriginal people think about the nature of reality and, more particularly, about human life, knowledge and value
- an inability to notice the extent to which this thinking shapes the practical, daily lives of Aboriginal people
- a reluctance to recognise that these beliefs and practices differ from those of mainstream European Australians in significant ways.
This may be very important for some Indigenous Australians, however there is an assumption that it is important for all.

2.7. Conclusion

This chapter argues that there are two main approaches to culture. The first focuses on the cognitive aspects of culture (beliefs and values). This approach within the nursing and midwifery literature tends to provide generic information about different groups of CALD people. This generic information is then used to provide a ‘cookbook’ or ‘recipes of care’ for people with CALD backgrounds. This approach on the whole does not take into account other factors which may impinge on the individual such as their socioeconomic status or educational level. Therefore illness or prevention of illnesses may be seen as the individual’s responsibility regardless of their position within society.

The second approach to practice is broader and includes a structural framework that focuses on the individual’s social position, socioeconomic and educational status, and how this has impacted on their health and well-being. This approach has recently gained attention under the concept of cultural safety which has now been adopted by professional bodies such as the ANMC and the ACM. While the concept of cultural safety has much merit, there is little available evidence to support how this concept is being incorporated into practice. It is in danger of becoming rhetoric only and health care professionals appear to be confused by its exact meaning.
The literature proliferates with suggestions, for assisting health professionals to understand ‘difference’ and to improve the way nurses and midwives provide culturally appropriate care such as ‘value clarification exercises’ (Erlen 1998) and ‘case conferences’ (Omeri & Malcolm 2004). However there is little evidence that this approach, which focuses on the cognitive aspects of culture has impacted in a positive way on the health care offered to CALD populations and Indigenous people. In fact, it can be argued that it tends to reinforce a stereotype approach to practice.

On the other hand any approach to practice which incorporates the history of contact, like cultural safety does, provides a more meaningful insight into the reasons for the poor health status of the Australian Indigenous population. At this stage though, there is limited evidence on how this approach is being incorporated into health services and into clinical practice. There is a danger that new concepts will continue to proliferate without a practical way to implement them.

In an Australian context, the literature describing the experiences or needs for Indigenous women during pregnancy, birth and the postnatal period has combined a cognitive approach to care with the latest concept of cultural safety. There is a danger that care plans will be endorsed which fail to take into account individual life experiences and needs.
CHAPTER THREE: EXAMINING DISCOURSE

3.1. Introduction

As indicated in chapter 1, the use of discourse and the way power is circulated has been used in this study to explore and interpret the perspectives of the participants. It has been used to elicit their understandings of culture and cultural sensitivity and the factors which impact on their ability to provide culturally sensitive care to their clients. Discourse requires the use of language, and language is the way that individuals understand their social environment (Danaher et al. 2000). This chapter commences with a discussion of discourse and how it is used to produce knowledge about the world in which we live. Discourses have effects (they are constitutive) because of the elements of truth, power and knowledge (Foucault 1980). These elements are discussed in this chapter using a Foucaldian approach.

Following on from the above discussion, an account of how discourse has been used to describe people from CALD backgrounds is provided. Discourse has been used in the Western world to explain difference, and has allowed ‘discursive practices’ to be used to ‘produce social and psychological realities’ (Davies 2000, p. 88). As argued by Davies (2000) discursive practices are best understood as the use of language or symbols at the institutional level, such as government, to describe particular groups of people or topics. This chapter will demonstrate that certain discursive practices have been used to label people from CALD backgrounds as the ‘other’. Discursive practices are also used to direct how an individual may view the world (Davies 2000). In particular, practitioners or
members of particular groups learn how to fit or remain in a discipline by using the
discourses of their discipline (Danaher et al. 2000). For example, the nursing and
midwifery professions are governed by discourses that shape how individual nurses or
midwives practice. These discourses are shaped by the rules and behaviour set down by
their professional bodies; this will also be highlighted within this chapter.

A discussion on how discourses impact on the way midwives provide care for
childbearing women is presented. Discourse theory is useful in analysing the
relationships between childbearing women, midwives, the medical profession, institutions
such as hospitals (where most births occur) and regulatory policies and practices.
Dominant discourses here emphasize the medicalisation of childbirth and the role of
biomedicine and ‘science’. This is contested by discourses positioning childbirth as a
‘natural’ process and emphasising the agency of (some, though perhaps not all) women
and their ability to make choices. These discourses both constrain and provide
opportunity for professional practice. These issues are discussed using Foucault’s
concepts of disciplinary power and governmentality.

This chapter concludes with a description of the discourses which are used to describe the
Indigenous population and how these various discourses have impacted on the way in
which the Indigenous population is viewed and positioned within Australian society.
3.2. Discourse

Discourse in Foucault’s view involves the ways in which the social production of the meaning for objects and events is developed and maintained (Cotton 1997). Discourse has been described as the way individuals communicate with one another verbally or in writing (Mills 1997). However Foucault viewed discourse as a whole, not just the way people talk and write to each other, but by the way in which their communication is affected by the ‘rules and procedures’ of the individuals’ social environment (Mills 1997). Discourses in this sense ‘are sets of sanctioned statements which have some institutionalised force, which means that they have a profound influence on the way that individuals act and think’ (Mills 1997, p.55).

Foucault was concerned with the way in which these rules and procedures were developed. Discourse is depicted by Foucault as a series of statements produced by those with power and discourses are always related to power and knowledge. As discourses are produced by the powerful they create a ‘regime of truth’ (Hall 1992, p.295). In the Western world, discourses are often created by those who use scientific evidence to support their discourses, such as obstetricians. These dominant discourses become embedded in the social environment and provide a way of viewing the world. Power circulates through society and the discourses of the powerful become accepted as the ‘true’ or ‘natural’ way.
Dispersion is described by Foucault as the way power operates everywhere through the use of discourse, that it is circulated throughout society, therefore it is not the powerful that dominate, as power is not to be ‘had’ (McHoul 1993, p.39); instead power has a subtle dispersion throughout society.

Power is everywhere; not because it embraces everything, but because it comes from everywhere…One must suppose rather that the manifold relationships of force that take shape and come into play in the machinery of production, in families, limited groups, and institutions, are the basis for wide-ranging effects of cleavage that run through the social body as a whole…Major dominations are the hegemonic effects that are sustained by all these confrontations (Foucault 1979, pp. 93-94).

Foucault is inferring that there are always power contestations; however there will always be dominant discourses. Power is not just about relationships between individuals and governments: Foucault argued that power is transmitted throughout all social institutions by the use of discourse and although there may be resistance, in the end it is the discourse of the powerful that is seen as being truthful (Foucault 1977).

Mills argues that the term ‘hegemony’ when used in a Foucauldian sense, is used to describe the process of how individuals who are dominated by others within their social environment take up the philosophy and values of those who dominate. These views are then seen as their own and allow them to see their position within the social environment
as ‘natural or for their own good’ (Mills 2003, p75). As described by McHoul and Grace (1993), the role or actions of subjects (individuals) was recognised by Foucault. He argued that individual thought is developed through the individual being subjected to the various forms of power within their social environment which in turn shapes how they act and think (Foucault 1977). He argued that individual thought is an action that is brought about by the individual’s ability to reflect on an experience or object.

Thought is freedom in relation to what one does, the motion by which one detaches oneself from it, establishes it as an object, and reflects on it as a problem (Foucault 1997, p.xvvv).

However, Foucault also stated that it is possible to resist dominant discourses (Foucault 1977). He argued that wherever there are dominant discourses there is resistance. This resistance is seen to be natural as when there is no resistance, there cannot be power relationships and change does not occur (Mills 2003).

The idea that there could exist a state of communication that would allow games of truth to circulate freely, without any constraints or coercive effects, seems utopian to me. This is precisely a failure to see that power relations are not something that is bad in itself, that we have to break free of. I do not think that a society can exist without power relations, if by that one means the strategies by which individuals try to direct and control the conduct of others. The problem then is not to try and dissolve them in the utopia of completely transparent communication but to acquire the rules of the law, the management techniques, and also the morality, the ethos, the practice of the self, that will allow us to play
these games of power with as little domination as possible (Foucault 1997, p.298).

Foucault is inferring that there are always different discourses in circulation. However, these discourses are often constrained by ‘power’ games. For different discourses to be heard and for the dominate discourse to be challenged it is necessary to know how to ‘play the game’, to know the rules and how to manage these. Although discourse is powerful, possibilities for resistance and individual action exist. The individual cannot escape from the structures, the rules and organisations within their social world, such as the government, which surround them (Danaher et al. 2000). Nevertheless, they can recognise these structures and form knowledge that enables them to alter their strategy in regards to how they react to the events around them.

The concept of power as defined by Foucault is evident by the way:

Power is exercised both in intersubjective relations and through objectivized institutions: the micro-powers of everyday life and the institutional macro-systems mediate each other (Fornas 1995, pp.64-65).

Individuals at the ‘micro’ level can be controlled by different disciplines that use power to control behaviour, such as the discipline of medicine. Foucault argued that although power at the ‘micro’ level is constraining it should not be viewed negatively as it actually produces action or production (Fornas 1995). However, individuals at the ‘micro’ level
may resist the domination or prevailing discourses of those with power, such as the
government. By this resistance the discourse of the powerful is challenged and may be
altered to reflect the concepts of the individuals at the ‘micro’ level. Surtees (2004) refers
to the connection of the ‘macro’ and ‘micro’ powers as:

…a capillary network. The ‘microphysics’ of power involves the subtle, multiple
directional relations between specific individuals…Power in this sense, then, is
seen as productive and diffuse, rather than repressive and exclusionary (Surtees

Foucault referred to the ability of individuals to act as a reaction to the structures or
forces that govern people. He argued that these forces or ‘technologies’ shaped individual
and collective actions. Foucault referred to the use of four types of ‘technologies’ which
enable individuals to act and make sense of concepts. Foucault argued that the four
technologies usually work together. These four ‘technologies’ are:

1. Technologies of production - the ability of an individual to produce actions or
   objects.
2. The technology of sign systems - the use of ‘signs, meanings, symbols, or
   signification’ by individuals.
3. The technologies of power - which preside over individual behaviour and by
   which they are dominated.
4. Technologies of the self - the way in which individuals act to achieve their
   aspirations or desires (Foucault 1997, p.225).
Foucault states that each technology is concerned with ‘a certain type of domination’; the technologies are involved in individual training and are responsible for the development of skills and attitudes (Foucault 1997, p.225). The first two technologies of ‘production’ and ‘signs’ are concerned with ‘science and linguistics’ (Foucault 1997, p.225). Foucault (1997) does not expand on what he means by ‘science’ and ‘linguistics’, however linguistics according to McHoul and Grace (1993) in Foucauldian terms is the production of meaning in the form of language and the representation of language, for example, signs and symbols. From Foucault’s previous work, ‘science’ can be taken to be the discourse of ‘truth’ which according to Foucault:

… is centred on the form of scientific discourse and the institutions which produce it… it is produced and transmitted under control, dominant if not exclusive, of a few great political and economic apparatuses (university, army, writing, media); lastly, it is the issue of a whole political debate and social confrontation (‘ideological’ struggles) (Foucault 1980, pp.131-132).

However, Foucault is most concerned with the last two technologies which he argues are concerned with ‘domination and the self’ (Foucault 1997, p.225). Domination in this sense refers to how the individual is influenced by the discourse of their social environment. Foucault (1997) outlines what he considers to be, throughout history, the development of ‘self’ which is closely related to the discourse of the individual’s social environment. He maps the development from the Roman Empire of the discourse espousing ‘take care of oneself’, which developed into ‘know yourself’ as the way in which individuals abided by the rules that governed society (Foucault 1997).
This was further developed by Christian morality, where the ‘self’ seeks to follow the rules of acceptable behaviour and involves examining one’s behaviour and the use of a verbal ‘confession’ to another of one’s weakness or ‘sins’ (Foucault 1997). This according to Danaher et al. (2000, p.130) ensured that the individual acted in an acceptable manner and by doing so enhanced the society in which he/she lived. In today’s world the use of the Christian confessional has to some degree been replaced by medicine, psychology or psychiatry and individuals now discuss their well-being with these professionals (Danaher et al. 2000).

Although the individual is governed by discourses that circulate through the social environment, the individual can choose to be dominated or they can resist domination:

Perhaps I’ve insisted too much on the technology of domination and power. I am more and more interested in the interaction between one-self and others, and in the technologies of individual domination, in the mode of action that an individual exercises upon himself by means of technologies of the self (Foucault 1997, p.225).

It is important to note that in ‘the technologies of the self’, an individual’s beliefs or actions are not predetermined or inborn characteristics of the individual. Rather they are a result of the individual’s subjectivity to past and current discourses, as well as the structure of the law or government. These individuals’ beliefs are not predetermined but rather shaped by past and present events (McHoul & Grace 1993).
The use of discourse and how power is circulated throughout an individual’s social world allows for an understanding of how dominant discourses within the Western world define individuals who appear different to them. The next section of this chapter will discuss the discourses used to describe ‘the other’ and how these are legitimised.

3.3. Discourses of / about the ‘other’

It has been suggested that the term ‘culture’ did not exist until after 1750 (Page 2005) and according to Barker (2000, p.35) there is no ‘correct’ definition of culture. Barker (2000), states that the word culture was originally used as a noun to describe the process of cultivating different field crops. However, the meaning was extended to include the free spirit or cultivated person. In the nineteenth century this concept was expanded and a more anthropological definition was given to the concept of culture. This definition describes culture as a ‘whole and distinctive way of life’ placing particular weight on the ‘lived experience’ (Barker 2000, p.35). Since the nineteenth century the definition of culture has been altered by many scholars including, social scientists, behavioural scientists and anthropologists (Page 2005).

However, to use the term ‘culture’ to describe people who appear to belong to a broader group of people is problematic in two ways. The first is that it is often used as:
… a transitive verb, as if culture were an entity that could do something. Public discourse has become riddled with this particular misuse of the cultural concept… (Page 2005, p.iii36).

The second problem with the concept of culture is that it allows for individuals or groups of people to use ‘blanket terms’ to describe individuals who appear different to them, for example, the use of the term ‘black’ or ‘Hispanic’ (in an Australian context, Aboriginal) to describe people with dark skins (Page 2005, p.iii36). Therefore, discourse is an essential component of how the concepts of culture are constructed:

…identities are not things which exist; they have no essential or universal qualities. Rather, they are discursive constructions, the product of discourses [original text in bold] or regulated ways of speaking about the world. In other words, identities are constituted, made rather than found, by representations, notably language (Barker 2000, p.11).

This quote shows that, it is through the use of discourse that ‘subjects’ are portrayed and developed. Hall (1992) argues that the use of discourse (throughout history) allowed for the development of ‘discursive regimes’ that described the attributes of people who were and are labelled as belonging to a specific group or who have specific conditions or problems such as ‘the madman, the hysterical woman, the homosexual, the individualized criminal, and so on’(Hall 1992, p.80). Under colonial regimes, such as Australia, discourse positioned Indigenous people as the ‘inferior other’ (Jupp 2002).
Discourses of difference and how these are used have been analysed by colonial and post colonial scholars. One of the foundation scholars of colonial/post colonial discourse theory was Edward Said. Said utilized Foucault’s views on how discursive discourses operate to create images (Mills 2003). Foucault argued that:

Each society has its regime of truth, its ‘general politics’ of truth; that is, the types of discourse which it accepts and makes function as true…(Foucault, 1980 p131).

Said (1991, p.3) states that he used Foucault’s ‘notion of discourse’ to underpin his analysis of the way the ‘West’ viewed the ‘Orient’. He demonstrates how discourses of the ‘West’ created the images of the ‘Orient’, and how throughout history these images have been changed by the discourse of the time;

…that Orientalism makes sense at all depends more on the West than on the Orient, and this sense is directly indebted to various Western techniques of representation that make the Orient visible, clear, ‘there’ in discourse about it. And these representations rely upon institutions, traditions, conventions, agreed – upon codes of understanding for their effects, not upon a distant and amorphous Orient… (Said 1991, p.22).

This quote clearly depicts how the use of discourse and power relationships have constituted images of ‘Orientalism’ which represented Western viewpoints in regard to ‘material civilisation and culture’ (Said 1991, p.2). In other words the Orient was only
ever viewed or described from a Western context and this discourse was used to maintain power for political and economic gains (Said 1991). Said was mainly concerned with discourse used first by the British and French and later the Americans, in regard to ‘Orientalism’. The way in which discourse was used and is currently used by these countries to describe the ‘Orient’, particularly the Islamic Orient, (Said 1991) can be applied to the way in which discourse created images of Indigenous, Asian and Muslim populations in countries such as Australia.

However, Said (1991) argues (unlike Foucault) that the individual author of texts does have a personal authority on the subject; that they showcase their own individual views of the ‘other’ which are often untrue. Whereas it is argued by Mills (2003) that Foucault is concerned with how representations are developed and, as previously discussed, ‘truth’ is only a construct of the discourse at work in the social world. Therefore it may not be possible to have ‘true’ descriptions of any subject or form;

Said struggles in his use of Foucault’s work on the question of truth of these representations, since, at the one and the same time, he is forced to see the constructedness of these ‘factual’ accounts, while wishing to somehow contrast this with a ‘true’ description of these countries. Such a description of what these countries and their inhabitants were really [italics in original text] like is, in Foucault’s terms, equally fictional and constructed (Mills 2003, p.75).
It has been argued by Anderson et al (2003, p.197), that the approach to the ‘other’ as depicted by Said (1991) where their viewpoints are silenced, is enacted by some health care professionals in Western countries. This allows for the labeling or stereotyping of individuals who appear different. The individual’s identity then become ‘socially constructed’ by health care professionals (Puzan 2003, p.19).

The term culture has also been used to describe organizations or professional bodies, as these organizations shape practice and the conduct of individuals who are employed by organisations or part of professional bodies (Barker & Galasinski 2001). It can then be argued that nursing and midwifery are also governed by professional discourses that determine practice (Winch et al. 2002). These discourses are determined by how power is dispersed throughout organizations and professional bodies. The next section of this chapter will discuss how power is circulated within society.

3.4. Dispersion of Power

Foucault has given the ‘encounter’ of the technologies of the self and the power of others, the label of ‘governmentality’ (Foucault 1997, p.225). The term describes the process of dispersion of power from the macro level to the micro layer of the individual’s world (Barker 2000). At the ‘macro’ level the government rules, however at the ‘micro’ level, individuals can be managed or monitored by regulation which operates through various professional bodies (or in Foucault’s terminology ‘disciplines’) such as the medical
profession. At this level the individual maybe under surveillance by those with power. The individual under surveillance would therefore adjust their behaviour to meet the requirements of the social environment (Danaher et al. 2000). Foucault refers to this form of power as disciplinary power (Gilbert 1995).

This constant form of disciplinary surveillance has been referred to as the ‘panopticon’ gaze. Panopticon was a term given to the structure of a prison, designed by Bentham, where all the inmates believed that they could be seen at all times by the guards in the prison tower and therefore behaved in an acceptable manner. The term ‘panopticon’ was used by Foucault to describe the tool of surveillance used by those with disciplinary power, such as those involved in the discipline of medicine or government services (McHoul & Grace 1993).

Disciplinary power can be divided into two forms, the first form being concerned with ‘the ways that the body can be productive’ (Gilbert 1995, p.867). The notion of power over bodily productivity evolved in the 17th century and allowed for the development of disciplines such as medicine to emerge to monitor the production of the body (Gilbert 1995). The monitoring of the body also included reproduction, in particular, pregnancy. The stages of pregnancy were categorised and monitored (Foucault 1973). The place of birth and the way in which women were able to birth was controlled. The discourses of science became and continue to be dominant in childbirth practices. Scientific knowledge is discursively constructed as superior knowledge and therefore this knowledge forms the basis of the dominant medical discourses (Foucault 1997).
The second form of disciplinary power is concerned with ‘mortality, morbidity and fertility’ (Gilbert 1995, p.867). This involves the surveillance of the health of the whole population; births, deaths and statistical information in relation to health are recorded and monitored (Gilbert 1995). Both obstetricians and midwives use surveillance to monitor the progress of the pregnancy, labour and the birth. For example, birth statistics are kept by the NSW Health Department and birth outcomes, rates of intervention, maternal morbidity and mortality are monitored (NSW Health Department 2001). Comparisons are made and specific groups of women such as adolescents or Indigenous women may be targeted by the NSW Health Department to try to improve outcomes. Further surveillance is initiated. These two forms of disciplinary power have become focused on the family and women in particular, as they are viewed by some (individuals) within the social environment as the protector or enforcer of their families’ health and well-being (Gilbert 1995). Others have viewed this form of disciplinary power over women and families as a power relationship between genders (Mills 2003).

Between every point of a social body, between a man and a woman, between the members of a family, between a master and his pupil, between every one who knows and every one who does not, there exist a relations of power which are not purely and simply a projection of the sovereign’s great power over the individual;…The family, even now, is not a simple reflection or extension of power of the State; it does not act as the representative of the State in relation to children, just as the male does not act as its representative with respect to the female. For the State to function in the way that it does, there must be, between the male and female or adult and child, quite specific relations of domination
which have their own configuration and relative autonomy (Foucault 1980, pp.187-188).

Therefore Mills (2003) is correct in arguing that not only is Foucault’s notion of disciplinary power involved in the monitoring of the health and well-being of individuals but that it is also concerned with how power and domination occurs between males and females and in turn the domination that adults have over children.

Power circulates through the social environment. Foucault argues that families, and in particular women and children, are not directly dominated by the ‘State’. However, women and children are affected by the dominant discourses that guide the ways in which women’s roles are viewed by those within the social environment. Dominant discourses in relation to women’s roles and behaviour circulate through every aspect of their lives including reproduction and in particular, childbirth (Cheek et al. 1996).

3.5. Disciplinary Power within the Hospital Setting

Midwifery practice is mainly performed within a hospital setting where practice is dominated by the hospital hierarchy. Within the institution of a hospital, there are various power relationships - between the administration, the medical profession and the nursing and midwifery professions. At the bottom of this hierarchical system is the patient or women in the case of childbirth. Power is constantly being circulated through the
environment and often it is childbearing women who experience the effect of this power in the form of dominance by both obstetricians and midwives (Cronk 2000; Kirkham 2000; Thompson 2004).

There is contestation over who should provide care to pregnant women, obstetricians or midwives (Kent 2000; Thompson 2004). The domination of childbirth practices by the medical profession has been seen by some authors to impact negatively on midwifery practice (Kirkham 2000; Woodward 2000; Thompson 2004). The medical profession, which includes obstetricians, is dominant as they have used scientific discourse to enhance their power and this discourse is seen as an apparatus of truth (Foucault 1997). The dominant discourse relating to childbirth is based on the medical model which is portrayed as superior to other alternatives which are therefore suppressed by the medical profession (Edwards 2000).

Foucault’s concept of power discussed earlier in this chapter provides a framework for understanding the discourses surrounding childbirth in Western countries (Edwards 2000). The application of a Foucauldian analysis to childbirth practice reveals the political nature of midwifery practice.

The changing nature of childbirth over the past two centuries demonstrates the increasing control of the medical profession over women’s bodies. Up until the close of the seventeenth century, attendance at childbirth had always been the preserve of women. Midwives assisted women in labour…Throughout the
eighteenth century a struggle took place between female midwives and the emerging male-dominated medical profession over the control of intervention in the birth process (Lupton 1994, p.147).

Contestation allows for other ways of viewing health to be heard as power relations are challenged (Cheek et al. 1996). Discourses surrounding the ways in which the body can be productive, for example, have been challenged over the last 20 years (NSW Department of Health 1989; Page & Hutton 2000). In particular women have demanded changes to childbirth practices which were previously dominated by medical discourses (Harding 2000; Thomas 2000) in which women were seen as passive recipients of care. The medical discourses that supported these practices have to some extent been replaced by discourses which position patients (women) as consumers who are able to make informed choices about their care (Harding 2000).

3.6. Contestation of Disciplines; the Impact on Childbearing Women

Midwives are striving for professional recognition in regard to their ability to care for women who are experiencing a normal pregnancy, labour and birth. Historically midwives provided this care. However with the development of the discipline of medicine, the midwife’s domain as the provider of care to pregnant women was taken over by the medical professional. The discourses of childbirth were altered by those with
power, the medical profession, and alternative discourses are seen as being ‘subversive’ (Jackson & Lumby 2003). Therefore midwifery discourses, which position childbirth as a normal life event and which centre practices around the birthing woman and her wishes (Page & Hutton 2000; Thompson 2004), are not often listened to by the medical profession or government bodies. However some midwives are demanding that their voices be heard, and the conflict over which professional body is the most suitable to provide care for healthy pregnant women is ongoing (Edwards 2000). The role of obstetricians and midwives is now constantly debated and a power struggle has developed over the care of pregnant women.

Two distinct discourses in relation to childbirth have emerged within this ongoing debate, the ‘natural’ and the ‘medical’. At times, the midwives, depending on where they work, will use one or the other or both discourses (McLauchlan 1997). It can be argued then that structure or bureaucracy in the form of hospital policy and procedures may ‘engulf’ midwives’ practice within the medical discourse of childbirth. Their way of practising may then not be in line with the women they are caring for:

… the level of congruence between the women’s and midwives’ belief systems, and the predominance of a technocratic model with its practices and policies, shaped information exchange, on which decision-making and ultimately control were largely based (Edwards 2000, p.69).
Midwives may be intimidated by the dominant discourse within hospitals, even though they are aware of this and they may accept it rather than take any overt actions to change the domination (Fahy 1998; Benkert et al. 2005). This is an example of the impact that structural frameworks such as hospitals have on the provision of care. The control the medical profession has over childbirth may have a negative impact on the care that some midwives provide, as they may actually oppress the woman under their care, rather than challenging the domination of the medical profession (Edwards 2000). This can also be seen as oppressed group behaviour or subjectification where midwives due to their domination by the medical profession and ‘hospital hierarchical systems’ adopt the dominant model and control the women under their care (Kirkham 2000, p.233)

On the other hand, challenges to the dominant discourses do take place and change occurs as women and midwives challenge the hierarchical system and oppression that women (both childbearing women and midwives) have experienced (Leap 2004). However sometimes the women or midwives who have challenged the medical dominant discourse have been disempowered (Fahy 1998), as in the end the discourse of the medical professional is adhered to. This occurs as midwives may be vulnerable to the power of the medical professional inherent in the hospital system (Fahy 1998). Fahy argues that this disempowerment was evident in the research she undertook to investigate ‘how power operates in the medical encounter with childbearing women’ (1998, p.5). She provides examples of how medical dominance may control both women and midwives. The transcripts from Fahy’s research clearly identify how the dominant medical discourse is sometimes (not always) used to frighten women into compliance with the doctor’s
wishes (by saying that the woman’s life or the baby’s life is at risk). The midwife may be controlled because she/he may not wish to, or lacks the skills, to advocate for the woman’s wishes.

Fahy (1998, p.8) describes how midwives employed in hospitals are often ‘docile subjects’. If midwives do not follow the acceptable ‘norm’ within the hospital setting they may be ‘ostracised’ by their colleagues and can be subjected to ‘formal administrative’ action, and therefore confrontation with doctors may be ‘risky’ even if the midwife is acting as the woman’s advocate (Fahy 1998, p.12). When medical dominance, such as the type discussed by Fahy (1998), is not addressed, this reinforces the medical profession’s ‘authoritarian’ discourse on health care, and those receiving care can be marginalised, silenced and excluded from their health care decisions (Cheek et al. 1996).

The discussion so far has focused on medical discourse and the effect this has on the woman and the midwives who provide care to women. However, it has also been discussed in the literature (Fahy 1998; Cronk 2000; Edwards 2000; Kirkham 2000) that some midwives may in fact exert power over the women for whom they provide care.

It is also argued that some midwives prefer to work in a medical model of care. They may not view ‘pregnancy and birth to be a normal life event’ (Thomas 2000, p.177) and therefore these midwives prefer the use of technology to monitor pregnancy and labour. Similarly, there are doctors who are advocates for natural birth (Thomas 2000). It is
important to recognise that when this occurs, midwives (who prefer the medical model of childbirth) and doctors (who are advocates for less intervention and normal births) are actually resisting the dominant discourses of their professional bodies.

Midwifery power can be seen in different ways. Authors including Leap (2000) and Freeman, Timperley et al. (2004) argue that all relationships are based on power, especially when the relationship includes using a particular expertise (such as midwifery). Leap (2000) argues that midwives need to be aware that their position is unique, as women ask midwives to be with them. However, Leap (2000, p.5) states that:

> Recognising and owning our midwifery expertise is an important step in understanding the power dynamics of the situation. Equally important is understanding of the limitation of our expertise. There is a fragile element within the notion we call ‘informed choice’. Apart from the potential for decision making that is biased by the person who is doing the informing, there are many situations in which no amount of information will clarify the decision making process for women…This is not about engendering a passive fatalism but more about enabling women to learn to trust that they will cope with what ever comes their way. Working through these issues is particularly important in a culture that privileges the notions of ‘choice’ and ‘control’.

The essence of the woman/midwife relationship in this sense is for the midwife to use her expertise appropriately without taking control and power from the woman. The role
of the midwife in Leap’s (2000) view is to provide resources that enable women to make the decisions and choices about their pregnancies and birth and at the same time informing women that there may be occurrences that cannot be planed or managed in advance. By working in this way, midwives enable women to ‘have the stamina and courage to handle anything that comes their way’ (Leap 2000, p.16).

However, not all midwives recognise and acknowledge the inherent power relationships between women and midwives, between midwives and obstetricians and between obstetricians and women, and how this impacts on care. It has been argued (Kirkham & Stapleton 2004) that the hierarchy within hospital systems leads to midwifery ‘oppressed group’ behaviour which allows ‘horizontal violence’ within the midwifery profession to flourish. This is when midwives do not support one another; rather they may go out of their way to be unsupportive of each other.

When analysing this behaviour using a Foucauldian approach, this can be seen as power working at the ‘micro level’. Here views are contested and competition occurs between different parties, for example between obstetricians and midwives or between health providers who belong to the same broader profession, like the medical profession or the midwifery profession. Foucault (1973) in his text ‘The Birth of the Clinic’ discusses the hierarchy that developed within medicine where there is contestation over who is the most qualified - the physician or the surgeon to provide health care. This contestation between health care professionals is ongoing as the increase in ‘sub-speciality’ continues.
to expand (Lupton 1994). The specialization of the body, particularly during pregnancy, has lead to the fragmentation of care provision for pregnant women (Kent 2000).

However the discourses of both the obstetric profession and the midwifery profession cannot be viewed in isolation to the structures that govern their practice, in Foucault’s words the ‘politics of health’ (Foucault 1980, p.167). Foucault discusses how ‘Western medicine’ has been developed and governed by different agencies, such as the government, charity organisations including religious institutions and academics. All of these agencies monitor the health of the population and through their discourses direct health care provision (Foucault 1980). Therefore, when analysing the provision of care to women, including Indigenous women, the ‘politics of health’ need to be considered.

3.7. Discourses of Difference

The colonisation of the Australian Indigenous population and the subsequent social injustice caused by this has had a major effect on the well-being of the Indigenous population. The mortality and morbidity rate of the Australian Indigenous population is far greater than that of the non-Indigenous population (Australian Bureau of Statistics 2007) yet little that has been initiated overtime has improved Indigenous health outcomes (Ring & Brown 2002). The use of power and its effect on the Indigenous population’s health outcomes is demonstrated by the following quote from Lowitja O’Donoghue:
The word *culture* implies that we are dealing with a whole array of public processes involved in shaping and implementing Indigenous health strategies. We are not just talking about individual behaviours here. We are talking about social structures. We are talking about institutional practices. We are talking about professional priorities. We are talking about people’s lifestyles. And we are talking about the philosophies that underpin all of these. These are all part of the *culture* that shapes Indigenous health and health care, and to change a *culture* requires changing all of these (O'Donoghue 1999, p.64). [Culture in italics in original source]

The structures that O’Donoghue is referring to can be understood in terms of Foucault’s ‘macro’ and ‘micro’ powers that maintain power within an individual’s social environment. At the ‘macro’ level, government determines policy and at the ‘micro’ level, different disciplines such as medicine monitor the health of the Indigenous population. Most important is Lowitja O'Donoghue’s reference to the ‘philosophies that underpin all of these’ (structures), the way individuals or groups are viewed is dependent on these discourses which are based on power relationships. There is little recognition of diversity within groups who are perceived to be different. Individuals who are perceived to belong to a certain social group are not viewed as having individual characteristics and behaviour. This perspective can be seen as ‘essentialism’, where individuals who are identified as belonging to the same group are viewed as having the same characteristics and behaviour as each of the other members of the group (Ashcroft et al. 2000).
The way discourse is used to describe Aboriginal people is important because it impacts on the way individuals (including midwives) view the Indigenous population. The discourses relating to the Indigenous population have altered since colonisation (Cowlishaw 1988; Langton 2003). Colonial discourse originally described Indigenous Australians as being inferior savages, this discourse then changed to one in which Indigenous Australians were described as ‘people with kinship and ceremonies or tribal remnants who had lost their culture’ (Cowlishaw 1988, p.87).

The colonisation of Australia introduced change, for both Indigenous and non-Indigenous Australians. Wherever there is change, individuals will be affected. It is impossible for change not to be circulated throughout a social environment. Changes unfold and traditional practices may be altered or lost. This leads to the subtle amalgamation of some practices and it is impossible to determine when exactly this occurs as it is the result of contact between different groups.

To refer to traditional or ‘real’ Indigenous culture as unchanging can be viewed as a stance that is based on essentialism. Some Indigenous and non-Indigenous people believe that there is an unchanging Indigenous culture and identity and do not recognise the impact of a changing social environment on all practices, Indigenous and non-Indigenous. Some Indigenous people, by having an essentialist viewpoint, are in fact reinforcing the non-Indigenous discursive language in regard to the Indigenous population, as well as not recognising that there is difference within the Indigenous communities (Holland 1996).
Essentialism within the murri [⁸] communities only works to reinforce the racism of the dominant culture. It is evident in the way some murris say that only aboriginal (sic) people can speak on aboriginal (sic) matters. It is also evident in the way some murris make out all whites are bad. Essentialism is evident in the way some murris want to romanticise the so-called traditional aboriginal (sic) society and write off the society we live in today...Essentialism within many murri communities is about the denial of difference that has always existed and continues to exist within our communities (Holland 1996, pp.105-106).

It is the recognition of difference that most concerns Holland (1996). She discusses the difficulties she has faced within the Australian community as an Aboriginal person who does not physically appear Aboriginal. It is important to her that her Indigenous ancestry is recognised by the people that she comes into contact with. However, the majority of people do not realise that she is ‘Aboriginal’ unless she tells them. Holland gives an account of her life growing up in Australia and her adult life as a teacher to explain what it feels like to be viewed as different to non-Indigenous Australians. However she recognises that her experiences would be different to ‘a murri living in a black body’

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⁸ Some Indigenous Australians use names to identify the geographical location of where they were born or live. Murri refers to Aborigines who live in the state of Queensland (Australian Broadcasting Commission 2006). In NSW, Aboriginal people refer to themselves as Koori. However, Aboriginal people also belong to language groupings which are dispersed over different areas of Australia. Prior to the colonisation of Australia, there were over two hundred and fifty different Aboriginal language families. Currently it is estimated that over one hundred different Indigenous languages are spoken (Bell 2003, p.162).
The most important element that needs to be considered in Holland’s view is the way in which discourse shapes the views of individuals.

Subjectivity is dependent on coming into language in a way that enables us to identify ourselves. It is through dialogue with each other that we will come to understand the difference and complexities involved in living in a post-colonial context (Holland 1996, p.11).

This discussion identifies the daily difficulties that many Indigenous people experience, if they do not physically appear to be Indigenous, as there is no acknowledgement of their ancestry. This impacts on services that may be offered to them, for example, some maternity services in NSW offer a specific service for Indigenous women. Midwives are required to ask all women if they are Indigenous, however, this question is not always readily asked (Roberston & Lumley 1995). Therefore these services may not be offered unless the woman discloses that she is Indigenous.

3.7. Discourses of Denial of Difference

Under the leadership of Prime Minister John Howard the previous Australian government’s discourse in regard to the Indigenous population, was one in which difference was not formally acknowledged. This is in direct contrast to the views held by the colonisers of Australia, the British, who sanctioned the view that the Indigenous population was indeed scientifically different and therefore inferior, ‘sub-humans’
(Hemming 1998, p.24). As previously discussed in this chapter the discourse of many Indigenous and non-Indigenous Australians in regard to the Indigenous population, is one in which ‘difference’ is acknowledged.

It can be argued that it suited the then Federal government not to view the Indigenous population as different or unequal to the non-Indigenous population, as fewer resources were then required and past injustices did not have to be officially acknowledged. An example of this is the former Prime Minister John Howard’s announcement to the media following a riot of Indigenous youths (February 2004) in Redfern, NSW. The problem in his view was that they wished to be viewed as different, when they should be treated in the same way as the non-Indigenous population.

Mr Howard said the riot \(^9\) arose from a combination of factors including a “total breakdown in family authority within Aboriginal communities”.

“I think they sometimes arise from a policy of treating different groups differently” he told 3AW [A Sydney commercial radio station]. “The solution very much lies in treating everybody equally and as part of the mainstream as far as law enforcement is concerned” (Shaw 2004).

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\(^9\) Mr Howard is referring to the Redfern (a suburb of Sydney, NSW) Indigenous community unrest and action against the police following the death of an Indigenous male adolescent on February 15th 2004. Thomas Hickey was impaled on a fence spike following a (push) bicycle accident. The Indigenous community believed that Thomas was being chased by the police (who were in a motor car) at the time of the accident. The Indigenous community action was violent and police reinforcement was required. The damage to community property was extensive.
This statement by the (former) Prime Minister John Howard does not acknowledge the impact that colonisation has had on the Indigenous population. The discourses in relation to the history of the Australian Indigenous population have only recently been brought into the public arena. Many Australians remain unaware of the social injustice and violence (Leigh 2002) that took place as a result of colonisation, including the forced removal of Indigenous children from their families under the discourse of assimilation (Bourke & Edwards 1998; Cunneen & Libesman 2000; Jamrozik 2004). They remain unaware of how social injustice continues to take place in relation to the Indigenous population (Cunneen & Libesman 2000; Leigh 2002).

The dominant political discourse under the Howard government was one which minimised public discomfort in relation to injustices against Indigenous people, the issues were diffused and the federal government refused to publicly apologise. This was a popular stance with some of the non-Indigenous Australian population and was a winning point for Howard in the 1996 federal election (Leigh 2002). However not all of the non – Indigenous population share this view. The history and present day circumstances of the Indigenous population has increasingly been brought to the attention of the public by the work of various Indigenous people, such as Lowitja O’Donohue, Charles Perkins and others (Leigh 2002, p.141). Many non – Indigenous people have rallied in support of the Indigenous population and reconciliation to the point of signing ‘sorry books’ (Leigh 2002, p.137). However, the previous federal government was not prepared to say ‘sorry’ (Leigh 2002).
As with some other areas of contested policy, the government takes the view that the community should ‘move on’ to other matters. This aim can only lead to a defeat by attrition of Indigenous Australians’ legitimate demands. Justification of the avoidance of consideration of ‘inconvenient’ aspects of the Australian past and rejections of claims for restoring integrity to Australian history on the ground that ‘that we need to move on’, not only reinforces the white blindfold view of legitimate claims by Indigenous Australians but also presents a whitewashed history of the British colonial occupation of Australia (Jamrozik 2004, p.83).

It can be argued that the failure of the previous Australian government to view Indigenous Australians as people who have been considerably disadvantaged by colonisation has added to social injustice and inequity for the Indigenous population. The Indigenous population were expected to be the same as non-Indigenous Australians, who mostly have not had to deal with or manage the impact of social injustice and who have not been historically excluded and hidden from Australian society. However, this may change, with the election in November 2007 of a Labour government. The new Prime Minister Kevin Rudd officially apologised to the Indigenous population for the Stolen Generations, on Wednesday 13\textsuperscript{th} February 2008. This apology was supported by a large proportion of the Australian population.

Whatever may occur in the future, how politicians describe Aboriginal and Torres Strait Islander Peoples impacts on the way in which Australian society views these populations.
Aldrich et al (2007) reviewed all political discourses about these populations over two decades, from 1972-2001. Their findings from this review identified that the language used by politicians was dominated by four main discourses. These four discourses centered around the ‘capacity and competence’ of the Aboriginal and Torres Strait Islanders communities in regard to improving their health outcomes, who ‘controlled’ and was responsible for this improvement and ‘the “problem” of ill health’ and the causes and solutions for this situation (Aldrich 2007, p.133). Underpinning all of these discourses was ‘the idea constructed discursively that Aboriginal and Torres Strait Islander Peoples were ‘other’ than most Australians’ (Aldrich 2007, p.133). Until marginalising discourses are no longer used by those in power, it is likely that mainstream Australian society will continue to view the Aboriginal and Torres Strait Peoples as the ‘other’.

3.8. Conclusion

This chapter has highlighted the importance of discourse in shaping the way individuals and communities view the world. Inherent in the use of discourse is the concept of power. The ways in which language is used, when and why, allows for the development of dominant discourses. Discourses are used to advantage and to legitimise actions, like the colonisation of Australia. However, wherever there is a dominant discourse there is resistance. This resistance allows for alternate views to impact on the groups or
individuals who espouse a particular dominant discourse. Despite dominant discourses, power relationships are always being contested.

Discourse and power have been identified as impacting on the health and well-being of pregnant women and new mothers as they experience mainstream health care provision. The dominant discourses of the medical professional impact negatively on the role of the midwife and the oppression felt by midwives is sometimes directed towards the women under their care. The structure and ‘governmentality’ of health provision can be seen to be immersed in power relationships, which may have a negative impact on those receiving care; especially those people who do not meet the perceived ‘norms’ of the dominant social environment, like the Indigenous Australian population.

Foucault’s theories on discourse and its inherent power relationships provide an extremely useful way of analysing the concept of power, the health care system and the impact of colonial discourses on the Australian Indigenous population. Foucauldian concepts of power allow for an understanding of the impact of power, including structural forces (for example the hospital setting) on midwifery practice. These concepts are also useful for analysing the experiences of midwives when providing care for Indigenous women.
CHAPTER FOUR: METHODOLOGY

4.1. Introduction

This chapter discusses in depth the methods used to investigate midwives’ use of culture and cultural sensitivity, and how they approach their practice when caring for women from CALD backgrounds, with a focus particularly on Indigenous women.

An inductive approach was undertaken, as the literature review revealed differences in the interpretation of the concept of culture and cultural sensitivity, and scant evidence on how these concepts might be incorporated into practice. The data collection and initial analysis were undertaken using a modified grounded theory approach. This meant I was able to follow clearly defined research steps which provided detailed attention to links between research concepts and substantiation for these claims (Seale 1999).

However, rather than aiming to produce theory, this study followed the ‘theory/concept driven’ approach identified by Grbich (1999). This is where the researcher identifies and becomes familiar with the theorist/s that best support the investigation of the topic. As the study proceeds, the emerging findings are explored with and compared to the relevant theoretical perspectives. As the previous chapter explained, discourse analysis provided the relevant theoretical perspectives in this case.
In this chapter, a detailed account of the following is provided: the methodology and its rigour, ethics approval, sampling and recruitment of the participants, description of data collection and data analysis.

### 4.2. Methodology

Qualitative research has a long history stemming from the early 1900s, originating in the disciplines of sociology and anthropology where there was a need to develop a method of inquiry into how humans lived (Denzin & Lincoln 2000). Qualitative research is now used by many different disciplines, including education and nursing (Denzin & Lincoln 2000).

Qualitative research (constructionism) as described by Crotty (1998 p.55) is based on the belief that ‘social realities are socially constructed’. Crotty (1998) argues that there are four elements to consider when undertaking research. These elements inform one another and consist of the following, epistemology, theoretical perspective, methodology and methods. Once the epistemology is identified it is then possible to use a theoretical perspective that can best be utilised to find meaning within the topic being investigated. Once the theoretical perspective is in place, the methodology of the study can be developed. Once the methodology is identified suitable methods can then be utilised.
However Crotty (1998, pp 13-14) states that ‘every piece of research is unique and calls for a unique methodology’. He argues that the researcher does not automatically commence the research journey by knowing what epistemology to follow. The research is developed around the questions to be answered. However the researcher needs to be able to justify why they have chosen to undertake their study in a particular way.

We acquaint ourselves with the various methodologies. We evaluate their presuppositions. We weigh their strengths and weaknesses. Having done all that and more besides, we still have to forge a methodology that will meet the needs of our particular purposes in this research. One of the established methodologies may suit the task that confronts us. Or perhaps none of them do and we find ourselves drawing on several methodologies, moulding them into a way of proceeding that achieves the outcomes we look to (Crotty 1998, p.14).

As indicated in the introduction I commenced the research process by using a modified grounded theory approach for the data collection and initial analysis as it provides a thorough approach to ‘initial analysis’ (Seibold 2006, p.24). This study then followed the ‘theory/concept driven’ approach identified by Grbich (1999). I identified and became familiar with the work of Foucault to support the investigation. An example of this is demonstrated by Seibold (2006). She used a grounded theory approach to explore women’s experiences of menopause. She also included feminist theory as a theoretical underpinning as she identified as a ‘feminist researcher’ (Seibold 2006, p.20). However as her study unfolded she became interested in the way discourse was used by the women to construct ‘their identity’ (Seibold 2006, p.20). This enabled her to redirect the focus of
her research from using a grounded theory approach for data collection and initial analysis to the use of discourse analysis for more detailed analysis and interpretation of the data (Seibold 2006).

Similarly, in this research, I became aware of how various discourses, in this case about culture and the ‘other’ shaped the participants’ views of CALD women and Indigenous women. The emerging findings were explored with and compared to the relevant theoretical perspectives. The work of Foucault and others scholars from postcolonial studies provided the theoretical perspectives.

There are numerous methods and approaches that fall under the banner of qualitative research. Examples of these approaches are interviews, case studies and observations that ‘describe routine and problematic moments and meanings in individuals’ lives’ (Denzin & Lincoln 2000, p.3). Although there are different qualitative approaches, it is important that rigour is demonstrated by the researcher. Rigour refers to the value of the research findings (Burns & Grove 2005).

The next section of this chapter discusses the concepts of rigour and demonstrates how rigour has been achieved in this study.
4.3. Rigour

Some authors argue that qualitative research is being compared inappropriately to a quantitative paradigm, where results can be measured statistically and verified to form the ‘truth’ of the social world (May 1997; Grbich 1999). However, as stated by Morse (1994), it is still important to have standards by which qualitative research can be measured. These standards although will be different to those used when evaluating quantitative research.

Morse and Richards (2002) state that the terms ‘reliability and validity’ are not accepted by the majority of qualitative researchers as these terms belong to the positivist paradigm. They argue that although the terminology is not suitable for qualitative research methods, there still needs to be a way of determining the quality of qualitative research. They also discuss how, in 1985, Lincoln and Guba developed terminology specifically for reviewing the quality of qualitative research.

Lincoln and Guba (1985, p.300) state that for qualitative (naturalistic) paradigms the terms, ‘credibility’, ‘transferability’, ‘dependability’ and ‘confirmability’ are the equivalent of the terms ‘internal validity’, ‘external validity’, ‘reliability’ and ‘objectivity’, which are used to validate quantitative research.

The authors describe how the four terms can be used and provide techniques to ensure that the researcher can achieve these aims. In this present study the following steps were
undertaken to ensure that the study met the criteria for credibility, transferability, dependability and conformability as outlined by Lincoln and Guba (1985).

4.3.1. The selection of an appropriate method

In the initial planning of the study a modified grounded theory approach was chosen to collect and analyse the interview data. A grounded theory approach allows the data collection and analysis to be conducted in a thorough and systematic manner (Charmaz 2000). A detailed account of this process will be provided under the data collection and data analysis section of this chapter.

4.3.2. Trustworthiness of the findings

This was enhanced by allowing the data analysis to guide the research process (Chiovitti & Piran 2003). The initial open ended interview questions were refined after the analysis of the first three interviews. Subsequent interviews were more focused on areas emerging from the analysis. For example, a question relating to community practice was included in all the participants’ interviews, as the data analysis revealed that there were important issues to explore. The first three interviews identified that community practice involved a more flexible approach to practice and a loss of control by the midwives who provide (or have provided) care within the women’s homes.
4.3.3. Collection of the data

Participants were selected according to their geographical location and the number of Indigenous births recorded in the area. Midwives were interviewed in urban, regional and rural areas. The type of midwifery education (hospital based or tertiary) undertaken by each participant was also elicited. The first seven interviews revealed that the participants’ initial midwifery education was hospital-based. ‘Purposive’ sampling was then made to ‘maximize variation’ (Gobo 2004 p.448) by including in the study midwives whose initial midwifery education was undertaken in the tertiary sector to ensure a cross representation of the midwifery population in NSW. As stated by Barbour (2001, p.1116), purposive sampling allows the researcher some control over the recruitment of participants ‘rather than being at the mercy of any selection bias inherent in pre-existing groups’. Purposive sampling also allows for the development of a ‘thick description’, which enhances transferability of the process, as the researcher will have described in detail the context in which the study took place (Lincoln & Guba 1985, p.316).

4.3.4. Participant validation

All participants were offered a copy of their transcripts and the majority of participants were provided with a copy of their transcribed interviews. However, three participants had changed their place of employment and I was unable to provide them with transcripts. Ethically, I could not ask the managers of the maternity services for their forwarding address but these participants did have my contact details.
Of those who received their transcripts, only two commented on them. One telephoned to comment that her transcript reflected her thoughts well. She had also read\textsuperscript{10} my publication in the Australian College of Midwives Journal (see Appendix G) and said she agreed with my conclusions about community practice. The second participant who commented stated that it had provided her with the opportunity to reflect on her practice.

The provision of transcripts to the participants provided an audit trail, as the participants were able to validate their transcripts. Member checking is viewed as part of auditing which enhances the dependability of this research. It demonstrates that the ‘process of the research is logical, traceable and clearly documented’ (Tobin & Begley 2004, p.392).

I have also presented material relating to this study at both international and national conferences (see Appendix H). A small number of the study participants have been in the audience for these presentations.

The next section of this chapter will identify the ethical considerations and the ethic committees’ approval and sites’ permission to undertake my research.

\textsuperscript{10} This article was published sometime after her interview.
4.4. Ethics

When research includes human participants, ethical and legal considerations need to be taken into account by the researcher. The researcher has a responsibility to ensure that no harm (physical or mental) will come to the participant (Schneider 2003). The ethical responsibilities that researchers need to be conscious of are:

- Age of the participants (are they legally able to consent?).
- Informed consent.
- No harm is caused to participants; risk management is performed by the researcher.
- Freedom of participants to disclose information without risk of penalty, for example, substance abusers.
- Participants are free to withdraw from the study at any time without risk of penalty or consequences.
- Confidentiality and anonymity is maintained at all times (Schneider 2003; Polit & Tatano Beck 2004).

Researchers undertaking qualitative research also need to be mindful of the relationship between the researcher and the participant. They are more likely to come into direct contact with the participants than those researchers undertaking a quantitative approach and this relationship may cause ethical dilemmas (Jackson et al. 2003). Throughout the research process, I was acutely aware of my position as a registered midwife and reflected on how this may have affected the relationship between me and the participants.
It could be argued that being a midwife assisted my research, as I was identified as being a colleague and part of the midwifery profession - which enhanced recruitment of the participants. However, I believe that they did not feel obligated to participate; two midwives declined the offer to participate.

4.5. Ethics Approval

This study was conducted in three area health services and three Aboriginal Medical Services in NSW. This necessitated the approval of different ethic committees and various site /organisation managers. The first ethics application was approved by the University of Wollongong’s Human Research Ethics Committee (Appendix A).

Permission from the three area health services was then sought. The regional health service sanctioned the University of Wollongong’s Human Research Ethics Committee approval. The rural health service did not require a separate ethics application but a review of the original University of Wollongong ethics approval was undertaken and permission was granted following verbal and written communication. The urban area health service required a separate ethics application. Consent to conduct the study in the three Aboriginal Medical Services was obtained through the managers of these services; no separate ethics applications were required. I then contacted the midwives employed or working in these services to ask if they were willing to take part in the study. Once their written consent was obtained, interviews were then conducted.
4.5.1. Informed consent

A letter of introduction regarding the research was given to all participants. This clearly outlined the research topic, the voluntary nature of the research participation, the right to withdraw at any time, contact details of the Wollongong’s Human Research Ethics coordinator and my supervisor’s name and contact details (Appendix B). A separate consent form was signed by all participants (Appendix C).

4.5.2. Confidentiality

Confidentiality of information and the anonymity of participants have been and are continuing to be conscientiously and thoroughly maintained. Only the researcher and supervisor have access to the tape-recorded interviews, records and data collected. All records have been and will be kept locked in the researcher’s office for five years. Records of names, identification codes and place of employment of the participants are kept in a separate locked file to that of the transcripts. The results/themes from the research have been and will continue to be disseminated in relevant professional journals and at relevant professional conferences. No information has been or would be provided that would identify individual participants. Pseudonyms have been provided for all of the participants.

The next section of this chapter discusses how the research was conducted.
4.6. Conducting the Research

Interviews were conducted with 32 midwives employed in regional, rural or urban maternity services in NSW.

4.6.1. Sampling and recruitment

Purposive sampling was utilised for this study. This is when the researcher uses their knowledge of the population to determine who should be included in the study. The participants are selected on the basis that they will shed the most light on the topic. The selected participants are also ‘considered to be typical of the population’ (Schneider 2003, p.261).

Three area health services (one urban, one regional and one rural) and three Aboriginal Medical Services were selected. The facilities were identified as having a number of Indigenous people within their local population and subsequently a number of births. The purposive selection of sites allowed for a wide cross section of participants with experience of caring for Indigenous women to be included in the study.

After discussion with the various site managers, I was given permission to visit the maternity services. I was known to some of the midwives in the regional and urban locations. My first interview was conducted with a participant from the southern regional maternity unit. From this stage on, a ‘snowballing’ effect (Grbich 1999, p.70) occurred,
as participants would recommend to other colleagues that they become participants in the
study.

The number of midwives employed in 2000 / 2001 in the four different health facilities
and the three Aboriginal Medical Services (AMS) utilised for this study are shown in the
following table.

*Please note the full time equivalent numbers consist of midwives who work part time.

One day of work equals 0.1 of a full time equivalent. In the smaller regional unit and the
rural referral centre there were a number of midwives who were employed part time.
However their combined working hours are equated into full time positions. The full time
equivalent numbers for the urban facility also includes other staff members such as
registered nurses and enrolled nurses.

Table 4.1: Full time equivalent (FTE) midwives provided by the managers of these
services and number of study participants

<table>
<thead>
<tr>
<th></th>
<th>Urban</th>
<th>Regional (Northern)</th>
<th>Regional (Southern)</th>
<th>Rural (Referral centre)</th>
<th>Rural (emergency midwifery only)</th>
<th>AMS Urban</th>
<th>AMS Regional</th>
<th>AMS Rural</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Midwives FTE.*</td>
<td>228.94</td>
<td></td>
<td></td>
<td>10.32</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>360.26</td>
</tr>
<tr>
<td>Number of study participants</td>
<td>7</td>
<td>4</td>
<td>8</td>
<td>8</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>32</td>
</tr>
</tbody>
</table>
The table below illustrates the variation in initial tertiary qualifications between the urban, regional and rural locations. In the urban and regional locations, there are local universities providing midwifery education. In the rural location, the majority of participants had completed a hospital based midwifery qualification at this location or another similar location prior to the cessation of hospital based programs. Only one newly graduated tertiary qualified participant was employed in the rural health facility.

**Table 4.2: Participants’ Educational qualifications**

<table>
<thead>
<tr>
<th>Location or organisation</th>
<th>Initial Midwifery Education Hospital based</th>
<th>Initial Midwifery Education Tertiary Based</th>
<th>Post Graduate Qualifications after completion of midwifery qualification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>3</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Regional</td>
<td>5</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Rural</td>
<td>10</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>AMS</td>
<td>3</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>11</td>
<td>17</td>
</tr>
</tbody>
</table>

The years of experience of the participants (as midwives) also varied. The table below identifies the location of participants and their length of service as midwives or years of experience as registered midwives.
Table 4.3: Years of service since initial midwifery education

<table>
<thead>
<tr>
<th>Years of experience</th>
<th>Urban</th>
<th>Regional North</th>
<th>Regional South</th>
<th>Rural Larger Hospital</th>
<th>Rural Smaller Hospital</th>
<th>AMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 5 years</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>5 to 10 years</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 to 15 years</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 to 20 years</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>20 years plus</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Total number of participants</td>
<td>7</td>
<td>4</td>
<td>8</td>
<td>8</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

The age and the ethnicity of the participants were not specifically collected as part of the demographic information recorded at the time of the interview. However, why the participants became midwives was asked. The majority of the participants described the journey they undertook to become midwives commencing with when they started their education as health professionals. Most started their nursing education on completion of school and then became midwives. The years that they undertook their nursing and midwifery programs were recorded and their ages have been determined by this information. During the interview participants were free to discuss anything that may have influenced their approach to CALD and Indigenous women. Some discussed their family ethnicity. Please see Appendix E for the record of the above information.

The geographical location and the number of participants for each location will now be described.
4.6.2. Regional location

The regional area covers a large geographical area, within which there are four maternity units. This area health service at the time the study was undertaken\(^\text{11}\) was described as having two boundaries, northern and southern. The northern end has the largest of these maternity units in the regional city centre; the maternity service here is also responsible for the smaller maternity unit in one of the suburbs of the city. The other two maternity units are located in the southern end of the area health service - one in a regional city and the other in a regional town. Both are approximately 60 minutes and 120 minutes respectively by road to the larger maternity unit in the northern sector of the service region. The maternity unit in the southern city of this region is approximately 120 minutes by road to the major maternity units in Sydney. The birth rate varies between the four maternity units, with the northern regional city maternity unit annual birth rate for 2000 being 2485 (NSW Health Department 2001 p.84) The maternity unit located in the southern regional city had an annual birth rate for 2000 of 838 (NSW Health Department 2001 p.84.).

4.6.3. Regional northern maternity service

The larger maternity unit at the northern end of the region has distinct ward and service areas, such as antenatal, birthing suite, postnatal and nursery, as well as community midwifery services such as home follow-up after planned early discharge. Some midwives rotate throughout these ward / service areas, others do not. Four midwives from

\(^\text{11}\) This area health service was amalgamated with another area health service in 2005.
this service were study participants. Staff obstetricians, registrars, residents and all other related services for example anaesthetic services, are available, therefore a full obstetric service is provided. There is an AMS in close proximity to the hospital. This AMS and the area health service employ a midwife to provide antenatal care to Indigenous women. This midwife volunteered to be part of the study.

4.6.4. Regional southern maternity service

The larger maternity service at the southern end of the area health service region is contained within one unit. All midwives (except for the midwives employed for the Indigenous community program and the early discharge program) work in all the areas of maternity. These midwives are rostered on a daily basis to either the birthing area or ward area. There is a nursery but this is not resourced unless there is a baby requiring special care. Antenatal services are not provided by the hospital. All pregnant women receive antenatal care from their general practitioner (GP) or three local obstetricians. There are no registrars or other designated doctors providing services other than the local obstetricians. Births are conducted by the midwives unless the woman has private health insurance and is under the care of an obstetrician. However, referral is made to an obstetrician if a woman requires assistance during labour and birth, for example for foetal distress.
Five midwives employed to provide inpatient services volunteered to take part in the study. The community midwifery program (early discharge program) employs a small number of designated midwives. One midwife volunteered to be a study participant.

According to the midwifery manager\textsuperscript{12} of the unit, funding from the NSW Health Department in response to the final report of the ministerial taskforce on obstetric services in NSW (1989) was received by this maternity service in the early 1990s to provide a service to Indigenous pregnant women (pers.com 2006). Three midwives, one full-time and two part-time are employed within this service. These midwives volunteered to be part of the study. The policies governing their role do not allow these midwives to provide antenatal assessments. Their role is solely to support Indigenous women during the antenatal period by providing antenatal education. The antenatal assessments for these women (under the governing policy) are to be performed by local general practitioners. However, these midwives do provide antenatal assessment if the woman has not been to the general practitioner or if the midwife has concerns about the well-being of the woman and the foetus.

\textbf{4.6.5. Rural locations - Smaller rural facility}

Two locations within a rural area health service were chosen. The first location is a maternity unit based within the rural city and the second is a small rural hospital that provides care to Indigenous women during pregnancy and birth if required. However,

\textsuperscript{12} To maintain the anonymity of this maternity unit, the name of the midwifery manager has not been given.
hospital policy was not to provide birthing services. Labouring women are transported to the larger regional city hospital (above). Antenatal services are provided by the Royal Flying Doctor service. Two midwives employed at this location as registered nurses and registered midwives consented to be part of this study. They provide nursing care to the general patients as well as emergency midwifery care to pregnant women.

4.6.6. Rural locations - Larger rural facility

The larger rural city hospital provided all maternity services including antenatal clinics, birthing, postnatal and early discharge programs. Women from the smaller surrounding rural communities were referred to this unit for their labour, birth and postnatal care. The midwives employed in this unit worked in all areas. There were many similarities between this unit and the southern regional maternity unit. However, at the time the interviews were conducted there was no permanent obstetrician and locums were provided by the hospital. The birth rate in 2000 for this maternity unit was 277 (NSW Health Department 2001, p.85).

The larger rural city also had an AMS. This service employed a midwife to provide antenatal and postnatal services to Indigenous women. This midwife consented to be part of the study.
4.6.7. Urban locations

The urban maternity service provides a distinct service which consists of antenatal, birthing, postnatal, early discharge program, and gynaecology and oncology services for women. The hospital is a major tertiary referral centre and therefore women from rural and remote rural services are often transported to this location for care. There are distinct ward areas such as antenatal, labour, birth centre, postnatal and outpatient services including antenatal clinics, within the maternity services. Some midwives rotate, others are core staff for a particular ward area. This maternity service also employs a midwife who is Indigenous and her main role is to support Indigenous women.

At the time of the interviews, there was not a designated midwife employed in the local AMS. Therefore another urban AMS (in a different area health service) was contacted regarding my research, and the midwife employed in this service consented to be part of the study.

The next section of the chapter discusses the data collection.

4.7. Data Collection

Personal information collected from the participants, such as their length of service as a midwife has been presented in table 3.
In-depth interviews were the primary source of obtaining the data. In-depth interviews are in essence about having a conversation with the participant; this type of interview allows the participant’s thoughts, feelings and attitudes to be freely discussed (Beanland et al. 1999). The duration of each interview was approximately an hour but some were longer. These in-depth interviews were semi-structured which allowed the researcher to gain the required information about the research topic. However, the participants were free to provide as much information as they desired, in their own words, to illustrate different points (Polit & Tatano Beck 2004). I prepared a guide to follow which included a set of questions (please see Appendix D) to allow the participants to talk freely in their own words about the area of interest. The prepared questions were open-ended and probes were developed for some of the questions. However, during the interviews, further ‘unplanned’ or ‘unanticipated’ probes were sometimes required to find out more about the participant’s views or practice in relation to the topic of discussion (Morse & Richards 2002, p.91). Probing is a technique used by the researcher to gain more information about a topic or to clarify statements made by the participants (Burns & Grove 2005).

All the interviews were conducted in the participants’ place of employment, except for one. This participant asked to be interviewed in my office as she felt that would provide a more suitable environment. All other interviews were conducted in offices or areas within the participants’ work environment. This, at times, was not ideal as there were interruptions from telephones, ward activity and work colleagues.
4.8. Audio Taped Interviews, Transcription and NVivo

The interviews were recorded on audio tape. This process was explained to each of the participants. General conversation would take place with each of the participants to help them become comfortable (Burns & Grove 2005). Once the participants appeared relaxed the interview would commence with several ‘grand tour’ questions (Polit & Tatano Beck 2004, p.340) to make the participants feel more at ease (please see Appendix D). The questions then became more specific about how the participants incorporate culturally appropriate care for women from different cultural backgrounds into their practice.

Although there was a predetermined set of interview questions, these were only used as a guide. I was very aware of each of the participants comfort level with the interview and adjusted the questions to suit each of the participants as required to allow them to tell their story. Questions were refined as interviews and analysis progressed.

Audio tapes are useful as they allow the researcher the freedom to concentrate on the interview (May 1997) rather than relying on note taking or memory (Tham 2003). However, in some instances the participants may be distracted by the tape recorder or feel uncomfortable whilst it is on. This rarely happened in my experience, however sometimes the participant would highlight an interesting point once the tape recorder had been switched off. Permission was then sought to recommence the recording.

On completion of each interview the audio tape was transcribed into a word document. The transcripts were completed verbatim to allow for the participants conversation to be
reflected fully within the written transcripts (O'Brien 2003). On completion of each transcript the word document was entered into NVivo 1.4, a qualitative computer software package. NVivo allows the researcher to code the transcripts, explore the data visually and to sort and store the relevant information (Bazeley & Richards 2000). This program does not perform an analysis or develop a theoretical framework. However it does allow the researcher to develop a coding frame that can be easily accessed and viewed which allows for more systematic and rigorous data analysis and comparison. This takes the form of a list of nodes (codes) for each transcript. This enables the researcher to see which participants have discussed the topic identified by the particular node and to explore the material so enclosed. This facilitates the grouping of nodes into categories. This process is described in more detail under constant comparative analysis in section 4.11.

4.9. Reflective Journal

To enhance my interview technique and analysis of the interviews, I commenced a journal to record my thoughts about how each interview progressed. According to Grbich (1999) maintaining a journal or diary allows for responsibility and reflection on the part of the researcher. By using my reflective journal I was also able to address issues of my own subjectivity (Speziale Streubert & Carpenter Rinaldi 2003) in regard to midwifery practice and caring for Indigenous women and women from CALD backgrounds. The reflective journal also provided an audit trail of the progression of the interviews.
4.10. Data Analysis

A modified grounded theory approach was utilised for the data analysis. Over time, numerous theorists, for example Annells (2003), have suggested modifications to the original grounded theory strategies as disseminated by Glaser and Strauss (1967). For the purpose of this study, the following modified grounded theory strategies were used: constant comparative data analysis which consists of coding the data, the integration of these codes into categories, theoretical saturation (Seale 1999) and finally theoretical sensitivity (Annells 2003). I also recorded my thoughts in relation to the data analysis by writing memos (Annells 2003). These strategies or steps will now be outlined.

4.11. Constant Comparative Data Analysis

Coding and analysis of each interview consecutively allows for constant comparison of the data. Data analysis commenced after the first interview was transcribed. Subsequent interviews were not conducted until each of the previous interviews had been coded. This allows for a constant comparison of the data to take place. The only exception to this was when I interviewed participants in the rural location. As I am employed full-time, I was granted leave to travel to the rural locations for the purpose of conducting interviews for my research. These interviews were conducted over a seven day period. Following each interview, I listened to the audio tape recording and made further notes. The interviews were transcribed as soon as I returned home. No further interviews were conducted until the transcripts of the rural participants had been coded.
The constant comparison of the data was assisted by the use of NVivo. I was able to electronically code each individual transcript. This was achieved by reading each transcript line by line. I developed nodes (codes) for topics that I identified in the first transcript (Bazeley and Richards 2000, p.23). These were then utilised for the next and subsequent transcripts. New nodes (codes) were added if any new topics of interest were identified as each transcript was analysed. NVivo allows the researcher to examine all the material from the transcripts listed under one node. It is possible to see which participants have discussed the topic identified by the particular node. It allows the researcher to explore the material coded under a particular node. This is further discussed in the next section of this chapter.

The nodes were then grouped into categories. The nodes were constantly compared with each other for the context in which they occurred and how they were similar or not similar to incidents previously coded under a particular node and the category to which the node belongs. As described by Glaser and Strauss (1967 p.106)

This constant comparison of the incidents very soon starts to generate theoretical properties of the category. The analyst starts thinking in terms of the full range of types or continua of the category, its dimensions, the conditions under which it is pronounced or minimized, its major consequences, its relationships to other categories, and all its properties.
An example of this within this study was the development of a node that I named ‘flexibility’, which was subsequently organised under the category of ‘approaches to practice’. When I examined the dimensions of this node, it became apparent that those participants who had a more flexible approach to practice had at some stage in their careers worked within the community, visiting women in their homes. When this node was compared to the node that I had labelled ‘control’, which came under the same category, approaches to care, I was able to theorise that community practice enabled midwives to be more flexible in their approach to care. However when care was provided within the hospital setting, control was a major issue, as the hospital structure influences how the midwives provide care in a variety of ways. This became an important aspect of this study as it allowed the researcher to understand how the context of care impacts on the participants’ ability to provide appropriate care. This is discussed fully in chapter 7.

4.12. Open Coding and Integration of Categories.

The first step in a grounded theory approach to data analysis is to code the transcripts line by line. This technique ensures that the researcher stays in touch with what the participants are saying and illuminates their thoughts; rather than imposing the researcher’s views onto the data (Charmaz 2000). These codes are then clustered under different categories depending on their similarities and properties. I allowed the data to show underlying meaning rather than attempting to impose the data into predetermined categories (Annells 2003). I named the codes to reflect what was represented by the
participants. In some cases the name of the code came directly from the participants. This is referred to as ‘in vivo’ codes (Strauss & Corbin 1990 p.690). According to Locke (2001 p.65) in vivo codes:

...capture substantive aspects of the research situation, especially the particular challenges its members face, and often expressed in the language of the context study...They are created through a bottom up process.

In vivo coding occurs at the beginning of the analyses, whereas theoretical categories occur later and are developed from a ‘top down’ process (Locke 2001 p. 66). This is where the researcher develops broader categories which have been derived from the knowledge and management of the data (Locke 2001). For example, in vivo codes from the participants’ description of the factors that affect their practice such as policies, funding, referral, medical models of care, support and continuity of care were developed into the category of ‘organisational culture’.

**Figure 4.1: Representing the category of organisational culture and some of the codes clustered under this category.**
As categories were developed I was driven to review relevant literature to explore how the different concepts and categories, as well as the various discourses of the participants, were situated within current thinking about the issues raised. As stated previously the literature relating to how power circulates throughout society was very useful to exploring how individuals view cultural difference. It was also very useful for exploring how power and control circulate within health care settings.

4.13. Theoretical Saturation

The categories that were generated by open coding were constantly compared. When no new information was gained from the analysis, I no longer conducted interviews as theoretical saturation of the categories had been reached.

4.14. Memo Writing

Throughout the analysis of the data, memos were written to record my reflective thoughts in relation to what the study participants were describing (Bazeley & Richards 2000). The use of memos also enabled reflection on the association between the data comparison and where the data was obtained. The use of memo writing in the research process was different to that of the use of a reflective journal. The reflective journal, as explained previously was used to reflect on the interview with the participant. Writing memos
pertained to the data analysis. The use of memos allowed me to record my thoughts and collate these in regard to the analyses. Memo writing also enhances the audit trail of the research process as it demonstrates the link between the development of my thoughts in relation to the analyses of the data.

I have provided (as Appendix F), one of the memos developed as each of the transcripts were analysed. This memo I called colonisation. In this memo I refer to how some of the participants discussed the effect of colonisation on the Indigenous population. For some there is little recognition of the ongoing effect of colonisation on the well-being of the Indigenous population, for others there is an awareness of the ongoing impact of colonisation.

Towards the end of this memo I am discussing how some of the concepts raised by the participants can be supported by the literature that I have been critically analysing to help me understand how the various discourses of the participants have evolved. Some of the excerpts from the transcripts contained within the memo are further explored within the data analysis chapters.

4.15. Theoretical Sensitivity

Theoretical sensitivity is the capacity of the researcher to have the conceptual ability to understand and make sense of the data (Strauss & Corbin 1990). The process of analysis,
combined with the literature, professional and personal experiences, are key sources of theoretical sensitivity (Strauss & Corbin 1990; Annells 2003). I continuously reviewed related literature as the categories were developed from the data (refer to memo on colonisation Appendix F). This enabled me to see if there were any commonalties to previous studies and helped give meaning to what the participants were saying.

The way Seibold (2002 and 2006) explains how theory guided the analysis for a study she undertook best describes the process that I utilised:

As analysis proceeded, theory guided, and was guided by, data analysis (Seibold 2002, p.13).

Seibold (2006, p.20) describes how she originally used grounded theory as a methodology to explore how women dealt with ‘menopausal symptoms and the debate surrounding the prescription of hormone replacement therapy (HRT) on the lives and decision - making processes of single midlife women’. At the beginning of the analysis Seibold (2006 p.20) was exploring the use of ‘symbolic interactionism’ and at the same time was using a feminist perspective as the theoretical underpinning for the methodology. However while completing interviews (in the first round) she became aware of how the women used discourse to construct ‘their identity’ (Seibold 2006, p.20). This then drove her to explore the use of discourse analysis as the methodology for her study (Seibold 2006).
I like Seibold (2006), originally used a feminist perspective as the theory underpinning the study as it was well suited to my research. Poststructural feminism remains ‘woman centred’ but does not categorise all women as being the same; it ‘values plurality, fragmentation and multivocality…’ (Cheek 2000, p.40). A grounded theory approach allowed me to use symbolic interactionism (Seibold 2006, p. 20) to explore the views of the participants. This exploration lead to the identification of the way various discourses were used by the participants to explain their care for CALD and Indigenous women.

In my study discourse analysis also provided an excellent framework for understanding how the participants view culture. I found the work of Foucault was particular relevant in linking how society allows for the production of meaning. His work has been instrumental in allowing the linkage between the concept of culture and power to surface within this study. Cultural studies have identified that the way in which power is circulated allows for the production of the ‘other’. Power and control are also deeply entrenched in the health care system which affects the way midwives practice and the care that women receive.

4.16. Conclusion

This chapter discussed the methods used to gain an understanding of how midwives incorporate cultural sensitivity into their practice. A modified grounded theory approach has been used for this study. In-depth interviews were used for collecting the data as the
method produces rich information. A constant comparative data analysis was performed until data saturation was reached. Theoretical sensitivity provided the direction for the theoretical underpinning of this study.

Throughout the research process I was conscious of the importance of ‘rigour’. A modified grounded theory approach was an appropriate method to utilise for this study. Trustworthiness of the findings was enhanced by allowing the participants to guide the research process; this was achieved by the use of open ended questions. Purposive sampling allowed for information on the topic to be acquired and to provide a true representation of midwives within NSW. Participant validation has been achieved by allowing the voices of the participants to be heard and the relationship of the literature to the data has been adequately explained.

The methods used in this study allowed me to explore the practice of the participants in regard to how they incorporate cultural sensitivity into their daily practice.
CHAPTER FIVE: DISCUSSING CULTURALLY APPROPRIATE CARE.

5.1. Introduction

When participants were asked about how they provide culturally sensitive care, most spontaneously discussed cultural groups other than Indigenous people. This is a reflection of the diversity of the Australian population, which is multicultural (Jamrozik 2004). The two main groups that were discussed by the majority of the participants (those employed in urban or regional locations) were the Asian (Chinese) population and Arabic speaking women or the Muslim population. This chapter illustrates how the participants talked about providing care for women they identified as ‘Asian’ or ‘Arabic’ or ‘Muslim’. The original emphasis of the research was to focus on how midwives provide culturally sensitive care to Indigenous women. However this material has been included because it illuminates the participants’ view of CALD women and provides insights into how they view difference, in particular cultural difference and how they provide care for these women.

This chapter identifies a distinct discourse within the midwives accounts of providing care to CALD women. This discourse is a discourse of difference, which is based on a nursing and midwifery approach to practice which focuses on the cognitive aspects of culture, ‘traditions’, ‘values’ and ‘beliefs’. As discussed in Chapter 2, this discourse directs how the provision of care is performed and the majority of the participants use the generic or ‘cookbook’ approach to practice.
The discourse of difference is prevalent as the majority of the participants had had some education or training about the cultural needs of women and this was mainly concerned with CALD women, for example, Chinese or Muslim women. There was little education provided about the cultural needs of Indigenous Australian women. The education programs (as described in Chapter 2) tended to focus on learning about specific cognitive aspects of culture, the beliefs, values and traditions of CALD women and I will discuss this first.

I will then discuss how the participants identified women from the two groups; Asian or Arabic-speaking or Muslim women. In the final section of this chapter, the participants’ accounts of care for these two groups of women are provided.

5.2. Preparing for Practice; Midwifery Education

The participants all discussed the need to have some information about the impact of different cultures on the health and well-being of individuals from CALD backgrounds. For the majority of the participants, information about the cultural needs of women from CALD backgrounds focused on the cognitive aspects of culture, in particular their beliefs, values and traditions. Education about different cultures was provided in a number of different ways; during their initial midwifery education, hospital in-services, hospital policies, literature, by other colleagues and clinical practice. This section of the chapter
discusses the ways participants have learnt about culture before moving onto the role of clinical practice in shaping the participants’ views of difference.

As identified in the methodology chapter (Chapter 4), eleven of the participants’ initial midwifery qualifications were undertaken in the tertiary sector. However, seventeen participants (in total) had also completed tertiary qualifications after completing their initial midwifery education, including those whose initial education was in the hospital system or the tertiary sector. Therefore, fifty three percent of the participants had completed some form of tertiary education. These participants talked about how they learnt about culture whilst undertaking different tertiary programs.

Participants who undertook their initial midwifery education in the tertiary sector or participants who had completed further tertiary education explained how some of the lectures and assignments were based on identifying and providing care for women from CALD backgrounds. This education focused on the cognitive aspects of culture and students were encouraged to identify traditional practices. This type of approach is viewed by some nursing and midwifery educators as allowing the nurse or midwife to become sensitised to the needs of specific groups of CALD women (Erlen 1998):

… we had to choose a particular community that was representative within the hospital here … [I] chose the Vietnamese community.
We had to look at, we had to talk to Vietnamese women and the interpreters or who ever we could meet and find out as much as we could about their culture. We did really. And then we had to plan a diet for pregnancy for someone from that culture and cook it for our classmates, which was really fantastic, so we all had a day where we brought in stuff. And so I found out heaps of stuff about calcium because Vietnamese cultures generally don’t use milk products so they use stuff like soya … and all that sort of stuff. I then got to know a lot about the history of Vietnam and the colonisation by the French and so they actually cook a lot of French food, which has become part of the Vietnamese sort of way of life and so… it’s really very interesting and it’s quite innovative I think to actually have us think about what do Vietnamese eat when they’re pregnant and I found out lots of stuff about it, what the mothers bring for their daughters, if they are fairly traditional and still do a lot of that stuff… hot foods and why they don’t you know like to be uncovered and when you don’t have to for a shower… all that stuff (Grace, urban).

The experience above highlights how midwifery education (in the main) has accentuated the cognitive aspects of culture. The focus of this type of education is on individuals within specific CALD groups exhibiting the same values, and ignores the influences of individual life experiences and the influence of the society in which they live on these perceived values and traditions (Duffy 2001). Students were asked to identify traditional practices of women from a specific CALD background, in this case women identified as being Asian. The experience of the student was then generically applied to all women
perceived to be from this group. Cioffi (2004) interviewed twelve midwives employed in a maternity unit in Sydney, Australia about their experiences of caring for CALD women. She states that although these midwives knew about the generic practices of Chinese and Islamic women, there was little recognition of ‘intracultural differences’ (Cioffi 2004, p.440).

Although there is a recognition that not all Vietnamese women will adhere to traditional practices, this is still a generic approach and an assumption that most women will appreciate recognition of their traditional customs and incorporation of these into midwifery practice. A cookbook approach (Duffy 2001) to care has been developed.

And I also learnt from one of the Vietnamese Women that they do this special baby massage……the baby’s heart. So if I have a Vietnamese woman and the baby does need some sort of tactile stimulation, I try and do that rather than just a general rub down….so I try and be just a little bit respectful. And I probably don’t do it anywhere near how they do it. But I am doing the best I can. Sometimes they notice it and appreciate it. And it makes me feel better (Grace, urban).

The majority of the participants had a desire and need to please women in order to feel that they were doing a good job. The literature identifies that for job satisfaction, midwives need to feel satisfied with the care that they are providing (Lavender & Chapple 2004; Kitzinger 2005). The participants incorporate what they believed to be
appropriate cultural practice (as long as it is seen as safe practice, see the following discussion on some women not wishing to shower following the birth of their baby). Hence, this midwife changed her tactile stimulation practice for babies whose mothers were identified as being Vietnamese, regardless of the fact that the information about a special baby massage being part of Vietnamese traditional practice only came from one woman. What is perceived to be culturally appropriate care for the mother and baby is often initiated by the participants without asking the individual woman about this practice. Although the participants are striving to please women, they often do not ask about individual preferences (assumptions are made) and practices are altered based on generic information about different groups of CALD women.

Another form of education that was discussed by the participants is hospital based in-service or orientation programs that sometimes include information about cultural diversity. The study participants discuss how they find these in-services beneficial as it provides them with culturally specific information about different CALD groups of women. Again, there is an emphasis placed on being able to apply this information to all women who are identified as belonging to a specific CALD group and the focus becomes directed at difference rather than similarities with the participants’ own culture.

I think it’s very important that midwives attend a cultural awareness program and it is part of the orientation of the hospital now. It wasn’t always a part of it but it is part of orientation now to have cultural awareness program sort of in it. People can attend cultural awareness days at certain times throughout the year and I’ve actually been involved in participating in them … I think it helps
midwives to work with other cultures and recognise some of the ways in which the women in pregnancy and afterward and also having the baby is very different to our culture (Cathy, regional).

In-services are sometimes provided from resources within the hospital infrastructure, such as the interpreter service.

So we had always a health care provider [from the] interpreter service, who would come in and give us information about specific cultural beliefs that we would need because of our population group … (Vivian, urban).

The above quote amplifies how all the participants’ desire information about specific cultural needs to assist them with providing appropriate care. However there is no recognition of the individual within this framework. This approach endeavours to identify traditions and cultural needs of different groups of CALD women without considering the effect of migration or the impact of individual life experiences on the needs of individual women. This is in direct contrast to the national competency standards for the midwife ‘overarching framework’ which advocates a ‘woman – centred’ approach to care (Australian Nursing & Midwifery Council 2006, p.10).

Hospital policies can also direct how the participants respond to people from CALD backgrounds. There is generic information provided about different CALD groups, in particular policies that cover, for example, the care of a deceased person.
Well, we have information here on the ward, we actually have a manual for various ethnic groups, particularly dealing with subjects like death and dying and what they like done with the body in the family, possessions and things like that (Deb, regional).

Specific generic policies provided by the hospitals can lead to a ‘cookbook’ approach to care. As discussed in Chapter 2, this approach can lead to stereotyping and loses sight of individual needs.

The participants were also asked if they utilised any relevant literature to assist them with care provision. The majority stated that apart from having to read appropriate journal articles for assignments, it was not something that they undertook on a regular basis when they completed their relevant degrees. As stated by McDonnell (2004), many nurses do not actively seek research information for a variety of reasons, including inability to access library resources at work and a lack of time.

I’d like to say yes but unfortunately (laughing) I’ve been so jolly busy. I haven’t had a great deal of time, with the journals, to actually go down and access the library which isn’t open all that often anyway. I haven’t done a great deal with that since I’ve been here unfortunately. I’m always interested in seeing the journal articles when they make an appearance on my desk at any time… (Bronwyn, regional).
However, some of the participants were aware that different professional organisations such as the Australian College of Midwives provide information about CALD groups of women.

I know the Australian College of Midwives got out a little booklet about culturally appropriate stuff (Amy, regional).

Only a minority of participants stated that they used midwifery literature to guide practice in their everyday working lives.

…sometimes it would be finding a good journal article if I was flicking through Midas something like that. I’ve got one up there on Muslim birth practices and different groups (Amelia, regional).

Again, there is emphasis on grouping women from a specific CALD group, in this case, women who were identified as being Muslim, as having the same birthing preferences.

The study participants also learn about specific CALD women’s perceived cultural traditions, beliefs and values from their colleagues.

I suppose just from working with other girls, with other midwives, perhaps as we do discuss care of patients and the way we find them, the way their needs…(Gail, regional).
Clinical practice had a major influence on how the study participants view women from different CALD backgrounds. Before discussing the participants’ perspectives of providing care for women with CALD backgrounds, a brief account of how the participants identify women as having Asian and Arabic or Muslim backgrounds will be provided.

### 5.3. Identification of Difference

In NSW, and in particular Sydney, there is a high proportion of the population who are from Asian countries (Australian Bureau of Statistics 2007). These populations can be easily distinguished by their physical characteristics and hence recognisable in a way that Indigenous women may not be. Similarly there is a high proportion of the population who are Arabic speaking or Muslim (Australian Bureau of Statistics 2007).

The high percentage of the population who are from Asian countries or descendants of Asian heritage accounts for why some of the participants singled out Asian women to tell narratives about cultural sensitivity and midwifery practice. Arabic speaking or Muslim women are also easily identifiable. These groups tend to be seen as homogeneous in Australia and are identified as:

…‘the Arabic other’, a supposedly homogenous category which includes those of Arabic or Middle Eastern or Muslim background. This is not a singular category, of course- it includes people from quite diverse ancestries and with
quite distinct histories— but it is seen to be a singular category (Poynting et al. 2004, pp.12-13).

Recognition of difference is tied partly to physical appearance, as is the case of Asian women, but also partly due to dress, for example the headscarf, the hijab. However, Muslims are to be found in many communities with different types of religious observance. The term ‘Arabic speaking’ refers potentially to many different countries of origin (including Australia) with again different life experiences and different ‘cultural beliefs’ in keeping with their country of birth.

The majority of the participants approach women as part of a group, as members of a larger whole. Midwives who use the group approach to practice consider that they are appropriately recognising cultural difference. They therefore perceive that they are providing culturally appropriate care that meets the needs of the women and their families. However, perceiving women who look similar, dress in a similar way, or who speak the same language belong to the same ‘culture’ (for example Asian women or Muslim women) and further assuming that these women have the same needs as a result may inadvertently lead to stereotyping (labelling all women from a specific CALD group as being the same; having the same beliefs and values).

The next section of the chapter will provide the perspectives of the participants in providing care to these two groups, Asian and Muslim and / or Arabic, women.
5.4. Asian Women and Midwifery Practice

The majority of the participants (except a minority who have only ever worked as midwives in the rural location) discussed providing care to women whom they identified as being ‘Chinese’ or ‘Asian’. These narratives focus on ‘differences’, such as breastfeeding practices and preferences for warm fluids rather than cold.

Filtered throughout the participants’ accounts are their concerns to provide culturally appropriate care. However this appears at times to be more complex than expected. The participants know about some practices such as yin and yang; how women from Asian countries prefer warm water to cold water (Cioffi 2004). Similarly, there is midwifery knowledge about Asian women’s preferred breast feeding practices. However, this may cause inner conflict for some of the participants as the women may choose not to breast feed in the first days following birth until their milk has come in; this is in direct contrast to what the participants regard as ‘best practice’. On the other hand there is a lack of knowledge or understanding about some cultural needs and the participants may stand back and observe rather than taking an active part in the provision of care.

The discourse of the participants frequently portrays all Asian women as having the same needs when, in fact, the Asian experience within Australia is diverse, some Asian families arrived in Australia in the early 19th century for example (Australian Bureau of Statistics 2007) and some are more recent immigrants. Hence, there are differences in terms of life experiences and adherence to any kind of [externally applied] cultural
‘norm’. This is not recognised by the majority of the participants. However, a small number of the participants did discuss diversity within groups.

I have noticed a big difference between women who are from poorer areas in China and the way they labour and generally speaking compared to well educated Chinese women who might be from Shanghai or somewhere that is really well developed and so I see a difference because they have got a different lifestyle and they come from a different sub-culture even though they are actually from the same [country] (Jessica, urban).

This description by Jessica is not concerned with recognition of specific cultural values and beliefs. Jessica is describing how there are social differences between women who have been identified as belonging to the same CALD group. The difference Jessica is describing here is related to the social conditions women may have experienced. For example, some women have experienced a lower standard of living and may not have had the educational opportunities of other women within their country of origin.

Midwives, as discussed previously, are governed by the Australian Nursing and Midwifery Council, National Competency Standards for the Midwife (2006) which endorses the respect for all women regardless of their beliefs, values or socioeconomic status. As the participants are governed by professional standards, and the policy and procedures in the health care setting, they attempt to provide appropriate care to all. However, some of the participants provide what they perceive women from ‘Asian
cultures’ want without asking the women first. The provision of providing care that is based on generic knowledge is performed out of a desire to please the woman and her significant other. The generic approach is perceived by the participants to make the woman feel understood and therefore increase her confidence in the midwives who are providing care. It is important to the participants that all women feel comfortable especially in the birthing environment.

Some of the simple ones that I have learnt are with your Chinese couples. It is great when they come in and you can just take in some warm water into the room instead of the jug of ice water and straight away they go, ‘ok’, and that is a really simple thing that we need to be mindful of and it is a very simple thing that makes them feel comfortable and [they] think, hang on she sort of understands a little more about maybe what our needs are (Amelia, regional).

Some of the participants strive to provide culturally appropriate care, to the point of providing warm water for Asian people to drink without first asking them if that is what they want. This was also the case in the study conducted by Cioffi (2004). Some of these Asian people would have been born in Australia and may prefer cold water to drink. The participants are acting on the physical appearance of the individual rather than asking pertinent questions or providing individualised care. They are also using a generic approach to care that they have either been told about or read about for example:

Chinese women will not eat cold or uncooked foods after they have given birth, so salads will be inappropriate if they are in hospital. Many women will prefer hot water for drinking…Community midwives should be aware that their
client’s house may smell very strongly of ginger and vinegar. Ginger has a prominent role in the diet, especially in the postnatal period (Neile 1995, p.35).

However, a generic knowledge does provide some insight into what people from different cultures may require. A minority of the participants understand that some Asian women may prefer warm water to cold water but do not suggest that all Asian women will want warm water. Some understand that they may prefer cold water. To these midwives, it is awareness of what some women may need rather than automatically implementing a generic approach to practice.

…if they come in and I mean, I may not even always, you know, specifically say, ‘Do you or don’t you want hot or cold water’, you know, I just automatically take them in a jug of cold water and then say, ‘Is the cold water ok?’ And if they say, ‘Well no’, then I go and get the hot water (Bronwyn, regional).

The concept of Asian women’s preference for hot water and their dislike of being cold were often discussed by the participants.

…being aware that for certain people, certain things are not appropriate for them. For instance, a lot of Asian women that I look after are very particular about hot and cold, they won’t drink cold water and, even their bathing can be an issue for them (Bronwyn, regional).
Again there is recognition that some but not all women who are identified as being Asian prefer ‘hot’ water.

I learnt some of the Asian women they are not allowed, they don’t shower often after delivery so we try to adapt to that as much as possible either by encouraging them just to wash if that’s the case (Wilma, regional).

There is recognition of difference by the participants, however they still encourage women who may not wish to shower to meet their expectations of at least washing. There is little midwifery knowledge about how some Asian women may attend to their hygiene needs following birth.

On the other hand, some of the participants are much more supportive of ‘difference’. Some of the participants understand about the need to discuss individual women’s preferences and how these should be met within the hospital system. These participants understand that Asian women are concerned about their hygiene, however in some cases women may prefer to use a bowl of water rather than the shower. Cioffi’s (2004) study of midwives caring for CALD women also identified that most midwives know the concept of ‘yin and yang’ and understand why some Chinese may not wish to shower following the birth of their baby.

I think with the Chinese women I think that real yin and yang about cold and hot and us [midwives] feeling that everyone must have a shower after they’ve had a baby. They must be clean and whatever and they [Chinese women] really only
wanted a bowl of water which I think initially that is the stuff you have got to take on board. It’s whatever, as long as it’s not affecting their health and not effecting the baby in any detrimental way …in a public health system in a hospital whether it be having a little sponge with a bowl as opposed to being wet from head to toe with a shower, then that’s what we should work with (Sarah, urban previous rural experience).

On analysis of Sarah’s description, flexibility can be seen to be a key part of her practice, as long as both the mother and baby are safe. It is the hospital system and midwives who need to be flexible to meet the needs of women who wish to do things differently, such as not showering directly after birth. Flexibility is often portrayed by the participants when discussing CALD women’s needs, especially in relation to their dietary requirements.

…where I did my midwifery in Melbourne, we had a very large Asian population. A lot of the midwives were Asian as well but there were a lot of Vietnamese people in the area. East Melbourne is very Asian orientated and they had their own cultural needs. A lot of the families brought in meals for them, and the staff there was supportive of that sort of thing. If the hospital couldn’t provide what the woman needed to meet her cultural expectations, they were more than happy for the family to meet and support that. They were flexible enough to allow that and to appreciate that it was what they required and it made life easier for everyone because if the patients are happy then the staff have less hassles (Amy, regional; discusses previous urban experience).
This practice of allowing the mother’s family to bring in suitable food ‘in insulated pots’ has also been discussed by Cioffi (2004).

However, within the hospital setting midwives see a range of different practices which may not be in their opinion ‘best practice’. Breastfeeding was frequently discussed by the participants. The midwifery discourse in regard to breastfeeding and ‘Asian’ women is one in which the women are portrayed as not having an understanding of breastfeeding. This conclusion is reached by some of the participants because some Asian women may not wish to breastfeed in the first few days following birth until their milk comes in (Cioffi 2004). They may also choose to give their baby complementary feeds of formula after a breast feed; some midwives believe that this practice is based on an ‘Asian traditional custom’ or because of pressure from their mother or mother in-laws (Cioffi 2004).

…with the majority of the Asian cultures there is the belief that there is no breast milk in the first few days or that … there is inadequate breast milk. So that they will be very keen to give supplement feeds to their babies. I don’t think that I would do anything different there other than educate them that the [breast] milk was there and the positive aspects of using that and supply and demand and using the literature (David, Urban).

The majority of the participants, although recognising that some Asian women will offer supplement feeds in the form of formula until their milk comes in, will alter their practice
to provide more information about the benefits of colostrum and breastfeeding on
demand. This is in the hope that the women will alter their practice. Yelland , Small et
al’s (1998) findings from a study conducted to elicit the views of Filipino, Turkish and
Vietnamese women on their experience of postnatal care in Melbourne, Australia
identified that of the 318 participants, 63.2% who breastfeed their baby exclusively in
hospital did so because they knew it was best for their baby. Of these women 75% needed
assistance to breastfeed and of these women 75% stated that the advice given by
midwives was helpful.

One of the participants provided her perspectives in regard to Asian women and
breastfeeding. In this discussion Faith talks about the attitude of some her colleagues to
‘difference’, where they may make derogative marks about breastfeeding practices that
are not based on what they believe to be best practice. She talks about how some Asian
women do not like to breastfeed after birth when colostrum is present. However she does
not know why this is the case. She has made some enquiries and has been informed that it
is because some Asian women perceive colostrum to be dirty milk. She then goes on to
say that she does not have the right to change a ‘traditional practice’ that has been going
on for centuries.

…when I looked after Asian women in labour and afterwards, like often you
would hear people, staff that I was working with mocking them, just over little
things like they don’t like to give their babies colostrum, they like it to go on the
bottle and then they will give them breast milk then they actually might give it
formula and breast milk and I always thought that’s really interesting, I wonder why they do that?

Did you ever find out why?

Well, I’ve been given a few explanations, one of them was that they thought the colostrum was dirty, dirty milk and like I never felt oh god that’s stupid, I need to change this woman’s perception, I didn’t think I needed to mock them or anything. I thought oh isn’t that interesting and then I’d tell them what we [midwives] thought what colostrum is, that it’s not actually dirty it’s meant to be this really good milk and when I was telling them that information it wasn’t like I had to change the way that they, like what they believed. They have believed this for centuries, it wasn’t for me to come in and say right oh you need to change your opinion about this cause its wrong. So from there I thought, oh I wonder what other cultures do (Faith, regional).

Some of the participants, like Faith, are not concerned if the women are not following their advice, as they are seen as following their ‘cultural’ or ‘traditional practice’. However, some of the other participants remain unhappy with women’s decisions that are not based on the discourse of current, Western-based scientific evidence.

I know we [midwives] have had an issue with especially I think the Chinese culture… giving the babies boiled water instead of just breastfeeding continuously and we [midwives] do try to promote breastfeeding as much as possible but if that is what they want to do, it is their custom, we then relent to
that and allow them to do it if they wish. And we just instruct them and encourage breastfeeding as much as possible in that situation (Zoë, Regional).

This pressure to breastfeed exerted by midwives was also found in the study conducted by Yelland, Small et al (1998). These authors state that 4 % of the 318 women in their study (discussed previously), commented about how they felt pressured by the midwives caring for them to breastfeed their baby even though they did not want to.

Nevertheless, the majority of the participants have tried to incorporate what they perceive to be ‘culturally appropriate care’ into their practice. However, the discourses of the participants’ social environment, for example the media, impact to some extent on how they view people who are different from them. This becomes apparent when analysing the accounts of the participants especially when they are discussing caring for ‘Arabic’ or ‘Muslim’ women.

5.5. ‘Arabic’ or ‘Muslim’ Women and Midwifery Practice

When talking about providing care for Arabic speaking or Muslim women, the participants have a generic knowledge about their cultural needs which they defined as the women’s need for privacy in the antenatal, birthing and postnatal periods. Participants
also talked about the Arabic or Muslim women’s primary role in child rearing in comparison to their male partners. Their role was viewed by the participants as being subordinate to their male partners. Consequently, the participants are often taken by surprise if Arabic speaking or Muslim women do not behave as anticipated. For example some participants assume that Arabic speaking or Muslim women require more privacy in labour or that their partner will not be an active support person. However, this may not be the case for individual Arabic speaking or Muslim women.

There is often negative media coverage of people who have been identified as being ‘Muslim’ or Arabic’, and this view of an ‘Islamic civilisation’ impacts on midwifery practice (Poynting et al. 2004). Midwives, like others in the community, may believe that there is an ‘Islamic’ surge and are fearful of an Islamic take over of their social environment. However, some of the participants recognise that assumptions are made based on what midwives may hear or read through the Australian media.

But, hearing certain things people automatically make assumptions and I suppose teaching people about assumptions. Teaching people about how we do make assumptions and breaking those things down and saying what are you frightened of. If you’ve got someone coming from a Muslim country, you are going to think that they are a fanatic because that’s what you’ve heard (Emma, AMS).
Emma’s description identifies the discourse surrounding people who are identified as being ‘Muslim’. They are labelled as the ‘other’ and are feared as they are all regarded as being potential terrorists by many Anglo –Australians (Jupp 2002).

Regardless of how Muslims are portrayed by the media, or how the participants’ personally feel about the ‘Muslim culture’, midwives are required to provide care to all women. The number of people who are Muslim within Australia is increasing. Therefore, some of the participants have been educated in a generic way about ‘Arabic’ or ‘Muslim’ women. For example information in regard to Muslim practices, such as the fasting practices of women who are Muslim during Ramadan (Murray 2003). As discussed by Bronwyn:

…the beliefs in relation to diet with some of the Middle Eastern people

(Bronwyn, regional).

The generic education provided to midwives in regard to ‘Arabic’ or ‘Muslim’ women is heavily influenced by the perceived role of women in Muslim communities. Midwives are told that Muslim women value their privacy (Cioffi 2004). Therefore Muslim women will be modest about revealing their bodies and the women may desire to only have female health professional provide care for them (Bradshaw 2000; Cioffi 2004).

…a lot of Muslim woman birth here as well too... I think most people generally know that they only like female carers, so we try to accommodate that (Hayley, Urban).
... devout Muslim women would prefer not to have a male looking after her [them] and obviously not performing invasive procedures (David, urban).

... there have been a couple of women that have come from middle eastern countries or the Balkans and they’ve been Muslim women so they are particularly concerned about modesty and not having male partners present for the actual birth which is not acceptable just for those groups of women (Hanna, regional).

Muslim women and their partners are grouped together as having the same preference. It has been assumed that for all other women, their male partners should be present for birth. When a woman who is not Muslim asks to be seen by a female health professional, some of the participants may ask further questions to see if there is any relevant background such as previous sexual abuse. Assumptions are made about both ‘Muslim’ and Anglo-Australian women. It is assumed that because a non-Muslim woman asks for a female health professional that she may have other issues, when in fact she may also be modest and prefer a female health carer.

...a Muslim woman was in here and asked if she could see a female doctor, I would assume that [request] is because she is a Muslim. If a white Anglo-Saxon woman came in and specifically asked for a female doctor I would probably question her a little bit more to find out why to make sure that there wasn’t something else in the background. Whereas [with] the Muslim woman I would
probably just sort of assume it’s because she is a Muslim. I would not have gone into more detail with her to see if she had been sexually abused or anything like that (Wilma, regional).

A generic approach to practice (as above) may exclude Muslim women from being asked about any of their personal history that may impact on their care. These women are then not offered referral to resources that other non-Muslim women would receive, for example counselling services or referral to a social worker if required.

Participants feel comfortable when they have looked after a number of women who are identified as belonging to a specific CALD group, as they are able to develop a generic care plan to meet the needs of these women.

I’m sure the more exposure you had to say Muslims, for example, or Aboriginals, the more comfortable one would become with that particular, with their particular care plan (Nita, rural).

However, the participants’ education about the ‘Islamic culture’ enables them to understand why some Muslim women will not breastfeed their babies in public.

Providing privacy for all women within maternity units is a challenge for midwives. Visiting hours may vary from hospital to hospital, some being more open than others. Women are expected to feed their babies on demand. Some of the participants believe that breastfeeding is so natural, that it should not matter where a mother feeds her baby.
However, there is recognition that for ‘Muslim’ women breastfeeding in public is not appropriate.

…we try and promote breastfeeding and it should not matter where you feed but for them [Muslim women] it does. They only show their face, let alone show their breast. We [midwives] find that they never want to breastfeed while it was visiting hours, which is understandable. You have a baby that was probably a little bit dehydrated or something, so you sort of had to work with this fact. How about we give the baby a feed now? Or we would actually ask them if they would not mind feeding. Let’s go feed the baby in another place for 20 minutes because there would be so many visitors then they could all entertain themselves anyway. So I didn’t find it difficult. It was just a learning thing, you would just learn about each culture … (Sarah, urban).

The comment made about the visitors entertaining themselves is interesting as it suggests that Muslim women always have a lot of visitors. Managing visitors for this group of women has been identified as an issue for midwives in a previous study (Cioffi 2004).

Some of the participants have a desire to know as much about a ‘cultural group’ as they can. This desire is born out of their need to provide what they see as cultural appropriate care. They have a women-centred approach where they would like to be able to incorporate women’s needs and desires into their midwifery practice. Participants discussed how they would like to have more informal meetings with women from
‘different cultures’ to their own. However, the current workloads of some midwives do not allow this to happen. Midwifery practice within a hospital setting is controlled by the hospital administration and policy and procedures. The bureaucracy of the hospital system may impact negatively on the midwives’ ability to do something out of the ‘norm’, such as talking informally with different ‘cultural’ groups. Amelia talks about her desire to know about the local Arabic women. She would like to spend some more time with them on an informal basis to help her understand their particular needs. However, participants commented that their workloads do not provide an opportunity for them to spend time with women to develop a greater understanding of their needs.

We have got the Arabic women that come from [local suburb] and I have actually looked after quite a lot of them. It is quite nice when they come up for their tours because they have got their kids. They [health service] used to do a community midwives’ clinics out there so you actually develop an understanding. It does not take long once you have looked after a couple of women in that group. I think they get word around themselves and they talk obviously about you or, you talk to different people in that group. That is where I think I have got a lot of information from them or from their interpreters or those [women] that come in sometimes, you can ask them some more specific questions about their experiences or what they think are important things from that cultural group. They would be the main one… It would be a great opportunity to actually sit down and have a chat to them about what we can do to change our practices or to make them feel more comfortable (Amelia, Regional).
Again the emphasis is on the need to know about specific cultural practices, the focus is on a generic approach rather than an individualised approach. Further on Amelia talks about her experience of caring for women who are Muslim. She tells the story of how she has been surprised to find that some of the ‘Muslim’ or ‘Arabic’ women and their partners that she has cared for were no different to other women and their partners.

I think that it is really interesting when you have your Muslim women and they have all their scarfs and things on and they come into the room [birthing room] and you can see a completely different side of them. It is fascinating to see how once they get into the privacy of the birthing room … I tended to think that they were much more conservative and a bit more conscious of issues of privacy and things than the average women [referring to women who are not Muslim] but in the end they are really [the same]. Once they get into the confines of their own room they are able to do as they please and as they feel comfortable and sometimes their husbands encourage them to do that. [However] that might not be appropriate if they were out in the broader community. So they have two different faces as we probably all do. One that we have where we feel safe and having our own experience and one when you are trying to be socially correct (Amelia, regional).

Amelia provides a very perceptive analysis of the situation showing empathy. In particular she recognises that all people react in an expected way if they are in the public gaze. However, on an individual basis, some Muslim or Arabic women are able to do as
they please whilst in labour. Their male partners are supportive of this. Amelia was initially surprised by this as she has been informed that Muslim women are not respected by Muslim males and their perceived submissive roles are very different to those of Anglo-Australian women.

However, Amelia’s clinical experience dealing with individuals from other cultures has not always been positive. This has been echoed by other participants who have at some point felt uncomfortable when providing care. Amelia talked openly about having observed women not being treated as equal within a family, as well as witnessing at times inappropriate use of communication by partners or other support people to the labouring women in her care.

You mentioned sometimes that you feel uncomfortable. Can you give me an example of what might make you feel uncomfortable?

I mean things like the role of women in some cultures. Women certainly do not have the same respect or autonomy within their families or within their culture that we might expect. Some of the roles that are played within the labouring situation and sometimes the way words are spoken or conversations are had, you sort of might go, that’s not fair or why is he speaking to her like that … you have to respect the fact that maybe that is much more normal and that is their normal lifestyle and interfering by making a judgement on those sorts of issues can be quite damaging to the new relationship with the midwife, where you are professional with the couple (Amelia, regional).
There is an inference that this is acceptable Muslim behaviour or a ‘cultural norm’. Therefore, to provide culturally appropriate care, Amelia ignores or does not act as a result of the partner’s behaviour. This then creates inner conflict for her in respect to her own feelings in regard to how the woman is being treated by her partner and her professional practice.

Other participants discussed how sometimes the roles of Muslim fathers were different to those who are not Muslim or from Arabic backgrounds. Some of the midwives have a tendency to expect all fathers to be involved in the basic care of the baby. When this does not happen they have to assess their feelings about this. Once the participants realise that the couple are happy with their roles, then the midwives will respect their way of doing things. However, the majority of the participants view fathers who do not participate in the care of their baby as not ‘normal’ by Western standards. Fathers who are non-Muslim are expected to provide care for their newborns. ‘Muslim’ or ‘Arabic’ fathers who do not participate in the care of the newborn are seen by some of the participants as being ‘different’. This difference is accounted for under the label of ‘culture’.

… religious and cultural things to me are very much intertwined…with some of the Middle Eastern people. We have a couple here at the moment who [are an] absolutely beautiful couple. The father is a very traditional Muslim who will not have anything to do with the hands on care of the baby. That is their culture and I have to respect that. He will not be involved in nappy changing, the bathing of the baby, that is the wife’s responsibility in that situation [and] they are both happy within that parameter. I think as a midwife I have to respect that works for
them as a couple and there is cultural thing and that it is not for me to impose my personal views or values on what somebody else believes… (Bronwyn, Regional).

Bronwyn is explicit in her discussion that she can not bring her own views or values into providing care for couples who are different to her. She believes it is a cultural difference and she should not interfere.

5.6. Knowing Self; Acceptance of ‘Others’

Similarly, other participants express the view that they believe it is necessary for midwives to have an understanding of their own beliefs in order to recognise difference and to be accepting of other practices. This concept, already discussed in Chapter 2, has been identified by several scholars as being crucial to providing culturally appropriate care (Erlen 1998; Omeri & Malcolm 2004; Benkert et al. 2005)

…there’s a big need for you to understand different cultures and I, from my view point, I think it’s more about leaning to understand your own culture and understand your own culture norms so that when someone doesn’t behave as you would expect given the social circumstance you need to have insight into what are actually your cultural needs and so if a person doesn’t act in a particular manner in a given situation you need to have it in sight that maybe that’s actually got to do with your cultural norms and your cultural rules and
understand that and be able to then look at and say well maybe they are actually behaving according to their cultural norms (Kaylene, rural)

Kaylene talks about her need to recognise her own values and beliefs so that when people behave differently she is able to understand that their practice may be normal for their personal beliefs. Grace (like Kaylene) understands that her own ‘cultural’ background may impinge on her practice. She personally has found out more about her own cultural expectations when she has come into contact with ‘different culture’ to her own.

I guess also it means identifying that you are from a culture yourself, like as I have said that’s where a lot of us [midwives’] go wrong not actually recognising how our culture informs how we view…it is what we grew up with, and we often not have any sense of that unless you are immersed in another culture, I think that the best time to learn about your own culture is when you are outside of it (Grace, urban).

5.7. Community Experience; Stepping into Difference

In some of the participants’ accounts of caring for CALD women, their community clinical experience was discussed. These midwives had either worked in or were working in maternity early discharge programs. These programs allow women and their babies to be discharged within a certain time frame after birth to their homes. The hospital then provides a service where a midwife will provide postnatal assessment and education
sessions in the woman’s home on a daily basis (usually) until five days post birth. The participants who have provided care within women’s homes have learnt from their experiences about different cultural practices.

…well for instance at the moment I’m looking after an Asian lady who is actually married to an Australian man and I guess I just basically stand back a little bit and I appreciate that they eat different food, that the cutlery and things on the table are different and I guess I haven’t had a lot of in depth education on the different cultural backgrounds but it’s kind of a case of sitting back and watching and really allowing them to, I guess in a way, dictate to me what they are wanting to do (Deb, regional; community practice).

Participants who have experienced community practice learn by observation within the clients’ own home. This clinical experience allows the participants to see that individuals may live differently to how they may personally live. It also challenges the participants, as the woman may chose to do things her way.

Consequently, community practice expands some of the participants’ perspectives in regard to providing care and information to the woman and their families.

I take off my shoes when I walk into the house. There are a lot of people to whom that is important. You go to some peoples houses who are from some Asian countries and it’s insulting for them for you to wear your shoes in their house. So you take off your shoes. You include the grandmothers in the
conversations because they are the significant female member of the household so you make sure that you’re not just telling mum. That you are telling the whole house so that grandma knows that, you think she’s a very important part of it because in their culture. She is a very important part of this new unit where that may be completely inappropriate in an ‘Anglo’ household to be telling Grandma how you want things to be going for this baby (Madison, Urban).

Madison is comparing the family network of Asian women to women with an Anglo-Australian background. She recognises the importance of the extended family in the care of the woman and her baby for a woman who has an Asian background. This approach to practice of including the grandmothers in all decision making as they are the main care providers of the baby following birth was also demonstrated by the midwifery participants in the study conducted by Cioffi (2004). However, there is an assumption that this is the case for all Asian families. There is also a surmise that Anglo-Australian women would not want to include their mothers in any discussion about their care or their baby’s care. Recognition of differences within cultures has not been acknowledged. Once a woman has been identified as belonging to a specific culture, a generic approach to practice is undertaken; this is both for individuals who are perceived to be from different cultural groups and also for those individuals who are identified as belonging to the same cultural background as the participants. This approach can be seen as one in which only the cognitive aspects of culture are taken into consideration. The interaction of the individual with their Australian social environment, for example the media or television,
and the effects of this interaction, are not taken into consideration. The individual can be lost in a generic ‘cookbook’ approach to care.

5.8. Conclusion

This chapter has identified that the participants do try to incorporate cultural sensitivity into their practice. The dominant discourses in nursing and midwifery which place emphasis on providing generic information about cultures other than the midwife’s own have shaped their views of individual needs.

The participants express the desire to know about other cultures in order to provide appropriate care. For some of the participants, there is a need to be able to provide appropriate care on recognition of ‘difference’ without waiting to ask the woman what her individual needs are. This is seen as being caring and recognising needs without being directed or asked. However, this approach is based on ‘generic’ information which may not be appropriate for the individual woman receiving the care. This practice can be seen as stereotyping.

Differences in beliefs between the participants and women from CALD backgrounds in some cases causes discomfort for the participants, as they see some practices as harmful because they are not based on scientific evidence. However, when the participants are unsure of what is expected, some stand back and observe. In some cases, this causes
distress to the participants as they are not in control of the situation and they are not providing care as ‘a good midwife’ should.

The participants’ voices also show difference in the way they approach practice. The majority of the participants feel they need to have a ‘generic’ knowledge of women from different cultural backgrounds. Others use a more individualistic approach to all women as they recognise the uniqueness of each individual regardless of their backgrounds.

The context of care also impacts on how midwives provide care to women. The participants who provide care within the community setting, for example, in women’s homes, have indicated that their approach to practice is altered. They have indicated that to some extent, the locus of control has shifted to the women and they become more flexible in their approach as the women direct their own care. Chapter 7 will focus on the context of care.
CHAPTER SIX: CARING FOR INDIGENOUS WOMEN.

6.1. Introduction

As discussed previously, when asked to provide accounts of how they view cultural diversity and how they incorporate cultural sensitivity into their everyday practice, the majority of the participants talked about their experiences of caring for women from cultural groups rather than women from Indigenous backgrounds. The exceptions were those midwives employed by Aboriginal Medical Services. There may be two reasons for this. The first is that the Indigenous population who birth in some hospitals is small in comparison to women from other CALD groups. The second is that women may not be identified as being Indigenous by midwives due to the fact that Indigenous women are not always easily identifiable by physical characteristics or dress. However, in response to further questions the participants did address this issue and this chapter explains these accounts.

I have organised the chapter according to the different discourses that are discernable within the midwives’ accounts. The first discourse of ‘cultural difference’ is very similar to that apparent in the participants’ accounts of caring for women from CALD backgrounds, discussed in Chapter 5. In this discourse, culture is synonymous with ‘traditions and customs’ and there is a desire among the participants to find out about these and translate them into appropriate care plans. However, when Indigenous women are seen to no longer adhere to practices thought to be traditional for all Indigenous women, regardless of their geographical location, it is concluded that they have lost their
culture. This discourse focuses on culture and cultural loss in a very particular way. It enables decisions to be made about who is a ‘real’ Indigenous person and who is not. This is not the case with CALD women. The other aspect of this discourse which concerns difference is a focus on comparing Indigenous and non-Indigenous ‘cultures’ as if it were possible to do this, which tends to stereotype both. It is expressed by the participants’ along the lines of ‘we do this, they do that’. This aspect of the discourse of cultural difference allowed some participants to express negative views about Indigenous people.

I have called the second discourse ‘a discourse of social justice’. This discourse recognises the ongoing effects of over two centuries of colonisation and is similar in many respects to the perspectives of ‘cultural safety’, though no participant used this term. Participants who recognised the ongoing impact of colonisation on the well-being of Indigenous women believe that health care providers should be aware of the history of inequity and be more supportive of Indigenous individuals and communities. In some cases, participants indicated that their own life experiences, particularly that of being an ‘outsider’ in various ways, have influenced the way they view people from cultural backgrounds different to their own, including Indigenous people.

The final discourse I am calling a ‘discourse of denying difference’. Participants who espoused this discourse acknowledge that Indigenous people have suffered from discriminatory policies in the past, but this was not the fault of the current non-Indigenous population and the situation now is quite different. Everyone should be
treated equally and, as a corollary, everyone should adopt and follow the same social norms. This may be phrased as ‘they should move on’. In many ways this reflects a common discourse about Indigenous people, one which was apparent from the pronouncements of the previous government (discussed in Chapter 1). However, it is important to note that some of the participants use more than one of the discourses outlined above. I have discerned that some of the participants who expect Indigenous women to follow traditional birth practices, are also inclined to use the discourse of denying difference, that the women should ‘move on’ and forget past injustices.

In this chapter, I first discuss how participants learn about Indigenous women’s needs. In comparison to their education about the needs of women from CALD backgrounds, the participants received little or no formal education about the needs of Indigenous women and their families. I then focus on how midwives recognise Aboriginality. The three discourses identified above will then be discussed. Finally I provide the strategies used by some of the participants when they are providing care to Indigenous women.

6.2. Preparing for Practice

6.2.1. Pre service education

The majority of the participants had little initial education about the Indigenous population. This reflects Australian history. The average age of midwives in Australia in 1999 was 40.7 (Australian Health Workforce Advisory Committee 2002). The interviews
for this study commenced in 2000. Therefore the majority of the participants would have received their initial school education in the 1960s and 1970s. At that time the representation of Aboriginal people within school curricula was usually based on colonial discourses which recognised Australian history as commencing with the arrival of the first fleet (Cavanagh 2005). During the 1960s, there was particular emphasis on assimilation and its supposed benefits for the Aboriginal population. In the 1990s, there was a change of focus in school curricula to improve the representation of Aboriginal people. However, it is argued by Cavanagh (2005) that some of the advances made in the last 25 years were eroded by the formal federal conservative government (March 1996 to November 2007) as it attempted to remove what it considered to be an unwarranted misrepresentation of the effect of colonisation on the Indigenous population in the teaching of Australian history.

6.2.2 Midwifery education

The majority of the participants had little initial education about the needs of Indigenous women in relation to midwifery care. This is in direct contrast to learning about ‘other cultures’. When asked if their midwifery or nursing education contained any information relating to Indigenous women or their culture, the participants generally replied in the negative.

I have not learned anything in particular about their [Indigenous] culture that I should be aware of (Wilma, regional: initial midwifery education in the tertiary sector).
Not in my training (Sue, AMS: initial midwifery education in the hospital based system).

This reflects that, in Australia, the history of colonisation and the subsequent health inequality for Indigenous people compared to non-Indigenous people has not been incorporated into nursing and midwifery curricula (Goold 2001) until recently (Mortley 2007). The majority of the participants have learnt about the needs of Indigenous women from personal experience or other sources such as hospital in-service or orientation programs, literature or other colleagues.

6.2.3. Hospital in service programs

Hospital in-service or orientation programs were often discussed by the participants (particularly in the rural location) as providing information on the needs of Indigenous people. The participants in the rural location were more likely to care for Indigenous women and their families due to the higher number of Indigenous women living in this area.

We have actually got a cultural perspective awareness lecture that [is] compulsory to attend, it’s mandatory so I attended that last year and there is always something culturally going on with Aboriginal people, there is always lectures or something like that happening around within this health service, so I think they’re fairly well catered for… (Isla, rural).
As this workshop is compulsory, the rural participants discussed their views on the content of the program. A minority of participants found this experience to be very positive.

I should have done this ten years ago, I attended a cross cultural awareness workshop which was conducted by the University department at … two years ago. That was a full day workshop …[it] did cover the history of Aboriginal people in the far west of NSW the different tribes, the influence of European colonisation and that really gave me more awareness of the history …(Hanna, regional previous rural experience).

However, other participants voiced their concerns about the content of these compulsory workshops.

Oh, I, some of it, it actually let you see the other side, let you concentrate on how it would feel to be Aboriginal and how you would feel to be quite isolated and taken over by authority so you can get an understanding, or you can get some feel for, I don’t think you really do understand completely. You can get a feel for how it feels to have somebody come in and be totally in charge of your country and direct you in whatever direction they want to. You do get a feel for that, a lot of the cultural perspectives from early on I didn’t agree with, I can’t see how you can keep blaming white people 200 years down the track for what happened 100 years ago but I do acknowledge that dreadful things were done…but a lot of things they, that some of the Aboriginal people from that perspective are complaining about also happened to a lot of the lower class white
people, like their children were taken away from them as well. I’ve got girlfriends that were placed in orphanages… it is sort of what you can come to terms with and move on and I think some of the Aboriginal people have a very hard time coming to terms with what happened to them. It’s very ingrained and it has gone on for generations and it is very difficult for them … (Linda, rural).

The majority of the participants agree that colonisation impacted negatively on the Indigenous population at the time it occurred. However, there is little understanding of the ongoing effect of this process on the Indigenous population. A discourse of the denial of difference is espoused, and it is articulated that the Indigenous population should forget the past and move on. This is echoed by other participants from other areas who did not attend the above program.

Well, I think the history, the Aboriginal Australians and the way that our ancestors, the way they were treated when they came out to Australia was very poor indeed. …It was appalling what happened in the past but I don’t know, in some ways I think, everyone should get over it, you know, move on. It’s a new era and deal with it and move on rather than kind of. There seems to be resentment sometimes (Bronwyn, regional: tertiary educated).

Some accounts of these compulsory workshops were extremely negative. Participants expressed their view that they actually found the workshop to be ‘racist’ in the way the content was expressed.
I don’t think it’s as good as it probably could be. I think the way it is structured [workshop], they’re trying to sort of set us up to not really fit in I suppose with Aboriginal ways, but they’re trying to. It is like a bit of an inverse type of racism really. I find a lot of the times I, some of the Aboriginal people want you to, not necessarily the women, especially this group that has set up this cultural awareness workshop. They want you to not bend, that’s not probably not the right word, but be very compliant about the Aboriginal ways but there’s no sort of giving or taking on the other party (Nita, rural).

Some of the participants find the emphasis on the effect of colonisation in the workshops to be disproportional or one-sided. They are more interested in learning about perceived customs or traditional practices, than the impact of colonisation on the well-being of the Indigenous population.

There was a man about, probably about 10 years or more [ago], even probably be more now. He came out and he also talked about [in] a broad sense about the Aboriginal culture, and that was good… he talked a lot about totems and you know how Aboriginal people were quite different to white Australian people… [discussing the impact on the other midwives and women in the unit] they all seem to identify with anything he said about the true Aboriginal person (Nita, rural).
The focus of this account is on the cognitive aspects of culture, the perceived traditions, values and beliefs which are identified as being very different to the Anglo-Australian way of life. These perceived beliefs, traditions and values are seen as representing the ‘true Aboriginal’ person. There is no recognition of individual differences; all Indigenous people are grouped together and they are ‘different’ because of their traditions. However, at the same time there is ‘denial of difference’ when the ongoing effect of colonisation is not recognised by these participants.

The majority of the participants focus on particular forms of cultural difference; they have a need and desire to know about perceived cultural traditions, such as ‘smoking the baby’ for example (discussed in further detail below). As previously discussed when describing the care provided by the participants to CALD women, the participants require generic information about women who are identified as being different from them (this includes Indigenous women) to formulate care plans for them.

This desire for culturally appropriate care plans has been reinforced by in-services/lectures that the participants have attended.

… there is a strong argument which says that in the Koori culture that birthing is women’s only business…I remember in the session talking about the Aboriginal culture and women’s only business and I remember the lecturer talking about one of the birth centres or the delivery areas places up in the Northern Territory, where they’ve designed it specifically so that everyone can go outside and
labour and deliver outside and so forth and things like that. But again, you know, that was one session (David, urban).

…in Alice Springs, they have a sort of set up … geared for the cultural ways of Aboriginal people … (Nita, rural).

The participants are discussing Alukura, an Indigenous birthing centre that was opened in 1984 in Alice Springs, Northern Territory. The philosophy of the unit was to provide a birthing environment that allowed for traditional Indigenous birthing practices to be performed (Carter et al. 1987). Traditional practices discussed by Carter et al. (1987, p.10) include such practices as placing the baby in warm sand following the birth, and sometime later the mother and baby are smoked for ‘preventive and ceremonial purposes’. There are other publications which discuss the use of traditional practices (Callaghan 2001; Sarzin 2003). However, the majority of the participants have not seen these practices being performed; they therefore tend to assume that the Indigenous women that they care for have lost their traditional values. Browne and Varcoe (2006, p.156) argue that ‘popularized assumptions’ about Indigenous cultural practices can influence the views of health care professionals caring for Indigenous people.

However, this assumption can only be made once the participants have identified the woman they are caring for as Aboriginal. In their accounts, participants discussed how they identify women as being Indigenous.
6.3. Recognising Aboriginality

Participants primarily recognised Indigenous women by their appearance. Indigenous Australians may have a dark or different skin colour to that of non-Indigenous Australians. However, not all Indigenous Australians have darker skin and may therefore appear to be non-Indigenous. Midwives recognise these Indigenous Australians by the services they use, for example the Aboriginal Medical Service, or by where they live as some Indigenous Australians live in distinct communities. However, assuming that a woman is an Indigenous Australian by the services she uses or where she lives is problematic. The woman may not be Indigenous, she may have an Indigenous partner and therefore uses the services available to her partner and lives in her partner’s community.

I am sure I looked after a number of Koori [Indigenous] women. A number would not be obviously facially identifiable but have a Koori background which was marked on their obstetric history or something, also their partner [is Indigenous] …they had some contact with the hospital initially but basically they went through the Aboriginal Medical Service (Amelia, Regional).

However, it is important to note that some Indigenous women are not identified as being Indigenous, as not only do they not appear Indigenous, they do not live in distinct communities. They may also choose not to identify themselves as Indigenous for fear of being ‘discriminated against’ by health care workers (Jackson Pulver et al. 2003, p.20). Robertson and Lumley (1995) also reported in their study on the ways midwives identify Indigenous women, that midwives were reluctant to ask women if they were Indigenous
even though it is compulsory on admission of women to maternity services to record this information. The midwives only asked women if they were Indigenous if they looked Indigenous, had a surname that indicated that they may be Indigenous or were accompanied by an Indigenous partner. Jackson Pulver et al. (2003, p. 23) also reported that the ‘forced field’ to record whether a woman is Indigenous in the hospital admission database of a maternity service often remained incomplete as the women were not asked. Robertson and Lumley (1995, p.26) stated that midwives were uncomfortable asking women if they are Indigenous ‘as they felt that both Aboriginal and non-Aboriginal women would feel ill at ease when asked if they identified as Aboriginal or Torres Strait Islanders’. This was mainly as the midwives had perceptions of Indigenous women that were negative and in some cases discriminatory.

Some of the participants also reflect in their accounts on Indigenous identity the change in the social view about who is Indigenous. As stated by Holland (1996), it is important for some Aboriginal people that their Aboriginal heritage is recognised and accepted, even if the individual does not appear to be Indigenous.

I have worked with Aboriginal people all through my training. My daughter-in-law is Aboriginal, though she does not look Aboriginal but years ago we used to say part Aboriginal but now you are either are or you’re not (Trudie, rural).

The participants’ accounts of caring for Indigenous women will now be provided. These accounts have been grouped together as either ‘discourses of differences’ or ‘discourses
of denial of difference’. In some cases the participants use both of these discourses in their accounts.

6.4. A Discourse of Cultural Difference

6.4.1. A discourse of traditional practice

The loss of perceived traditional Indigenous culture was discussed by the participants. Many believe that Indigenous women all followed the same cultural childbirth practices, such as the ‘burying of the placenta on traditional lands’ or ‘smoking the baby or placing ash on the baby’ following the birth. Due to the fact that only some Aboriginal women actually do this, the participants feel that ‘traditional practices’ have been lost.

There are the odd Aboriginal that would want to take their placenta back to their birth land and bury it on their birth land and ash the baby. We do not see that very often these days at all with the young girls. But you have got to be aware of it (Sue, rural AMS).

Views such as these are indicative of essentialism and do not recognise the diversity within the Indigenous population. As argued by Browne and Varcoe (2006, p.162), relying on conceptualisation of Indigenous culture allows health professionals to ‘relate to Aboriginal peoples as objectified Others’.
I feel that the Aboriginal people are losing their knowledge of their culture and their traditional ways; very rarely would I have an Aboriginal woman wanting to practise some of her old ways [traditions]…none of these women [local Indigenous] have those sort of practices, so I think they have lost their tradition. The Aboriginal people that we deal with they are more into our [non-Indigenous] way of looking at life (Isla, rural).

This apparent loss of traditional birthing practices is viewed by some of the participants as a loss of ‘cultural identity’. Cultural practices are seen by many as a way of identifying an individual as belonging to a different ‘cultural group’. When an Indigenous person does not follow the perceived traditional birthing practices, they are viewed as being without a culture - or ‘a - cultural’- they no longer fit the accepted mould of being Indigenous.

…the Aboriginal women we have coming through now they are using more of our [non-Indigenous] ways rather than sort of years ago they were really quite sort of culturally Aboriginal. Whereas nowadays, they are picking up lots of white ways, as well as their own Aboriginality, a lot of them I suppose you could say are really a-cultural. They do not sort of fit into an Aboriginal culture, really … you talk about the Aboriginal culture here for example, in Alice Springs [Alukura], they have a sort of set up … geared for the cultural ways of Aboriginal people whereas here a lot of the women they will just go with whatever really (Nita, rural).
Participants from the urban and regional areas also articulated (like their rural colleagues) that if Indigenous women did not follow the perceived ‘cultural norm for birthing’ then they were not linked closely to Indigenous ‘traditional culture’.

… [Indigenous] birthing is women’s only business. Having said that I have never had one of the Aboriginal women I have looked after say that they did not want me looking after them and it comes to a question of do they feel or [are they] in a position of where they can say no. But predominately the women that I have had contact with have been young inner city women who perhaps are not as closely linked to that traditional culture (David, urban midwife).

There is recognition by this participant and others (when they are discussing the removal of Indigenous women to birth in hospitals away from their communities) that some of the Indigenous women may not be in a position or have the power to question care provision. This is a reflection of the history of Aboriginal women’s position in Australian society where they have not had the power to question authority.

6.4.2. Discourse of difference; they are different

When discussing the differences between their own culture and the Indigenous women that they care for, some of the participants provided descriptions of Indigenous peoples’ ‘way of life’ in comparison to their own. These descriptions focused on how Indigenous women and their families live, their values and work ethic. Some of the participants discuss how the Indigenous population has a casual or laid back attitude to employment.
There is an assumption by some of the participants that all Indigenous people are not concerned with material wealth, the way non-Indigenous people are.

The cultural difference that I deal with is mainly Aboriginal women. I have not [worked as a] midwife in any other major capital [Australian city]. So I am not seeing Asian or Indian or whatever [women]. I deal with the Aboriginal cultural difference … I see the difference in the culture there. With Anglo-Saxons [non-Indigenous people] we have high expectations. The Aboriginals will just let it go as it comes. We are very materialistic; they are not (Sue, AMS).

Another participant called Maureen takes this perceived lack of desire for material possessions further and surmises that some of the Indigenous people prefer not to be employed. She does not understand why this is the case. Maureen infers that it is a ‘cultural’ way, to be laid back and to do other things rather than be employed and that it is a ‘cultural norm’ for Indigenous people to not be reliable employees. Participants who view Indigenous people in this light are blaming them for their plight (Browne & Smye 2002). Maureen also uses stereotypical language about Aboriginal people when voicing her opinion.

…it’s their lifestyle they have no ambition in life, they have nothing to do except play competition, play golf or hit and drink especially the ones in [rural community]. No it's their lifestyles.

There is no point if there isn’t any opportunity for them there either?

There is but they don't want it. There is employment. I don't understand this stuff. I think they should work. There's that ‘sure way employment’ or
something and they are also building a new hospital in [rural community] so there's plenty of employment but there's trouble keeping some of Aborigines coming to work… (Maureen, rural).

Maureen is viewing this particular Indigenous community from her own values. She believes that there is work available and therefore the Indigenous individuals who are not employed should find themselves employment. She does not discuss lack of employment from a post colonial perspective, which would involve critiquing the historical, economic and social factors that have impacted on Indigenous people’s well-being (Anderson, 2003). The Indigenous individuals that she is discussing may not have the skills required for the positions (that she states are available). As stated by Collins (1996) Indigenous individuals living in remote or rural areas have high rates of unemployment due to lack of employment prospects which often stem from their lack of education and other factors that can be attributed to [the history of ] colonisation.

Another participant Nita describes how she views the Indigenous population. She compares the Indigenous population to the non–Indigenous population. The way in which she portrays people who are Indigenous can be viewed as racist because she views Indigenous people as being inferior to non-Indigenous people. Nita uses a childhood analogy to describe the development of the Indigenous people. This can also be seen as being discriminatory, by inferring that the Indigenous population is ‘inferior’ to the non-Indigenous population.
I sort of think that Aboriginal people as a group as a culture are at the puberty stage in a person’s development. They’re getting some white ways but they have still got some of their own ways and as an adolescent they are sort of making, this probably sounds stupid, but this is how I believe it. It’s like starting to make their demands and some are coming through and starting to become more sort of self sufficient as adults. Coming into hospital and bringing their supplies and just fitting into more of a, not necessarily white women’s ways, but just becoming more sort of self sufficient to themselves (Nita, rural).

Nita correlates being able to be self sufficient with adulthood; there is failure to understand why some Indigenous women are admitted to hospital with no supplies such as nightie and soap. However, other participants are aware of the social inequity that affects many Indigenous people and accounts for why some Indigenous women do not have enough money to come prepared to hospital.

6.4.3. A discourse of social justice.

The second component of the ‘discourse of difference’ focuses on the issue of inequity and the Indigenous population. This section provides the views of some of the participants who talked about the Indigenous population highlighting the ‘differences’ between Indigenous and non-Indigenous Australians which, in their opinion, is a direct consequence of [the history of] colonisation. This difference is manifested by the social inequity which affects the everyday lives of Indigenous Australians.
One participant, Vivian has been employed in the public health sector for over twenty years. She has worked in a variety of different hospital and community settings, in both rural and urban locations, and has experienced changes in Australian history that have affected the Indigenous population.

…certainly you only have to look at their [Indigenous population] history in society. Within our Australian population, I worked in a country hospital, certainly back in the 60s, early 70s, where they [Indigenous people] weren’t even admitted to our hospital. They had an outside section in our hospital. They were only given rights to vote in 1968\(^{13}\). So, I mean, everyone’s got to look at cultural history in terms of what’s happening in our society that impacts on their [Indigenous] views, opinions, and attitudes towards any authority.

In her account Vivian expresses her understanding of how the exclusion of Indigenous Australians from the rights and services available to non-Indigenous Australians has had a long term effect on their general well-being. She then goes on to describe how the attempt by the federal, state and territory governments to assimilate the Indigenous population has caused the majority of the Indigenous population to mistrust anyone who has authority, including midwives. Vivian is explicit in stating that some of the Indigenous population do not feel safe when dealing with people in authority.

\(^{13}\) The referendum to alter the constitution was held in May, 1967. However the words of the participant have been used in this instance.
… We had a fairly big Aboriginal community in [name of the community] so I have had experience in terms of working with a rural Aboriginal community. They have had the stolen children generation. They have had issues that really they don’t; maybe some don’t feel [safe]. You look at their education ability. In terms of what’s happening in education for them. You look at rural isolated communities. It’s this access and equity issue. Whether it is being Aboriginal or another marginal group … (Vivian, urban).

Vivian discusses what she considers to be social inequity for the Indigenous population Australia. It is well known that the Australian Indigenous population lags behind the non-Indigenous population in terms of life expectancy, educational levels and earning capabilities. She particularly notes that the inequity is more prevalent in rural and remote communities and that these issues of inequity may also affect other marginal groups, although she does not say who these groups may be.

Similarly, other participants provided accounts of how they felt that the Indigenous population are afraid of people with authority, especially people who wear uniforms. In some cases Indigenous people may have a right to be frightened, as it has been expressed they are often accused by non – Indigenous people as being trouble makers or non-law abiding people:

It probably can reflect on really what has happened to previous family members, previous hospital admissions for other family members. Anything in a uniform
maybe…the fact that they might be an Aboriginal or Torres Strait Islanders … they will be the first one to get harassed or told to leave or whatever purely because of the history of maybe potentially [being dangerous], someone [Indigenous] in the area who has not been law abiding or whatever. So I think that follows through here. We all wear uniforms. There is that hierarchy thing…the history that has gone with that. Like even here [large urban tertiary referral centre for women] there are probably a good percentage of the women that we see that know of someone that has had a run in with somebody for whatever reason. There are lots of reasons around it but things have not gone well or they have had their children taken off them. Their grandmother might have had their children taken off them. There wasn’t DOCS [Department of Community Services] in those days but it might be something else. So it is and it seems like … they’re going to come in here again, will someone take my baby? (Sarah, urban with previous rural experience).

Several of the participants refer to the effect that the historical removal of children has had on the Indigenous community, particularly the women. However, Sarah is not only discussing the Stolen Generations but is also referring to the mandatory reporting to the Department of Community Services (DOCS) in NSW of any concerns that health care professionals or others may have about the well-being of children. Currently the

14 The Department of Community Services (DOCS) monitors and assesses children welfare. DOCS have the authority to remove children from their home environment if they are concerned about the child’s welfare.
Indigenous population has more children removed by government agencies, than non-
Indigenous people and there is ongoing distrust and fear of these agencies in the
Indigenous community (Cunneen & Libesman 2000).

…with my Koori [Indigenous] clients I feel that the big issue in birthing and
parenting is what has happened in the past and the, sort of trans-generational
trauma that has occurred with children being taken away. I still think to a certain
extent people think it happened in the past therefore it is not relevant today. But
from the clients that I see when I talk to them about things, they had an aunty
taken or they had a grandmother taken or there is a real concern with any
dealings with anybody in authority from what I have talked to the [Indigenous]
women about. Even with anybody under 16, I have to notify DOCS because
they are under the age of consent and even though I discuss with them that this is
purely to ensure their safety and their babies’ safety, I have to be really [careful]
with mentioning DOCS with Koori clients (Emma AMS).

The participants who work in specific services for Indigenous women provide their
account of how difficult it is to maintain a rapport with the women if they are required to
report them to DOCs. For example, if the woman is under 16 years of age midwives must
report the pregnancy to DOCs. Although they know that they have no choice in the
matter, they are concerned about losing the woman’s trust.

…there is a lot of distrust of the big white cars that you know came and took
their children away and there is still grannies in the [Indigenous] community that
remember that happening. So mainstream services have to do a lot to regain the
trust of the communities and recognising the women, well a certain element of Aboriginal women don’t want to be part of the main stream services (Amy, regional).

The participants, who provided these accounts of fear of mainstream health services, support the provision of specific Indigenous health services. Some stated that there are not enough specific Indigenous services for women. It is their belief that some health services do not recognise the affect of colonisation on the Indigenous population and that these services fail to appreciate why the Indigenous population has such a high mortality and morbidity rate.

I do not think maternity services in Australia deal with specific needs of Aboriginal women particularly well and I do not think they recognise for a start, they do not acknowledge the impact of the last 200 years on the health status of Aboriginal women and I think unfortunately they have found too many people that are prepared to judge on what they see when Aboriginals present for care without taking into account how they got there, the consequences of lack of education, poor health and factors like domestic violence and sexual assault which in my experience unfortunately occurred far too commonly in the Aboriginal communities I have worked in (Hanna, regional with past rural experience).
Inequity, according to this participant, has lead to the Indigenous population having higher rates of morbidity and social problems such as domestic violence and sexual assault. The accounts given by Emma, Hanna and Vivian clearly identify how a ‘discourse of difference’ has impacted on their view of the Indigenous population. They have not received any education on cultural safety but have identified how the effect of colonisation continues to impact negatively on the well-being of the Indigenous population.

As a consequence of the higher mortality and morbidity rate for Indigenous women and babies during birth in comparison to non-Indigenous women, the NSW government endorses the policy of transporting Indigenous women from their communities to birth in hospitals that may be hours away from their homes. The women are often flown in by the Royal Flying Doctor Service. Several of the participants have provided accounts of how distressing this is for the Indigenous women. I have used Olivia’s description to relay how some of the participants feel about Indigenous women being removed from their community and then having to make their own way home after the birth of the baby.

I still feel I have do something when they come into the hospital with nothing but what they are standing in which could be if they were transferred from [small rural town] in the middle of the night with a nightie and a dressing gown or just their clothes that they’re standing up in. That’s it and I, it makes me angry but then I think why should I get angry but I feel I have to do something. I feel like I have to provide them with things. That’s just my culture…It matters more to me than it matters to them…Most of them seem happy. They wait until their
money comes through and they go out and buy something for the baby. We arrange for them to go to get back home. They bring them in but they don’t take them home…And that hurts me…And they don’t provide them with anything…Babies born, babies safe. A woman hasn’t bled to death. That’s it, end of story…It’s very sad. That makes me very angry (Olivia, rural).

A study undertaken by Watson et al (2002c) to elicit the opinions of health care professionals about caring for Indigenous women also identified that the majority of these professionals recognised the impact of separating Indigenous women from their community for the birth of the baby on the mother’s well-being. These authors stated that some of the health professionals recognise that they contributed to the women’s negative experience of hospitalisation but on the whole they tried to provide appropriate care.

In some cases the participants indicated that their own life experiences have impacted on the way that they view people from different cultural backgrounds to their own.

6.4.4. Discourses of difference; empathy

Depending on their own personal experiences midwives may identify with or show empathy to the colonisation of the Indigenous population. Participants may have migrated to Australia, or their parents migrated, and they comment about their country of origin or their experience of immigration. Although these participants have empathy with Indigenous people because of their understanding of the impact of colonisation, they do
not necessarily understand or experience what it is like to look different to other people, for example to be classed as ‘coloured’.

I don’t think I’ve found a problem because I’m from a different country as well and I think a lot of things that are in the Aboriginal culture are in the Irish culture too so it’s not sort of heaps different I think that’s probably why. It seems easy to work with them. I found it easy to work with Aboriginal people.

You mentioned that obviously you’re Irish so you feel that there are some similarities there. Could you enlighten me by giving an example of some of the similarities?

I guess, historically, there were Aboriginal people in Australia, being the first people here. In Ireland we were the first people in Ireland too, but we had problems with England taking over Ireland and it’s still happening, and feeling like half of Ireland, the top half, Northern Ireland and I guess that sort of historical sort of, trying to think of a word, just between the two countries. Between like Australia and Ireland and with the British influence in both of them I think that’s probably where it comes from (Cathy, regional).

Cathy recognises the social disadvantage that stems from colonisation and the constant power struggles that follow on from colonisation. As Cathy was originally from Ireland she has empathy for any people who have experienced the effects of colonisation.
Similarly, other participants had experiences that they felt provided an understanding of what it feels like to be ‘different’.

I have moved every few years throughout my childhood and we lived in different countries so it may not have been my non-English speaking background, but it could still be very different to what I was used to. And my family are Eastern European and part of the family is Indian… I think in some ways, I am quite lucky I guess in a funny sort of way in that they are from a background that I am from. I have some sensitivity about how it is to be dispossessed I guess and I do have a kind of an empathy or sympathy for the effects of dispossession (Grace, urban).

Grace’s sentiments are echoed by Claire who experienced how her mother, an immigrant to Australia was treated when she moved to a small rural town. These personal experiences have infiltrated how these participants care for women from different groups to themselves.

…probably it was a little bit in-built from childhood because my mother was Scottish and she met my father in Mildura and came to live in [rural town] here and my mother was, it was quite, I don’t know whether you’d call it a closed town but it was a different town to what it is now, it was quite unionised and you had to be born in [here] to work in the mines and my mother was excluded from a lot of things because she wasn’t born in [town] and that had a bit of an effect on her and I always understood that from very early on (Claire, rural).
On the other hand, other participants do not discuss personal issues but refer to knowing about their own culture which, in their opinion, allows them to understand other perspectives and therefore provide culturally appropriate care.

Whether it is being Aboriginal or another marginal group … it’s really that we may have perceived views and attitudes that we’ve grown up with within our family dynamics that maybe impinge on our opinion or our views to work with Aboriginal women. So we’ve got to really identify our own views and opinions (Vivian, urban).

These participants all expressed how they view people who are different to themselves. Intertwined throughout their descriptions is how their personal experiences have allowed them to reflect on the care that they provide. However, some of the participants do not share this reflection.

The next section of this chapter provides the views of the participants who believe on the one hand that Indigenous people are different because of their perceived cultural beliefs and traditions. However, they do not recognise the impact of colonisation on the Indigenous population and do not understand why specific services are provided for Indigenous communities.
6.4.5. Denial of difference

The participants who ‘deny difference’ are aware of the history of Australia, including the colonisation of Australia. However, they have taken the stance that many in the non-Indigenous population have taken, which is the denial of the consequences of colonisation of Australia for the Indigenous population. Whilst they acknowledge that colonisation in itself was in some instances atrocious, they believe that this is now past history and part of the difficulty with the Indigenous population is their refusal to move on and forget the past. Some of the participants talk about the history of colonisation in terms of it being dreadful for both those who were transported to Australia, and for Indigenous Australians. However, as previously highlighted by Bronwyn’s and Linda’s accounts, they are explicit in stating that non – Indigenous Australians (at this time in history) are not responsible and therefore the past should not be dwelt upon by the Indigenous population; they should ‘move on’.

These participants have expressed the view that health services should be equitable, that all people are entitled to receive the same services.

What particular strategies would you use when caring for Aboriginal women?

The same as for everybody else, I don’t believe in, I think we do pander more to our Aboriginal ladies, we are very aware that we are often accused of being racist. I think we really do pander more to them sometimes than we do to our
other ladies\textsuperscript{15} to try and overcome that which I think is a bit sad. I think we should treat everybody equally and that’s how I feel after working as a nurse for 23 years. I think that it needs to go both ways with both Aboriginal and white people and they need to respect each other (Isla, rural).

Some of the participants describe how they go out of their way to accommodate Indigenous women’s wishes at the expense of caring for non-Indigenous women. However, in Isla’s discussion she implies that this occurs in order to negate being accused of being ‘racist’ by the Indigenous women and their families.

Similarly denial of difference is articulated by some of the midwives who voice their concern that some of the Indigenous women come into hospital without what they consider to be the basic personal requirements of a nightie, soap, or sanitary pads.

\ldots I think they [local Indigenous women] should be more independent. That is probably not the right word but we get [Indigenous] women coming in here they don’t have anything. They come in with nothing except for a packet of cigarettes under their arm. It would be good if we could encourage them to be just have a bit more self esteem I suppose. They would not have much self esteem either when they have to come up and ask for a pad and things like that. If they could just become more independent from that point of view, their own sort of cares

\textsuperscript{15} The use of the term ‘ladies’ or ‘girls’, by midwives to describe women or colleagues is discussed in chapter seven.
and body functions really. That would be helpful for them and the staff [midwives] here. Everywhere for that matter (Nita, rural).

Again, there is denial of past policies that have been brought about social inequity for the majority of the Indigenous population.

I suppose the only thing that’s sort of different is they [Indigenous women] get more from us than what the white ladies will. People [Indigenous] that come from [small rural town] most times don’t bring anything with them and we have to supply their pads and if they’re going to artificially feed, we supply the formula, we supply everything (Trudie, Rural).

The study conducted by Watson et al.(2002b) on the experiences of Indigenous women whilst inpatients in a maternity unit provides an insight into how Indigenous women feel when they have to ask for personal supplies such as sanitary pads. I have included the transcript of one of the women interviewed in their study.

I asked them (They said) ‘You’ve got to buy your own. You got any money to buy them? And I said, ‘Look, I just come in from…’ She made me feel shame. So I asked another girl and she gave it [money] to me but the other lady she didn’t…I think they are a bit too rough with us, you know. Yes, they were watching all the time, everybody. (Brenda) (Watson et al. 2002b, p.158)
Some of the participants also indicate that they feel that the provision of distinct health services for the Indigenous population to be inequitable. They believe that all individuals should receive the same services. The flying doctor service is used by some as an example, as Indigenous women are flown in from their communities to birth. However, non–Indigenous women are required to make their own way to the hospital for the birth of their baby.

Well I suppose it’s frustrating because of that [discussing providing formula and pads for lochia to Indigenous women when they are inpatients], there are other instances: they get flown in by the flying doctor service because they are queried [to be] in labour and if they’re not in labour they’re made to go [home], some of us just look at the money and occasionally you think the white girls, are coming to town and have to stay somewhere and these people [Indigenous] get flown in. For instance, last week a [Indigenous] lady was in town, her baby was due, her child was in the Children’s Ward, she was due any day and they asked her about staying and she said, ‘no, I’ll be back when I have my baby’. She got back to, back to [small rural town] that day and had to be flown back in, in labour. And it’s just annoying sometimes, little things like that…It is just added expense and sometimes you think why can’t everybody have it … (Trudie, rural).

However, there is no mention by the participants who feel this way of the fact that the Indigenous women are made to leave their home to birth and are required to find their own way back at their own cost. Whereas, as previously discussed, other participants are
aware of this and are distressed about how the Indigenous women are flown in without a chance to prepare and by the lack of provision for these women to return home.

Regardless of the participants’ views on colonisation and the current status of the Indigenous population within Australia, they are required to provide midwifery care to Aboriginal women and their families. Therefore it was important to know if the participants did anything different for Aboriginal women and what strategies they used to provide care.

6.5. Strategies for Care Provision; Communication

Participants frequently discussed communication and how it differs between Indigenous and non-Indigenous Australians. However, in doing so, they are inadvertently stereotyping both groups as behaving in the same way. As argued by Eckermann et al. (2006) communication not only varies between different cultural groups but within groups.

The main form of communication discussed by the participants is eye contact, followed by the difficulty in building a rapport with Indigenous women. Watson et al. (2002c) also identified that health professionals, including midwives, often experience communication difficulties with Indigenous women which cause frustration. On the other hand, some of
their study participants were able to build a rapport with Indigenous women in their care and they found this to be satisfying.

The participants in this present study discussed how Indigenous people did not like to have direct eye contact with other people and that it was a sign of disrespect on their behalf if they tried to maintain direct eye contact. The participants are aware of this, as it is discussed within the literature and they are informed that ‘Indigenous cultures look upon this [eye contact] as aggressive, rude, or disrespectful’ (Goold 2001, p.98)

You’ll get some women [Indigenous] that never look you in the eye and they just, that’s the way they are, they don’t, they find it disrespectful to be looking at people in the eye (Linda, rural).

So I learnt a little bit about … communicating with some Aboriginal woman and I think it differs depending on their age group you are talking about and also their traditionality…. But like for instance I always try and ask where they are from, I always try and not met the eyes of older woman for instance… (Grace, urban).

Participants frequently discussed their difficulty in building a rapport with Indigenous women. The women from the rural communities are not given the opportunity to meet the midwives providing care before they are admitted to hospital and these women are often alone and anxious due to the separation from their community. Goold (2001, p.98) points
out that silences ‘are common in Indigenous styles of communication’ which some health professionals may find daunting. She also states that in some instances withdrawal by Indigenous individuals is in direct response to difficult situations where they felt misunderstood. It this instance they may give the answers that they think the health professional wants.

The participants were asked about strategies for improving their communication and rapport with Indigenous women. In some cases, they stated that they actively listen to Indigenous women, especially those midwives who are employed specifically to enhance Indigenous services. They then may alter their normal responses to be more reflective of the Indigenous woman’s needs.

I guess its listening skills really. I mean, you listen to what they want and if it’s not possible then you have to explain why you have to deviate from their choices but still try to think how you can best adapt what you have to do to make it acceptable to them as possible… [Further on] The listening skills aren’t different I don’t think, but the information you get when you do listen is often different and I guess it’s being open to hear the differences that I mean. Does that make sense? …So if you have just tunnel vision, that this is the way, you can listen but in a very peripheral sort of way because you don’t want to be swayed from your path (Amy, regional, hospital based Indigenous community outreached program).
Amy is discussing how she alters her listening technique when communicating with Indigenous women. Amy infers that some of her colleagues do not actively listen to women as this may require them to adjust their care plans. Beth, who works in the same program as Amy, discusses how there are different midwifery skills used within the hospital environment in comparison to the community setting. The inference is that midwives who work in the community setting are more likely to actively listen to women, whereas those midwives employed in the hospital setting are more likely to follow ward routines.

I think in general they [midwives in the hospital environment] are not as understanding that the women are sort of shy, they are very reluctant to come to hospital, they hate coming to hospital. They can’t wait to get out and really that’s a foreign place… I think if a woman just feels comfortable with you and you’re just there to listen they find it very helpful. It does get away from the actual education and midwifery and all that sort of stuff but I find that it’s just as important. I mightn’t do anything; …Mostly their problems are so insurmountable anyway that there’s nothing I could do whatever to change them but just the fact that they can talk about them as I have said to someone outside the family they feel better (Beth, regional hospital based Indigenous community outreach program).

Beth describes how she actively listens to Indigenous women to the extent that they feel comfortable enough to disclose their personal situation or problems to her.
However, sometimes the recognition of Indigenous difference leads some participants to assume that Indigenous women may not be able to understand questions in the same way as non-Indigenous women do. In this case there is inadvertent stereotyping of Indigenous women. Some of the participants describe how they alter their approach when caring for Indigenous women but do not do this for non-Indigenous women. There is an assumption that all non-Indigenous women are the same as the participants and therefore they will understand what they are talking about.

Is listening different with Aboriginal women [in comparison] to if you were caring for an Anglo-Saxon woman (the participant’s previous description)?

Yes. I do think it is different because an Anglo-Saxon woman will have a better understanding. She will talk straight. She, if I ask her a simple question she’ll know what that question is and she’ll answer that. An Aboriginal woman, if you ask her a question she might hear it and interpret it differently than an Anglo-Saxon woman.

So you are listening to the response and …?

Yes, I listen to the response and because of my knowledge of the Aboriginal community and families and whatever, I would just talk to that woman in a way that I felt was appropriate for her. I don’t know how to describe it. I would, there are so many things about just sitting and talking to someone that you can find out. I don’t know how. I would just depending on the situation I would know how to deal with that woman. And her attitude, like other people might be offended by the Aboriginal woman’s attitude or what they would feel is their
Val is inferring that because of her experience with Indigenous communities that she has understanding of Indigenous peoples’ needs and how they interact. Val also infers that other health care professionals may not have this understanding and may not be able to obtain information from some of the Aboriginal women in their care.

It is important to note that for some Indigenous women, English is their second or third language and they have may have difficulty understanding what the health care provider is saying (Goold 2001). The Indigenous participants in the study conducted by Watson et al. (2002b, p.156) stated that ‘communication and lack of understanding’ was a major issue for them when receiving care from health professionals.

Similarly, it is because of the recognition of difference in communication needs and other requirements for Indigenous women that some of the participants in this study articulated that they thought that different antenatal and birthing services were appropriate for Indigenous women.
6.6. Conclusion

The discussion by the participants on how they provide care for Indigenous women includes the discourse of cultural difference, the discourse of social justice and the discourse of denying difference. All of the participants included discourses of cultural difference in their discussion about Indigenous women. However there was a variance in the way that the discourse of cultural difference was articulated. Participants either used the discourse of cultural difference in a derogatory manner to infer that Indigenous women were not at the same level as non-Indigenous women, for example the analogy given by Nita who inferred that the Indigenous population was at ‘the adolescent stage of development’.

On the other hand, other participants used the discourse of cultural difference to highlight the social inequity that the Indigenous population have experienced since colonisation. These participants are concerned that there are not enough specific Indigenous services to address the issues caused by social inequity. This discourse then developed into a discourse of social justice.

A discourse of denying difference was also used by some of the participants. Interestingly, these participants were more likely to discuss Indigenous women using derogative forms of the discourses of difference. These participants also articulated their belief that the Indigenous population should move forward and that they could not blame the effect of colonisation on their current well-being. In contrast, those participants who
discussed inequity issues were more likely to discuss the history of colonisation and the ongoing negative impact that this has had on the Indigenous population. They also provided (in some cases) explanations relating to their own or their families’ experience of being ‘different’ for the way they provide care for women who are ‘different’ to themselves.

How the participants have positioned themselves depends on how the discourses of difference and denial have been absorbed or entrenched in the way in which they view the world. This will be discussed in more detail in Chapter 8, the discussion chapter.
CHAPTER SEVEN: UNDERSTANDING THE CONTEXT OF MIDWIFERY PRACTICE, AND THE PROVISION OF CULTURALLY SENSITIVE CARE

7.1. Introduction

In this chapter, I discuss how the context of care impacts on the provision of appropriate care for women from CALD backgrounds, including Indigenous women. As previously discussed in chapters 3 and 4, discourse theory is extremely useful in providing an understanding of how the relationships between medical practitioners, midwives and government bodies or health infrastructures impact on the provision of maternity care to women and their families. Discourse theory provides a way of seeing how an individual constructs their view of the world. It shows how they adopt various social views that have been constructed by systems of power and knowledge. Discourse not only provides a way of viewing the world, it also shapes all actions and ‘working attitudes’ (Gubrium and Holstein 2000, pp.493-494).

In particular Foucauldian concepts of power provide a basis for understanding how control is entrenched in midwifery practice. Control is evident in both the macro and micro levels of midwifery practice. At the ‘macro level’, the hospital structure (the physical surroundings) and the infrastructure (hierarchy, policy and procedures), impact greatly on the care provided by health practitioners such as midwives. At the ‘micro level’, some health professionals consider their practice to be based on scientific evidence (known as evidence based practice).
Practitioners, who base their practice on the premise of ‘Western scientific evidence’, view this theoretical concept underpinning health practice as superior to other forms of health care. This dominant, naturalised (accepted as true), scientific discourse allows for alternative forms of health care to be marginalised (Cheek et al. 1996). For example discourses that support childbirth as a normal life event or alternative medical practices such as naturopathy, homeopathy, reflexology or acupuncture are, to some extent, discounted (Cheek et al. 1996), and in some instances seen as dangerous. When approaches to practice are based on the Western premise of scientific truth, judgements are made about practices that are not seen as the ‘norm’. These judgements are not made out of malice, rather they are made out of concern for the well-being of the mothers and babies receiving midwifery care.

Firstly, this chapter provides insight into how the dominant discourse of ‘scientific truth’ impacts on the way midwives practise and on their care provision. Secondly, the context of care, hospital or community based midwifery practice, and how these two different experiences determine or alter the participants’ practise, is presented. Lastly and most importantly, this chapter will identify that although midwifery practice is controlled by the bureaucratic system in which they work, some midwives like to be in control of health care situations. At times, they use their disciplinary power in opportunistic ways to ensure that women are receiving what they consider to be optimal care; this is especially the case for Indigenous women, where surveillance and disciplinary power can be enacted in the care that they provide.
The participants’ accounts within this chapter could have been included in the two previous chapters ‘discussing culture’ and ‘caring for Indigenous women’. However, I have chosen to use these accounts within this chapter as they clearly demonstrate how ‘scientific truth’ is enacted and most importantly, how a network of power is circulated within the health system in which midwives practice.

7.2. The Impact of Macro and Micro Powers on Midwifery Practice.

The social environment of midwifery practice in the Australian context is governed by the ‘macro powers’ - the government - and the ‘micro powers’ - the individual institutions (hospitals) that employ midwives. A bureaucratic system governs the provision of health care within NSW, Australia. The NSW Health Department is responsible for setting health policies at the macro level and for providing funds to implement these policies. At the micro level, hospitals also have a bureaucratic system of management. The Chief Executive Officer determines policies at this level and allocates funds to maintain services. The employees - in this case, the midwives - and the people receiving care, are often not consulted about changes to policy and funding.

…my job description when I first started at this hospital was to do outreach clinics and hospital base clinics. Unfortunately, 2 years ago they [the management] closed those outreach clinics down and my job satisfaction died …despite some community support and my vocal support we were not able to
keep the clinics open…they [the management] basically said it was for money reasons and staffing … and they [the management] tried to pull a safety issue on it as well. Working out there [community setting] at night etc but we never worked alone…they did a safety check and there was never an issue … [the outreach service] got closed down (Sarah, urban).

Decisions regarding health service are driven by the web of power that operates throughout both the ‘macro’ and ‘micro’ level of health provision. The medical profession has a substantial influence over the provision of health care. The dominant discourse of the medical profession is privileged as it is seen to be based on scientific rigour. Even within the medical profession there are power relationships, as different disciplines within medicine vie for funds and power (Cotton 1997). The medical profession, however, unites to ensure that the medical discourses based on Western scientific evidence (including clinical experience) and political power, are dominant within the social environment (Cheek et al. 1996).

In the bureaucratic system that governs health care facilities (in particular, hospitals) midwives are subservant to the medical profession (Cheek et al. 1996). This ensures that childbirth practices are dominated by a medical discourse\(^\text{16}\), and by medical practitioners. These are the people who hold the power in the health care system, especially those who

\(^{16}\) Medical discourse, as discussed in chapter 3, views pregnancy and childbirth as a potential hazard needing intervention, rather than as a natural life event.
are placed higher on the hierarchical scale of medical specialisation such as obstetricians or obstetric registrars. In their accounts, participants provided examples of how they have experienced medical dominance and have felt marginalised by this domination.

I have had obstetric registrars there [at the hospital] that are very, that come from hospitals that are not like ... they come from other places that are very sort of hierarchical. They tell you that I am an obstetric registrar and this is the way we will do it and you are an outsider. They will not know my role within the hospital. That registrar can work all the way down the line to have that effect on the residents and the other parts of the team (Val, urban AMS).

…occasionally some of the relieving doctors [obstetricians] will come in here and they are a little bit over the top … I mean they are here to help and sometimes just for a week, they try and take over and try and change what we do in a week (Trudie, rural).

This power (as demonstrated above), which circulates throughout the hospital infrastructure impacts on midwifery practice. The medical domination may also impact negatively on the ability of midwives to provide care as they would prefer. Some midwives appear to transfer what Edwards (2000) has called ‘oppression’ by the medical profession onto the women for whom they provide midwifery care. Women (in most cases) are required to attend the hospital for their antenatal care and birth of the baby. They are automatically controlled by the hierarchical infrastructure of the hospital system, such as the policies and procedures. The domination of the midwives (by the
hospital system and the inherent power of the obstetricians) may inadvertently or intentionally be transferred to the women that they provide care to (Edwards 2000).

Some midwives recognise that they have power over women, even while they would prefer it not to be so. They may be aware of their power base when providing care within the hospital setting and recognise that this is part of the ‘culture’ of the hospital system. This power exists because the woman is being seen in the hospital environment; therefore she has lost control of the situation and is dominated by the health care providers, including midwives.

I suppose it is the culture of the hospital. You are the staff at the hospital which should mean that you are their employee [the patients] in a sense but it really does not have that same feeling. It is that they have come to see you and that somehow makes your role, it gives you a bit of power over them. … I do not know why it’s not possible, but I really don’t think it is possible not to have that to some degree, however minor. I do think it is possible to be aware of it and to prevent it. I do not think [that] you should think that you can not be like that because then you are not going to be aware of it (Wilma, regional).

The language used by some participants to describe how they provide care to women can also been seen to be controlling. Callaghan (1996) argues that the use of the terms ‘girls’ or ‘ladies’ by midwives either to communicate with one another or for the women they care for is a direct result of their oppression by the male dominated medical profession. It also gives the control to midwives who have placed the women that they
care for in a subordinate role. By calling them ‘girls’ they maintain control and the ‘girls’ are seen as non-threatening to their controlling status.

..and … the Aboriginal (midwife) …, she keeps in close contact with us, she sees the pregnant Aboriginal girls and quite often it is not easy (Linda, rural).

7.3. Context of Care

There are distinct differences between the experiences of hospital and community based midwives. In hospitals, midwives are more likely to experience policies and procedures as controlling, and even stifling, practice. In the community setting, midwives are free to some extent to determine their own practice, but paradoxically lose the control over the women that they have in hospitals. This section of the chapter will provide the participants accounts of how the context of care impacts on their practice, commencing with their experiences of hospital based practice, followed by some of the participants experience of providing care in the community setting.

7.3.1. Context of care, hospital based.

As previously discussed in Chapter 3, midwifery practice within a hospital setting is governed by the hospital hierarchy. The hospital context of care is orientated to controlling or managing situations and is directed towards the institution’s requirements, rather than those of the individual women who are attending antenatal services or are inpatients. There are set rules, such as policy and procedures that should be adhered to.
Hospital policies and procedures are often perceived by midwives to be inflexible in relation to providing an individual, woman-centred approach to care. Some midwives even feel that the hospital infrastructure, and in particular the rules, can be detrimental to the care provided to women.

Sometimes we can be barriers; in that hospitals have rules and sometimes we can carry those rules out to the extreme and maybe to the detriment of a client without really realising … I think things are changing and people are trying to address the problem (Kaylene, Rural).

The enactment of regimented policy and procedures becomes a barrier that is used to prevent an individualised approach to care and becomes a way in which midwives do not have to think about their practice. Care for the woman and her newborn is automatically controlled. Some of the study participants recognise that this occurs and it is a ‘problem’ for the women receiving care; this has created a shift in practice. However, the change is slow and control is still a dominant feature of midwifery practice.

I think we like control … we are trying to bend and it is a little bit hard to bend after so many years of that rigid way we were … I mean hospitals have relaxed but they are not relaxing …(Sue, Rural AMS)

Some of the study participants recognise that they like to control the care that they provide. There is a realisation that midwives need to alter the way that they practice.
However, after having had control for such a long time, it is difficult for some midwives to alter their practice for the benefit of the women.

It is also very difficult for midwives to provide individualistic care to women as their workloads can be excessive. The turn around of women has increased, as many choose to be discharged soon after the birth of the baby and choose postnatal care provided in their home by midwives employed for this purpose. With the increased turn around of women and their babies, the hospital based midwives feel that they are working in a ‘production line’ - with little time to get to know the women in their care before they are discharged, and the cycle begins again. Within this setting, midwifery practice becomes focused on control to facilitate and meet the objectives of the bureaucracy; to manage the inpatient beds in an effective manner.

I think sometimes when you see so many women day in day out it is easy to forget how much, how broad each person’s life can be. Some days it can just feel like a production line of women and babies and women and babies …we have got this production line going …not having the time to give the kind of one to one care that that some of the women really need (Bronwyn, regional).

Midwives are concerned that women need to be aware of how the health system works in order to have some prior knowledge about their choices for care.

I think it’s really important these days, particularly the way the health system goes, that women are educated and informed about their choices … to be
confident at coming through the hospital system and accepting help. (Beth, Regional).

Although some of the study participants recognise the woman’s right to choice, they still may inherently believe that their way is right and therefore, that women need to accept their advice and assistance. In other words, the women need to do what the midwife recommends and control becomes an issue. In some instances, study participants feel supported by working within the hospital system because they are in control and can manage situations by following set guidelines. The hospital environment becomes their safety net. Some of the midwives feel that their level of control is challenged when they are not in their normal hospital or clinic environment.

It’s very easy looking after people in our environment where we are in control and because we are. If someone comes to me here [Aboriginal medical centre] I’m in control, if I go into someone’s place … no we are not in control of the situation. (Emma, AMS).

The midwives who provide care to women and their families within the community setting - the women’s homes - find that to some extent that they have relinquished control. Midwifery practice within a community setting alters the locus of control from the midwife to the woman. To some degree midwives are free from the disciplinary power of the hospital, where control is paramount. This allows some midwives to alter
their practice to be more flexible to meet the needs of the women and their newborns. This is discussed in more detail in the next section of this chapter.

7.3.2. Community based context of care.

The ‘micro powers’ that filter through everyday activities can be controlled by the women when they receive care in their own homes. It is the women’s environment that the midwife enters; the midwife no longer has the control that is inherent within the infrastructure of the hospital system.

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 are no longer the controlling body, they are (Deb, Regional Community Practice).

And the women are different. When I visit them here in hospital they still ... they sit and listen … when they go home … they are much more in control … they have choices (Ursula, Regional Community Practice).

The midwife becomes an invited visitor to the women’s homes. Access may be denied by the women sometimes overtly at other times less obviously; the women may not choose to be home when they know that the midwife is scheduled to visit.
…some other midwives say, oh well I wouldn’t bother after three visits; if they are not there they don’t want the service. They do want the service, but it might not be their priority on the day (Beth, regional).

There is also recognition by some midwives who provide care within women’s homes that the information and advice that they give to women in hospital is not appropriate. Women’s lifestyles and living conditions vary so greatly that it is not possible for them to follow the generic advice given by some midwives in the hospital setting.

I have learnt so much walking into people’s houses. When you say, when you go home you need to run through the following for this baby. And you walk into their house and you know that none of those are possible. That she is standing there, sitting there, going either I am a failure or you are an idiot because these things can not happen in my life. Like I suggest things, I know why I suggested things that in a lot of people’s lives who I have sent home, it just is not possible (Madison, urban).

However, choices made by individual women may not be seen by some midwives to be the right choices. Choices that are based on the current discourses of ‘best practice’ or ‘evidence based practice’ are seen by some midwives to be the correct way and therefore the only way. The next section of the chapter will discuss the concepts of ‘best practice’ or evidence based practice. However to conclude this section the differences between the
hospital context and the community context of care as articulated by the participants are summarised in table 1.

Table 7.1. Summary of Hospital versus Community Context of Care

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies-rigidity</td>
<td>Policies-adaptable</td>
</tr>
<tr>
<td>Professional Control</td>
<td>Individual Control</td>
</tr>
<tr>
<td>Workload - production line</td>
<td>Workload-flexibility</td>
</tr>
</tbody>
</table>

7.4. Western Evidence Based Practice; a Pervasive Discourse of Care

An analysis of the study participants’ discourses surrounding childbirth practices allows an understanding of how midwives practice is to some extent governed by (perceived) scientific evidence. Western childbirth practices have been dominated by the medical model, where the discourses are based on the ‘realm of truth’ of scientific evidence.

…we know what is best because we have researched it and we have used research that is steeped in western culture to prove that we know what we are doing is the right thing and it is the same approach that medicine uses towards alternative therapies by saying look it is evidence based that is the best thing to do when you are fairly new. Whereas someone who practices aromatherapy will
say, but we know this works. Well, where is your evidence, where is your research, where is your randomised double controlled trials. Which is an easy way to dismiss things that we don’t believe to be best (Sam, urban).

Some of the participants, because of their belief in western scientific discourses, are unable to readily accept that there may be other ways of doing things.

I perhaps did not realise that I was perhaps just careering down this road of intensity with their care and …so it is your commitment to provide good quality care of what you have been taught is the norm… the difficulty was that these people actually have a choice and regardless really of perhaps what your ideal for them was, theirs was different (Deb, regional).

Professional frustration can occur for some when the woman’s choice is not what the midwife believes to be best practice. Some study participants have difficulty accepting variations from what they consider best practice.

I think that breastfeeding is a big thing because, we [midwives] are here to promote breastfeeding so much and when they want to give the baby bottles of boiled water you really have got to step back and say yes it is their culture. I find that really difficult because we [midwives] are trying to just get them to breastfeed as much as possible to bring their milk in, so that is a big one and more than anything I think that it is really hard to take a step back sometimes and say, ok that is what you want to do. And that is what they are going to do
when they go home, so yes it is a big issue but not personal frustration. I suppose it goes against everything that we [midwives] have been taught and we have been pushed to promote and then because we do not like them to use anything even just giving the baby a bit of formula is something that I’m not happy with unless absolutely necessary (Zoe, regional).

When approaches to practice are based on the Western premise of scientific truth, judgements are made about practices that are not seen as the ‘norm’. Ultimately, the participants are concerned about the mothers and babies’ safety and well-being. The problem perhaps rests with who defines what is dangerous. Women who carry out certain practices (such as offering their baby ‘ginseng water’) may suddenly find that they are being accused of putting their babies at risk. There is an understanding by some of the study participants that women may find it difficult to accept that their way of doing something is ‘wrong’. However some midwives believe that the women need to be educated into conforming to ‘best practice’; practice that is based on Western scientific evidence.

…when people’s cultures have practices that contravene decent health care; when people want to feed babies ginseng water instead of milk. I try and convince them that this is not a good thing to do to your baby and that perhaps, yes, it was once considered right and a reasonable thing to do to a child. It isn’t such a good idea and there are the reasons why this is unsafe… if it is something that you can get around then you do not tend to fear it but if it is something that is going harm the baby or the mother or whoever your dealing with then that is
something I would say. I try and provide some education to correct the misunderstanding of the belief they have, it is dangerous. I mean I don’t care if it is a cultural practice that is not going impact on the mother or the baby negatively and they can do whatever they like but if it is going to impact negatively I think they deserve to have information to keep themselves and their baby safe. We are saying we are right and you are wrong. That has got to be hard to hear. And we think we are right because ... We’ve done it that way and it’s our culture. Or we have done some research and we actually have a scientific reason for thinking, it’s a good thing to do. I can see how you would not be impressed when being told it is my culture [that has] got it right (Madison, urban).

This desire to see that all individuals follow what the midwives consider to be safe practice sometimes extends to a wish by some of the participants for change to occur so that all individuals experience the same living conditions.

…the dream is that somewhere down the track and hopefully not too distant future, that a lot of these other areas that these [Indigenous] people have big problems with if they can be a little bit more controlled for them then the parenting may not become such an issue (Sarah, Urban).

However, this desire by some midwives for all ‘areas’ of society to ‘be controlled’ can be interpreted as a form of disciplinary surveillance, where individuals are under the
constant gaze of those with disciplinary power, such as the government or health professionals.

7.5. Surveillance

Within midwifery practice the monitoring of the health and well-being of individuals is commonplace. The stages of pregnancy are categorised and monitored, pregnant women are expected to have regular assessments. The Foucauldian concept of surveillance provides a way of subjecting these commonplace assessments and monitoring to close scrutiny and allows a more in-depth view of these practices and their connections with power. Power is inherent in the concept of surveillance, but not necessarily in the more benign term ‘monitoring’. It becomes apparent that power is exercised at both the ‘macro’ and ‘micro’ levels when the application of the concept of surveillance is applied to monitoring practices. This surveillance is routine, however it may be extended to women who are deemed as high risk. In Australia, due to the high morbidity and mortality rates for Indigenous women and their babies, specific programs have been introduced to increase their adherence to antenatal, intrapartum and postnatal services requirements.

Some study participants discussed how surveillance techniques are used to ensure that the monitoring of pregnancy for Indigenous women commences or is maintained. In some cases midwives have resorted to ‘opportunistic’ approaches. This is where they are
informed that an Indigenous woman may be pregnant but as yet, has not attended any pregnancy health care visits, or may not be a regular attendee and the midwife may then approach them in a public place to suggest that they attend their antenatal appointments or in some cases may actually provide the assessment on the spot.

[the midwife who is employed by the AMS] she does a lot of opportunistic visits; even if it is at the hotel bar and she drives past and she gets a lot of her work, we often get information from word of mouth as well. If you say to some of the Aboriginal girls that are in, who’s pregnant up there or who else is having a baby or … they will tell you three, four different girls and quite often they haven’t been for any visits so you can work out from there and … does her visits the same sort of way by word of mouth and if she is passing someone’s told her that someone’s in town and she is staying with Auntie Lola for a week and she’s pregnant, she will go and see them and do their bloods and try and convince them to come back to Aboriginal health, back to… and if they do not there’s nothing really we can do but she will do a whole lot of their bloods and she will keep them on record down there and she sends us a copy of their bloods here ( Linda, Rural).

When the first community midwife took the job it took her probably 12 months before she was invited into anyone’s house in …. but she never hesitated to do a visit in the car, on the riverbank, under the gum trees (Olivia, rural).
This practice of using an ‘opportunistic approach’ to care is not seen by the majority of the study participants as being intrusive to the individual; the midwives are concerned with maternal and foetal well-being. The discourse of childbirth, which is based on the dominant medical discourses, endorses monitoring and surveillance of the women and their foetuses. The midwives are not able to assess women who are not compliant with attending the antenatal clinic or community health centre for their antenatal assessments. It could be argued that these women have escaped from the ‘panopticon gaze’ of the health providers. However, some midwives are now expanding their gaze outwards to the community and if they are able to, they will approach the non-compliant women within their social environments such as the local shopping centres, or in some cases, the local hotels.

The use of monitoring and surveillance which underpins midwifery practice has made some participants reliant on having women’s antenatal records and blood results available before they are happy to provide care for labouring women. They have become dependent on this form of surveillance.

Quite often they [Indigenous women] will come in, in labour and you have got absolutely nothing on them and it makes it very hard to care for them when you have got no pathology, no history, and quite often they don’t tell you all the history that you need to know anyhow. Sometimes it’s hard to get them to open up to you to find out what has happened in the past, if they have had any previous pregnancies, any problem (Isla, rural).
We have a few women from whom we take blood at home as well just because that’s the only way we get blood results otherwise we would have those women fronting up here in labour without having had any antenatal care and no knowledge of their blood group or their hep B status or any of those things so it is certainly a valuable tool to reduce those unprepared women and the hassles that they cause, not just to themselves but for the staff and we also, like if we pick up anything in those blood results or if we are concerned on any of the assessments things that we do then we talk to whoever the obstetrician on duty is for that particular day and get guidance from them so we have got that back up should we need it (Amy, regional).

Amy and Isla discuss how they feel when a women presents with no antenatal history. They are ‘hassled’ and this is due to their fear of the unknown. They want to make sure that the pregnancy was normal and have become reliant on the antenatal screening, for example ultrasound results, to assist them to manage cases. Midwives are educated about infection control and using appropriate precautions (Department of Health NSW 2007) for all clients in regard to blood borne viruses such as Hepatitis B or HIV. However, the participants’ are concerned about their own health when they do not know about a woman’s status in relation to blood borne infections. They are much happier when the woman’s history is known.
Power in the form of surveillance circulates throughout the social environment where pregnant women receive care. However, some women, for example some Indigenous women, resist or ignore attempts to monitor their pregnancies.

7.6. Resistance

Some of the participants also use a form of resistance to the infrastructure of the hospital, by not adhering to policies and procedures that govern their practice. Some of the participants discussed how they have had to go outside the boundaries of the policy and procedures to provide the environment and care that the women want.

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 (Faith, regional practice, discussing previous experience).

Medical dominance and midwifery resistance to this were also discussed by some of the participants. To resist the dominance, midwives may actually use ‘evidence based practice’ to support their practice, and in turn, they are to able to direct policy and procedures when medical practitioners are not available on a full time basis.

I think from our point of view here in … it probably came about because how it was sort of a lack of doctors who were actually sort of calling the shots. You
know, like you have got to stay in bed for three days. You can not do this and the midwives started to be able to decide, oh yes you can go home if you want to today or you can stay a bit longer or what not. So in terms of a slow process it probably happened over about probably 5 or 6 years. I feel. … much more autonomy in terms of the midwives as well as the mothers (Nita, rural).

However, challenges to the dominant medical discourses by midwives can cause disempowerment (Fahy 2002). Participants are aware of this and;

…it takes enormous strength and courage to speak out and question things when you want to do things differently, just to challenge accepted practice (Hanna, regional).

7.7. Conclusion

The context of practice (hospital or community) has a direct impact upon midwives’ approach to care. The significance of this is related to the concept of the ‘macro’ and ‘micro’ powers that influence the provision of care. The provision of health care is directed by a bureaucratic system and web of power is interwoven within this system, where discourses based on so called scientific evidence underpin health professional practices.
The participants have articulated that when their work is based in the hospital setting, they are not consulted about the range of services available; there is a top down approach. As well as the bureaucratic system deciding on health care services, the participants’ practices are controlled by the dominance of the medical profession. This domination can contribute to midwives feeling that their views and practices are disregarded or marginalised. In contrast to this situation, some of the participants have used the discourse of evidence based practice to develop their own policies, when medical practitioners are not available on a full time basis.

However, some participants have stated that they too have power over the women who present for care within a hospital setting. The control within the hospital setting is circulated with its final effects being felt by the women who receive care. In some cases, the language used by the participants is also controlling or marginalising such as when they use the term ‘girls’ to describe women in their care or other colleagues.

The participants have voiced their concern that the infrastructure of the hospital does not allow them to provide an individualistic approach to care for women. They have commented that they feel pressured with the turn around of women, particular in the postnatal wards. Some of the participants feel that they are ‘working in a production line’. Some of the participants have also commented that the policies and procedures within the hospital setting can actually be a barrier to providing an individualistic approach to care.
On the other hand, when care is provided in the community setting, the participants do not have the same time pressures that they feel within the hospital setting and are able to provide a more individualistic approach to care. The locus of control is shifted from the midwife to the woman. This loss of control for the midwife providing the care is often disconcerting as the woman’s choices may not be the same as the midwife’s choice.

The discourse that supports best practice is firmly entrenched in how the participants underpin their practice. Some of the participants see their role as educating the women to follow what they consider to be best practice, which is based on Western scientific evidence. This is seen to be superior, and therefore the only way to achieve desirable standards. In some cases, participants marginalize alternative ways of caring or the way in which individuals rely on traditional (non Western) practices. Individuals who are not from a Western background, in the opinion of some midwives, need to be educated that the Western way is best.

The desire for good outcomes has been expanded to the women’s social environment; opportunistic approaches to care are undertaken by some midwives to maintain surveillance of women who choose not to submit to routine antenatal assessments and monitoring. They have become used to the technocratic approach to care. Some of the participants are afraid of the unknown such as when women present to the birthing units without adequate histories or without their blood results.
Other participants are aware that the control within a hospital situation is not always in the women’s best interest. They have resisted the ‘macro’ and ‘micro’ powers that govern childbirth practices. These midwives recognise that they need to go outside of the rigid policy and procedures to provide the care that women may want. It takes courage to challenge the ‘macro’ and ‘micro’ powers, however where there is resistance, there is possibility for change for the benefit of childbearing women and their families.
CHAPTER 8: DISCUSSION AND CONCLUSION

8.1. Introduction

Providing care that is culturally sensitive is discussed frequently within the nursing and midwifery literature and within education programs. There is a prolific amount of literature on how nurses and midwives can go about providing care that is culturally appropriate. However, there is little evidence to support how the concept of culture is defined and understood and how culturally appropriate care is actually incorporated into practice. The purpose of this study was to explore how midwives define the concept of culture and how they incorporate cultural sensitivity into their practice when caring for CALD women, especially Indigenous women. This study also explored the factors that impact on the incorporation of culturally sensitive care into midwifery practice.

An initial review of the literature had identified different approaches to the issue of providing appropriate, sensitive care. A majority approach focuses on the cognitive aspects of culture, such as tradition, beliefs and customs. Learning about particular CALD groups is believed to lead to the appropriate provision of care but, as I critiqued in Chapter 2, may encourage stereotyping and a reliance on standardised care plans (a cook book approach to care).

A minority approach in the literature provides a more critical analysis of the culture concept and how it may be used in power relations. This literature takes a wider structural
perspective and is more explicitly theoretical, utilising insights from post colonial theory. Proponents of cultural safety tend to come from this perspective.

Reading this cultural literature, which also deals with issues of power and control, led me to the literature about discourse and power, particularly the work of Foucault, which is used here to explain the findings of this study. This literature was discussed in Chapter 3.

In the empirical part of the study, the views of midwives across three different geographical locations within NSW were sought. These locations were purposively selected as the hospitals within these locations were known to provide services for Indigenous women. Midwives who were employed by Aboriginal Medical Services to provide care for pregnant women were also invited to be part of the study. Discourse analysis was used as the theoretical framework underpinning the study, as there are a number of different ways in which cultural difference are portrayed in an Australian context, particularly in relation to the Indigenous population. Initially, a modified grounded theory approach was undertaken for the data collection and analysis. This allowed for thorough and systematic steps to be applied to the study and provided comprehensive information that could not have been obtained by utilising other research methods (Seibold 2006). In-depth interviews were conducted with 32 midwives. The modified grounded theory approach consisted of utilising constant comparative data analysis, which consisted of coding the data and incorporation of these codes into categories, as described in Chapter 4, until theoretical sensitivity was achieved. The study identified that for the majority of the participants, a cognitive approach to culture is
applied when they are caring for women from CALD backgrounds, including Indigenous women. This approach is concerned with the traditions, values and beliefs which an individual is exposed to through socialisation. This was followed by an analysis of discourse as previously explained.

In this chapter, I identify and discuss the significance of the main findings in relation to each of the three research questions and suggest further research. Implications for practice are also included, as is discussion of the limitations of this research.

8.2. Meeting the Aims of the Research

The first aim of the research was to explore how midwives define culture and how they provide culturally appropriate care. The majority of the participants in their first accounts of providing cultural sensitive care chose to discuss caring for women with CALD backgrounds, for example Muslim or Asian women, before discussing providing care for Indigenous women.

The midwives in this study had all experienced some form of education, either through their formal midwifery qualifications, literature or from midwifery colleagues about the needs of different CALD groups of women, for example, women who are identified as being Chinese or Arabic or Muslim. The majority of the midwives wanted to know about women’s specific cultural needs and were looking for ‘recipes for care’. When the
participants use this approach to practice, they inadvertently group all women who they have identified as belonging to a specific CALD group as having the same unchanging beliefs and customs. This is a form of essentialism (Ashcroft et al. 2000) and may lead to the stereotyping of individuals (Smye & Browne 2002).

When using the cognitive approach to provide care to women, there is little recognition of the impact of the individual’s life experiences, including economic position, on their well being (Smye & Browne 2002). One of the key findings from the analysis is the way in which the majority of the participants not only used a generic approach for women from CALD backgrounds but also for women whom they identified as being ‘Anglo’ Australian. There is an inbuilt assumption that all women in specific groups will act in the same way and want the same care.

The midwifery profession advocates woman centred care (this was defined in Chapter 1). However, from the analysis of the interviews it is apparent that midwives do not always approach a woman as an individual. Once a woman is identified as being ‘different’ or as ‘Anglo’, a generic approach to care is undertaken. This approach is taken with the best intentions; midwives are striving to provide what they perceive to be the most appropriate care to meet the woman’s ‘spiritual and cultural needs and expectations’ (Australian Nursing & Midwifery Council 2006, p.3). The participants have been caught between two professional discourses. The first discourse, which espouses the cognitive aspects of culture, is prevalent within the nursing and midwifery literature and within the education
that the participants have received in regard to providing appropriate cultural care. The second discourse stems from the midwifery profession’s desire to provide ‘woman centred care’ that is focused on the needs of individual woman. However, a woman centred approach to care is often lost when midwives are working within busy hospital settings. The concept of individualised care in such settings has been replaced by the midwives’ need to anticipate care provision.

I would like to take this finding further and argue that this is because the participants wish to be in control of their work situations. If they know in advance what someone may require or that women from specific CALD groups have certain practices, such as Asian women not wanting to breastfeed whilst colostrum is present, the midwives are able to control the situation to some degree. The midwifery literature has also discussed the controlling attributes of some midwives (Edwards 2000; Fahy & Parratt 2006).

The midwifery profession espouses individualistic care; however, the participants’ practice is entrenched in the discourse of cultural difference. Educational strategies, as identified by the participants, have been directed at providing information about values and beliefs of different cultures. This education has focused on ‘differences’ rather than any commonalities between all individuals, such as family networks. The discourse then becomes focused on the uniqueness of the ‘other’ (Hall 2001).
Social discourses, such as political and media discourses, may also impact on how midwives view women from CALD backgrounds. Discourses that describe Arabic or Muslim people as fundamentalist and terrorist and as a subsequent threat to the Australian way of life may impact on the participants’ view of women from Arabic or Muslim backgrounds (Poynting et al. 2004)\textsuperscript{17}.

The midwifery and nursing literature has also provided very specific cultural recipes for care for women who have been identified as Arabic or Muslim (Hattar-Pollara 2003), for example, Arabic or Muslim women have often been represented as being submissive to their male partners and requiring the provision of care by women and the need for privacy (Purnell & Paulanka 2005).

However, not all of the participants used this cognitive approach to practice. A small number of the participants discussed a more individualistic approach to care. These midwives had in the majority of cases worked in some form of community practice, such

\textsuperscript{17} An example of how some of the Australian population do view Muslim’s as potential terrorists is provided in the following transcript from the ABC (national television) Four Corners documentary ‘Dangerous Ground’, reported by Sally Neighbour, which screened on Monday March 10th 2008. This report covered a public community meeting which was held to discuss the application to the local Camden council (NSW) for a Muslim school to be built

WOMAN: Sure we are racist if you call it racist not accepting a community that also happens to bear, they’ve got terrorists amongst them. Okay? We can’t say they haven’t, they have. If we let them in here they want to be here because they can go and hide in all their country little farmhouses (Neighbour 2008).
as early discharge programs, where they were able to observe women in their own homes.
Some had a more individualistic approach to practice due to their own life experiences,
for example, they had migrated to Australia with their families or their parents may have
migrated to Australia. These midwives were more likely to consider that there are
differences within specific CALD groups and that woman regardless of their backgrounds
are to be approached as individuals.

As identified in Chapter 2, the literature has identified that there is a need for health care
professionals to be aware of their own culture (Benkert et al. 2005) and there have been
various educational strategies suggested, such as case studies, to achieve this end. Some
of the participants in this study discussed that they actually had to recognise their own
culture or place in society to be able to understand the different perspectives or views that
CALD women and Indigenous women may have. This they felt was achieved by their life
experiences, such as working overseas in a non-English speaking country.

The second aspect of the study was to explore the strategies midwives use when
providing care for Indigenous women. The study identified that the participants use the
discourse of cultural difference to describe how they provide care. The discourse of
cultural difference is related to the discourses which have been used to describe the
Indigenous population in Australia. The participants’ accounts have varied, with some
using the discourse of cultural difference in a derogatory manner, and in some instances,
the participants reflected the past political discourse of denying difference. This is where
there is little thought given to the effect of colonisation on the Indigenous population and
it is considered that the past should be forgotten and the Indigenous population should move forward (Jamrozik 2004). On the other hand, some of the participants used a discourse of social justice to highlight the injustice and inequity that has occurred for the Indigenous population since the colonisation of Australia.

Regardless of the discourse used by the participants when describing how they provide care to Indigenous women, some used certain strategies that were not evident when they were describing the care they provided to non-Indigenous or other CALD women. These strategies were mainly concerned with improving their communication with Indigenous women, such as avoiding direct eye contact and actively listening to their needs. The last point is interesting as the participants often assumed that non-Indigenous women understood their questions and therefore they may not ‘actively’ listen to their responses, demonstrating once again how midwives tend to stereotype practice for all.

The third aim of the study was to identify the factors that impact on how midwives provide care. This objective has also been met. There are several factors that influence the provision of care, such as the institutions where the participants were employed, workloads, policy and procedures which are based on western scientific evidence. However, when viewed from a broad perspective, these factors are all concerned with control and power.
One of the primary factors is the institutions that govern midwives’ practice. The macro powers (the government) and the micro powers (hospital administration) determine the working environment within hospital settings. Busy workloads affect the midwives’ ability to provide care based on the woman’s needs. The turnover of women in the hospital setting is so rapid that some of the participants commented that they are working in a production line. This has been expressed in the literature ‘as working against the clock’ (Lavender & Chapple 2004, p.328) and this causes dissatisfaction with their role as a midwife because they do not have time to provide the care that they feel that the woman wants (Hughes et al. 2002). This has implications for women receiving care, especially in the postnatal wards where women have commented negatively about the lack of time that midwives have to provide the advice and care that they needed (Lock & Gibb 2003). Australian midwives have also voiced their concerns about their dissatisfaction with working in postnatal wards (Watson et al. 1999). Government and hospital managers often state that current midwifery shortages are to blame for women not feeling supported. However, it has been argued that bureaucracy and midwifery dissatisfaction with their work environments, particularly understaffing and the inability of midwives to provide one to one care, has added to the current shortage of midwives within the hospital system both here in Australia (McLintock 2007; Pollard 2007) and within the United Kingdom (Kirkham 2000; Kitzinger 2005).

There is discussion about the current Australian midwifery workforce shortage in relation to the education of the midwifery workforce and strategies to improve the intake of midwifery students, such as increasing Bachelor of Midwifery places, have been
suggested (Tracy et al. 2000). However, there has been little research on the factors that impact on maintaining the current midwifery workforce. The evidence suggests that midwives want to be satisfied with the care they provide (Lavender & Chapple 2004). This includes being more autonomous in their practice (Lavender & Chapple 2004). However, as described in Chapter 3, it is difficult for some midwives to work in an autonomous manner when there is an ongoing contest over who is best qualified to provide care to pregnant women - obstetricians or midwives. The medical profession uses scientific discourse to enable them to have power to direct how health care is to be provided (Kent 2000). Midwives, when employed by hospitals, are governed by the policy and procedures within the organisation, which are often controlled by obstetricians.

The analysis also revealed that some of the participants were able to be more flexible in their approach to practice. Community practice, where midwives provide care within women’s homes, appears to have provided those participants who have worked in this way with a more flexible approach to practice. They have been able to see how individual women live and to observe that regardless of their cultural background that not all women follow the expected ‘norm’ and this includes ‘Anglo’ Australian women. They have to some extent been able to provide a more individualistic approach to care. This is because they are no longer providing care within the hospital setting which influences approaches to practice. The participants are providing care to women in their homes and there is a shift in who is in control. This has also been identified in a previous study by Lock and Gibb (2003, p.132) where women identified that they were more in control of their
situation when being cared for within their own home rather than in a hospital postnatal ward setting where they felt ‘disempowered’.

However, regardless of the context of care (hospital or community), the use of western scientific evidence by the medical profession has to some extent impacted on how midwives practice. Midwifery practice is now heavily influenced by scientific evidence (Tracy 2006). Policy and procedures are governed by best practice, a framework developed from western scientific evidence which is often governed by a bio-medical approach to practice (Edwards 2000). This approach does not allow for other view points to be considered. It is apparent that some of the participants have (like some of their medical colleagues) disregarded or excluded alternative ways of managing health. On the other hand, some of the participants are supportive of alternative discourses about health care. However, the majority of the participants are concerned with safety and none condoned alternative practices that may put the mother or baby at risk, although other practices such as mothers not breastfeeding in the first few days after birth are tolerated.

Midwifery practice, when reviewed from a Fouculdian perspective, can be seen to be involved in the surveillance of pregnant women. Most of the participants, to some extent, rely on the woman’s history when providing care for her in labour. They have become dependent on knowing the results of any antenatal tests, for example blood results. As described in Chapter 7, this surveillance can at times lead to some midwives using an ‘opportunistic’ approach to practice. This is where women who may not be attending the health services for their routine antenatal assessments are in fact assessed in public areas
by midwives. The midwives are concerned with the mother’s and baby’s well-being; they
do not see ‘opportunistic’ visits as an invasion of the woman’s privacy.

Although midwives are to some extent, governed by the current dominant discourses
surrounding pregnancy and child birth, there is also resistance to them. As identified in
Chapter 7, some midwives have used scientific evidence to their advantage to change
policies and procedures for the benefit of the women for whom they provide care.
Interestingly, this was mainly identified in the analysis of the transcripts of the midwives
who are employed in the rural or smaller regional maternity unit. I would argue that for
these midwives there is less domination by obstetricians, particularly in the rural hospital,
which was having difficulty attracting a permanent obstetrician. These midwives are able
to practise more autonomously.

8.3. Discerning Discourse

Discourse and how it is used provided an extremely useful way of analysing how the
participants viewed culture and how they provided care for CALD women, including
Indigenous women. From the accounts provided by the midwives, three discourses were
discerned. These I have called:

- A discourse of cultural difference
- A discourse of social justice
- A discourse of denying difference
A discourse of cultural difference is used by the participants to describe how CALD and Indigenous women are different to ‘Anglo’ women. This discourse of cultural difference stems from the midwives’ cognitive approach to culture that views culture as being based on values, customs and beliefs, and the midwives’ focus particularly on the perceived traditional practices of CALD women and Indigenous women.

However, there is one major difference in the participants’ accounts of cultural difference. CALD women are not identified as having lost their culture if they do not follow traditional practices, whereas Indigenous women, according to the accounts of the participants, have lost their culture if they do not practise some of the traditional birthing practices these midwives expect all Indigenous women to follow. This discourse has stemmed from the historical discourse about the ‘other’, which described Indigenous people as ‘artefacts of the past’ who were child-like and in need of rescue by the ‘western orders of things’ (Nakata 2007, pp.195 - 196).

Theoretically, Islanders 18 were positioned as people from the past who were being catapulted onto the present by the presence of intruders into their previously timeless and unchanging lives – not by intruders into their present lives but intruders onto their lives from the past. Understanding Islanders came to be understanding the distance between the past (represented by Islander

18 Martin Nakata is of Torres Islander descent therefore his textbook focuses on the experiences of Torres Strait Islander people. ‘The focus of this book has been on Torres Strait Islanders but much of what I have put forward has relevance to other Indigenous peoples and contexts’ (Nakata 2007, p.218).
thinking, understanding and organisation of their world, which were all present and could be observed in the here and now) and present (represented by European understanding, thinking and the ways of organising their world which were also in the here and now and could be observed by the Islanders).

Understanding Islanders came to be not so much about Islanders as about understanding the distance between them and others – and managing the difference and disjuncture between the two (Nakata 2007, p.202).

As argued by Nakata (2007, p.202) the discourse that positioned Indigenous people as belonging to the ‘past’ allowed for the Indigenous population to become ‘theoretically submerged and marginalised’. The discourse of the past then allows some of the participants to decide who is Indigenous or who not and not does allow for a broader understanding of the Indigenous population position within Australian society today.

In contemporary times, Islanders are read through the prism of culture, itself a construction of the other that, as applied to the current context, misses the Islander experience of their engagement with the past ‘before time’, colonial and more recent events (Nakata 2007, p.203).

Some of the participants compared cultural difference between Indigenous Australians and non Indigenous Australians, which in most instances stereotyped both cultures. Comparisons were made about social issues, such as employment. When these types of comparisons were made, the Indigenous population was described in a negative way and
generalised assumptions were made about the Indigenous population not wanting to work or to help themselves. Brown and Smye (2002) argue that this type of discourse does not consider the historical factors that have affected Indigenous people social and economic well-being. This type of discourse allows the Indigenous population to be stereotyped and their social position considered to be a product of their ‘lifestyle’ choices.

On the other hand, some of the midwives discussed reasons why social inequity persists for the Indigenous population. This discourse I have called the discourse of social justice. These midwives were more likely to talk about the history of colonisation, and the injustices that occurred, such as the stolen generations. They recognise that the impact of colonisation has been and continues to be detrimental to the well-being of the Indigenous population. The social position of Indigenous people within Australian society affects every aspect of their life such as their economic and educational levels. These participants supported specific Indigenous maternity services for women, and often stated that more was needed to support Indigenous women during pregnancy, birth and the postnatal period. These participants also tended to respect the need for some Indigenous women to be closely aligned to their Indigenous identity. They recognised that this does not necessarily mean that these women wished to follow what are identified as or thought to be particular traditions and customs. As argued by Nakata (2007, p.196).

Contemporary theories of Islanders as culturally different but equal interpret us more positively through our cultural behaviour and customs, which demonstrate Islander distinctiveness, history and tradition. This framework is about returning to Islanders, in both theoretical and practical terms, our ‘equal’ humanity and
reinstating the value of our ‘different’ former lives in the past. This approach makes sense and is useful in explaining the Islander position because it seems to capture the best of both worlds. It allows Islanders some link with the past and it insists on equality in the present to eliminate any unequal effects of their distance from others.

However, Nakata (2007, p.196) is quick to point out that the discourse that describes Indigenous people has not changed greatly and they are still ‘constituted … to cohere with the evolution of changes in a Western order of things’.

Finally a discourse of denying difference is used by some of the participants who do not acknowledge the impact of colonisation on the current well-being of the Indigenous population. They expect the Indigenous population to forget the past and to move on. This discourse is very much a part of the public discourse about whether or not the Australian federal government should say ‘sorry’ to the stolen generations for the injustices they experienced. The previous federal Coalition Government (1996 to 2007) was opposed to saying ‘sorry’. However, the Federal Labor Government, under the new Prime Minister Kevin Rudd officially apologised through Parliament to the Indigenous population for the stolen generations on the 13th February 2008. This apology was supported by the majority of Australians. As a direct result of this apology, Prime Minister Kevin Rudd, has received a record high approval rate (Shanahan 2008).
Initially, the new leader of the opposition Dr Brendan Nelson was opposed to this apology. This is demonstrated in the transcript (below) of an interview conducted on the ABC 730 report on the 29\textsuperscript{th} November 2007;

\begin{quote}
KERRY O'BRIEN: And on Aboriginal issues, are you prepared like Malcolm Turnbull [a potential leader of the Liberal party] was, to say sorry, to join with Mr Rudd in saying sorry to the stolen generations?
BRENDAN NELSON: Look Kerry, we are very proud of what our forebears did at Gallipoli and other campaigns. That doesn't mean that we own them. Similarly, we feel a sense of shame in some ways of what was done in the past, where with good intentions, but not always with good outcomes, Aboriginal people were removed from what were often appalling conditions. We, in my view, we have no responsibility to apologise or take ownership for what was done by earlier generations (Australian Broadcasting Corporation 2007).
\end{quote}

This is an example of the discourse of denying difference which circulates throughout Australian society. Another example from the media is the following, in the Sydney Morning Herald dated the 11th December 2007, the following letter was published:

\begin{quote}
\textbf{Sorry, but now it’s time to move on}
Patricia Lemaire, like many of those who support an apology, just can’t seem to look forward, and in the process is ensuring our indigenous [sic] community remains stuck in the past (Letters, December 10)
Patricia, 1961 was 46 years ago. In 2007, the indigenous population does not suffer from the discrimination you described, at least not by the state. In fact, it
experiences reverse discrimination: the non–indigenous population is discriminated against to give an advantage to indigenous population.

As someone who has never wronged the indigenous population and has grown up in an Australia where opportunities are available for all, I do not wish the Prime Minister to apologise on my behalf.

The issue is divisive and counterproductive to achieving reconciliation. For the sake of the indigenous population, I hope the ‘sorry’ lobby is able to join the rest of the 21st century.

Mitchell Beston, Woy Woy

The views of Mitchell Beston echoed the sentiments of several of the participants I interviewed, such as Bronwyn and Linda, who stated that they are not responsible for what occurred in the past. Nita and Isla’s accounts also elicited that they felt that Indigenous women receive more support during pregnancy than other women, such as being flown by the Royal Doctor Service from their remote communities to birth in maternity services based in the city or larger rural centres.

However, a letter supporting the current political discourse of recognising the impact of the stolen generations on the Indigenous population was also published.
I hope Patricia Lemaire’s letter will start a plethora of memories from those who do remember and feel ‘sorry’ for the treatment of our first peoples.

Although I do not remember any Aboriginal children in my school (West Kempsey Primary) during the 1950s, I do remember that they lived near the garbage dump and that they were not allowed to swim with us in the public baths.

Unlike Patricia’s my father was a racist enabler who taught us the idea of eugenics and the “Stone Age people” who were to “die out” if left alone as nature intended.

May we who are still alive, still aware of what happened during our lifetimes, be the true voices heard for the coming “Sorry Day” by our new compassionate and thoughtful Prime Minister.

Alison Supple, Corindi Beach

This discussion brings into question the position of individuals and why they take up certain discourses. According to Foucault (1997) individuals do not choose which discourse to follow, rather they are subjects of discourse. Hall (2001), when discussing Foucault and his concept of individuals being the subjects of discourse supports Foucault by stating the following;
First, the discourse itself produces ‘subjects’ – figures who personify the particular form of knowledge which the discourse produces…But the discourse also produces a place for the subjects (i.e. the reader or viewer, who is also ‘subjected to’ discourse) from which its particular knowledge and meaning makes sense…But for them – us - to do so, they - we - must locate themselves/ourselves in the position from which the discourse makes the most sense, and thus become its ‘subjects’ by ‘subjecting’ ourselves to its meanings, power and regulation. All discourse, then, construct subject positions, from which alone they make sense.

This approach has radical implications for a theory of representation. For it suggests that discourse themselves construct the subject-positions for which they become meaningful and have effects (Hall 2001, p.80).

When the concept of subject positions was applied to the participants in this study, I understood how the study participants adopted various discourses about CALD women, including Indigenous women. The participants’ subject positions have been constructed by the discourses they have adopted. The analysis of the data revealed that there are various discourses that the participants used to describe how they provide care to CALD and Indigenous women. These discourses are widely discernible within Australian society.
8.4. Conclusion and Significance of the Study

The main finding is that midwives, like other individuals within society, are influenced by prevailing discourses about the ‘other’ and about the Indigenous population. The way midwives in this study viewed individuals who appeared different to them, including CALD and Indigenous women, depended on the way in which they have taken up various discourses about the ‘other’.

The dominant discourses within Australia have constituted CALD and Indigenous individuals as the ‘other’. This view has also been circulated throughout the education of midwives; the findings of this study have demonstrated that midwives tend to rely on a generic approach to the provision of care for CALD and Indigenous women. This generic approach consists of applying knowledge about traditions, customs and values without recognising the uniqueness of the individual and how their life experiences impact on their needs. The study findings question the utility of using this approach to practice. The challenge is to encourage midwives to value the uniqueness of each individual woman, appreciating broader factors which impact on her life, but not stereotyping. Is ‘culture’ the right concept for the job? If we decide it is, perhaps we can learn from other disciplines such as cultural studies to take a more nuanced and insightful view than this study suggests is presently the case.

The findings of the study have revealed that a cognitive approach to culture is taken by the majority of the participants. I argue that this is because the majority of the nursing
and midwifery literature supports this approach to practice. Only a minority of the participants discussed the impact of colonisation on the Indigenous population. As previously discussed, the concept of cultural safety, which espouses the recognition of power relationships within the health care setting, the wider community and the historical events which have impacted on the Indigenous population (Kirkham et al. 2002) was not widely disseminated prior to the commencement of this study. However, as discussed in Chapter 2, research has indicated that the term ‘cultural safety’ is not widely understood by health professionals or those receiving care in the Australian context (Johnstone & Kanitsaki 2007).

The study findings, particularly in regard to the factors that impact on care, can be situated within the discussion in the literature which has previously highlighted ‘control’ as one of the main factors that can have a negative effect on midwifery practice and the women to whom they provide care (Kent 2000; Kirkham 2000; Fahy & Parratt 2006). The health care system, in particular hospital environments which focus on the throughput of the women receiving care, does not foster an environment which supports the midwifery philosophy of providing women centred care. This philosophy states that the needs of individual women need to be considered. Instead, a generic approach to care for CALD women, including Indigenous women and also for ‘Anglo’ women is provided as it is the only way that midwives can control their workload.
8.5. Implications for Practice

The major implication for practice from this study is that the majority of participants view culture from a perspective that focuses on the cognitive aspects of culture. When midwives use this approach to practice they utilise ‘recipes of care’ that incorporate an essentialist view, which in turn can stereotype individuals who are identified as belonging to specific CALD groups, as well as for women who are identified as being ‘Anglo’ Australian. However, this approach to culture is not advocated currently within documents that govern midwifery practice. Professional bodies such as the Australian College of Midwives currently endorse competency standards that state that midwives are to provide care that ‘is holistic-addresses the woman’s social, emotional, physical, psychological, spiritual and cultural needs and expectations’ (Australian Nursing & Midwifery Council 2006, p.11). Competency Ten within these competency standards is to ensure that ‘midwifery practice is culturally safe’ (Australian Nursing & Midwifery Council 2006, p.23). Within this framework the midwife is to incorporate ‘knowledge of cross cultural and historical factors into practice’ (Australian Nursing & Midwifery Council 2006, p.23). The difficulty with this statement is that it does not provide any examples of how to disseminate this knowledge to midwives currently practising. Further, the inclusion of this concept in the competencies takes for granted that all midwives understand what is meant by the concept of cultural safety and how it may be incorporated into practice. There is an assumption that midwives will have knowledge about historical events and understand how colonisation has impacted on the Indigenous population well-being. However it has been demonstrated by Johnstone and Kanitsaki
(2007) that there is some confusion in the clinical setting about what cultural safety means.

The current documentation from the Nurses and Midwives Board (NMB) of NSW, the Guidelines for the Development of Course Leading to Registration as a Midwife states the following:

2.4. Indigenous health, including primary health care and community development, must be included in midwifery curricula. Indigenous community members should be involved in the design, development and teaching of midwifery curricula.

2.6. The course must enable students to develop awareness of the cultural diversity which exists in the Australian community and an understanding of cultural safety in maternity care (Nurses and Midwives Board New South Wales 2006).

However the majority of midwifery programs within NSW are offered as a twelve month, postgraduate qualification for registered nurses wishing to become midwives\(^\text{19}\). Within this time frame, there is a large clinical component which covers the clinical skills and competencies that are required by the NMB. The remainder of the program consists of the

\(^{19}\) I am currently a member of the NMB Midwifery Practice committee which reviews the different midwifery programs curriculums when they are submitted for accreditation or reaccredidation with the NMB and therefore I am aware of the content within these programs.
theoretical components which underpin midwifery clinical practice. There are no distinct subjects which focus on Indigenous issues; this component is woven into the various theoretical subjects. It is therefore extremely difficult to meet the course requirements (as above) in an in-depth way. However, as argued by Nakata (2007), the inclusion of some Indigenous material into curricula is beneficial. Even if the material is not researched or presented by Indigenous people, at least it is a step in the right direction, ensuring that it is covered in some way. Obviously, it would be optimal if all material relating to the Indigenous population was researched and presented by Indigenous people.

The movement towards making curricula more inclusive, whichever way it has been approached, relies largely on non-Indigenous research into Indigenous issues and has encouraged the extraction of elements of Indigenous ways of understanding the world – mathematical knowledge, astronomy, stories, mythology, art, environmental knowledge, religion – and insertion of these elements to fit with particular curriculum areas. The purpose of such inclusions is to develop students’ understanding of Indigenous Australia and current predicaments and much of this content contributes to the goal (Nakata 2007, p.219).

However, as the findings from this study demonstrate some of the participants responded extremely negatively to hospital based workshops on cultural diversity that focused on Indigenous issues, especially if the ongoing impact of colonisation was included within the workshop. This again identifies that these participants’ views of the Indigenous population have been shaped by discourses which do not allow this kind of thinking. This
type of discourse also fails to take into account the wider social and economic
disadvantage that the Indigenous population continues to face.

The discourse espoused by the previous federal government, now the opposition, in
regards to the Indigenous population was also not conducive to acknowledging aspects of
colonisation such as social inequality within the discourse of Australian history. The
discourse of denying difference which was dominant during their time in office, is one in
which the effect of colonisation on the Indigenous population was not acknowledged.
However, I argue that an understanding of colonial discourse and its relationship to how
Indigenous and non–Indigenous Australians view the concept of culture is crucial to
allowing a deeper analysis of the current situation of the Indigenous population. An
awareness of alternate discourses is important as it allows individuals to have knowledge
of the factors that have and do impact on the health and well-being of the Indigenous
population. An understanding of how various discourses are created enables the
recognition that power is central. It is inherent in different organisations, especially health
care organisations. Such an understanding provides a way of identifying how power is
circulated throughout these organisations influencing the care provided.

Education programs need to become more critical of the way in which culture is
portrayed. Culture is a concept that is given meaning by various discourses. Education
programs will need to provide students with the means to analyse these discourses so that
they may have tools to critique the health care environment, their place in it as midwives
and the effects on their clients. Included within this is the way individuals are labelled as
belonging to specific CALD groups and how this tendency can lead to stereotyping and a
generic approach to practice.

Negotiations with the current western world view of curricula within an Australian
context will need to be ongoing, recognising that the current university system is
grounded in ‘Western disciplines’ (Nakata 2007, p.220). This grounding stems from
historical factors, the use of the English language and the way in which the western way
is circulated throughout the university (Nakata 2007).

As the coordinator of a postgraduate midwifery program I have endeavoured to ensure
that the curriculum development and some of the subject material is inclusive of material
relating to Indigenous health and cultural safety. This enables students to be exposed to
the factors that impact on the lifespan of the Indigenous population and in particular
factors that impact on maternal and family health. For example, I coordinate a subject
that looks at the social context of midwifery. As part of this subject, the midwife
employed to care for local pregnant Indigenous women and the Aboriginal Health Care
Worker from the Wollongong AMS provide a workshop for the students. The film
Birthrites (2002) is also shown. Birthrites (2002) compares the health care system
provided for Indigenous women in remote and rural areas of Australia with Inuit women
in Canada. The students reflect on this session in class and complete a written
assessment.
All midwifery education programs in Australia will have to find ways of providing material to students which facilitates their understanding of how colonisation has impacted on the health and well-being of the Indigenous populations. The ACM National Competency Standards for the Midwife, Competency Ten; is to ‘ensure midwifery practice is culturally safe’ (ANMC 2006, p.23). Nursing and Midwifery Registration Bodies in Australia will need to make sure that midwifery programs meet the ANMC National Competencies before they are accredited.

For registered midwives programs will need to be developed to address the application of cultural safety. It is apparent from this study that some of the current hospital in-service programs are not conducive to facilitating an understanding of Indigenous health issues and cultural safety. Continual interest in cultural safety by the nursing and midwifery professional bodies may assist the development of a new discourse about Indigenous Australians that does not situate them as ‘the other’. Midwives will need to lead by example and truly work in partnerships with Indigenous communities.

**8.6. Limitations of the Research**

As this was a qualitative study, the findings cannot be applied to the wider population due to the non-probability sampling technique used. Midwives who were employed in locations where there were local Indigenous communities were asked to take part in the study. The study therefore focuses on the exploration of the views of these midwives.
Different results may have been obtained if midwives were included in the study regardless of their place of employment.

The interviews were conducted in 2001 and 2002. Since then, there has also been a considerable shift by the regulation body, the NMB, and the Australian College of Midwives to include cultural safety as part of the framework for midwifery practice and as a result, midwives may currently be more knowledgeable of this approach.

Since I commenced this study there has also been considerable work performed by the NSW Health Department and the NSW Aboriginal Maternal and Infant Health Strategy Evaluation Final Report 2005 has been released in August 2006. The aim of this strategy (discussed in Chapter 1) was to ‘improve the health of Aboriginal women during pregnancy and decrease perinatal morbidity and mortality’ (NSW Health Department 2006, p.7). The emphasis was on Aboriginal community development and enabling a primary health model of care which includes both a midwife and an Aboriginal health care worker. Emphasis has also been placed on providing education and training for Indigenous women to become midwives. This may have significant benefits for midwifery practice in the future.

The University of Technology, Sydney currently has a cohort of Indigenous students undertaking the Bachelor of Midwifery program. The Royal Hospital for Women (Sydney) has commenced a midwifery group practice to care for local Indigenous
women. The above initiatives have been disseminated through publications and conference presentations (NSW Health Department 2006; Caplice 2007). Therefore, if a similar study was undertaken in the future midwives may include in their accounts a more detailed discussion of issues pertaining to Indigenous health and cultural safety.

This study only elicited the accounts of the participants in providing care for CALD women, including Indigenous women, therefore the views of women about the care they received from midwives has not been addressed.

8.7. Future Research

With the current emphasis from the NMB and the ACM on the inclusion of the concept of cultural safety into midwifery practice, future research could be undertaken to ascertain current midwifery knowledge on this concept. This would entail interviewing midwives to explore their understanding and especially the application of this concept to practice. More importantly, future research should involve the recipients of midwifery care, especially Indigenous women. This has started (Watson et al. 2002b; Campbell & Brown 2004) but more needs to be done.

This study and others (Kirkham 1996; Lavender & Chapple 2004) has demonstrated how the infrastructure of health provision impacts negatively on the midwifery profession and their ability to provide individualistic care. As a result, this impacts significantly on the
well-being of the women receiving care. Further research is required into other models of care, such as midwifery models of continuity of carer, to see if the women receiving care are approached as individuals or whether a generic approach to care is undertaken. Continuity of carer models are still governed by health care facilities and to some extent the midwives working in these models of care are governed by various professional discourses, such as the midwifery professional body and the bureaucracy of the hospital system where medical power remains dominant. Future research is needed to see how these various discourse infiltrate the practice of midwives working in models of continuity of carer.

However it was apparent from this study that midwives, especially those working in rural and remote rural locations, do not have the opportunity to build a rapport with Indigenous women in the antenatal period. Models of continuity of carer are not readily available. Research is urgently required into the needs of all rural and remote rural women, and in particular, on the needs of Indigenous women and on the provision of appropriate antenatal, intrapartum and postnatal care for the benefit of all concerned.
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APPENDIX A: UNIVERSITY OF WOLLONGONG ETHICS

COMMITTEE APPROVAL

University of Wollongong

28 September 2000

Ms M. Williamson
Department of Nursing
University of Wollongong

Dear Ms Williamson,

Thank you for your response to the Ethics Committee’s requirements for your Human Research Ethics application HE00/160 “Dealing with Diversity: Incorporating Cultural Sensitivity into Professional Midwifery Practice”.

Your response and amendments meet with the requirements of the Committee and your application was formally approved on 20/09/00.

Yours sincerely,

Karen McRae
Secretary to the
Human Research Ethics Committee
Dealing with Diversity

Study Information for Participants

My name is Moira Williamson and I am currently enrolled in a Ph.D. in the Department of Nursing at the University of Wollongong. I am a midwife and have been actively involved in the midwifery profession since completing my midwifery education in 1979. I am presently employed as the co-ordinator of the Master of Science (Midwifery) degree, Department of Nursing, University of Wollongong.

For my Ph.D., I am researching how midwives deal with diversity in their clinical practice. The objective of my research is to gain insight into how midwives incorporate strategies for dealing with diversity into their practice and to be able to build on this information to enhance midwives education in this area.

I’d like to ask you to assist me with this study. This would involve giving up an hour of your time to be interviewed. The interview would take place at a time and location that is convenient for you. The interview will be recorded; this recording will remain confidential. Only my supervisor Dr Lindsey Harrison and myself will have access to the recorded interview. The interview transcript will be coded to ensure that you will not be able to be identified in any of the results from the study. The information from the study will be stored in a locked filing cabinet separated from the coded information.

You are free to terminate the interview at any stage and request that the tape recording be deleted. The interview will not have any bearing on your current or future employment.

Your assistance in this research project would be greatly appreciated.

Further Information
If you require further information or have any questions relating to the study please call me on 02 4221 3381 or my supervisor Dr Lindsey Harrison on 02 4221 4087.

Contacts regarding this Research
This research has been reviewed by the University of Wollongong, Human Research Ethics Committee, should you have any inquiries, concerns or complaints about the conduct of the study please contact the Ethics Officer on 02 42 21 3386 or Dr Lindsey Harrison on 02 4221 4087. The research has also been approved by __________________________ Area Health Service.
APPENDIX C: CONSENT FORM

Consent Form
Dealing with Diversity Study

I, ___________________________________________________ have read the Dealing with Diversity study information sheet. I understand that participation in the study is voluntary and that I am free to terminate the interview at any stage. I am aware that the interview will be audiotaped and that this recording will remain confidential. I am aware that the interview transcript will be coded to ensure my anonymity.

I understand that the interview will take approximately on hour and will take place at a time and location that are suitable for me. I am aware that the interview has no bearing on my current or future employment.

I understand that the information gained from the interview will be used to write a Ph.D. thesis and that the information may be published in appropriate journals and in conference proceedings.

I have discussed with Moira Williamson my participation in the study and I have had the opportunity to ask questions.

I am aware that I can contact either Moria Williamson (0242213381) or Dr Lindsey Harrison (0242214087) if I have any further questions relating to the study.

If I have any concerns or complaints about the conduct of the study I will contact the Ethics Officer at the University of Wollongong on 02 4221 3386 or Dr Lindsey Harrison on 024221 4087.

I agree to participate in this study.

Signature _______________________________ Date ___________________________
APPENDIX D: INTERVIEW QUESTIONS

Interview Questions

1. Can you tell me what made you chose midwifery practice as a career?

2. Why do you continue to work in this particular area?

3. The Australian College of Midwives, state that midwives should recognise cultural diversity. Could you tell me your views about that?

4. In what ways do you incorporate cultural sensitivity into your everyday practice?
   
   Prompt: Do you find this successful, can you give an example?

5. Have you had any difficulties in incorporating cultural sensitivity into your practice?
   
   Prompt: Can you tell me about them?

6. What particular strategies have you used when you are caring for Aboriginal women?
   
   Prompt: You gave an example of caring for an Aboriginal woman where you did incorporate some strategies. Was it successful? Was it difficult for you to do?

7. In what way did you initial midwifery education cover culture and diversity?
   
   Prompt: What would you have liked your initial midwifery education to cover?

   Prompt: What kind of information would have helped?
APPENDIX E: STUDY PARTICIPANTS’ AGE, GENDER, LOCATION AND ETHNIC BACKGROUND

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<th>Participant</th>
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Ages of participants were calculated from the information within their transcripts, when they commenced as a student nurse or midwife.

* Denotes community experience as a midwife or registered nurse.
APPENDIX F: MEMO - COLONISATION

Interview 8 (regional previous rural experience)

This midwife clearly discusses the impact of colonisation on the Indigenous communities that she has worked in. She believes that other health care professionals are too quick to judge individuals by the way they present (look) without considering the social factors that have impinged on their well-being.

*I don't think maternity services in Australia deal with specific needs of aboriginal women particularly well and I don't think they recognise for a start the, they don't acknowledge the impact of the last 200 years on the health status of Aboriginal women and I think unfortunately they've found too many people that are prepared to judge on what they see when aboriginal present for care without taking into account how they got there the consequences of lack of education, poor health and factors like domestic violence and sexual assault which in my experience unfortunately occurred far too commonly in aboriginal communities I have worked in.*

Interview 14 (rural)

This midwife is discussing the orientation - annual cultural awareness program presented by staff that are Aboriginal. She feels it is inverse racism (see racist memo). Interestingly I feel it is an example of Cultural Safety that has been developed in New Zealand. In this model an understanding of the effect of colonisation on the Maori population is being included in all nursing curriculum. However, this midwife states that the way it has been presented here in her opinion was racist, as it does not look at both sides of the issue.

Further on in the interview this midwife is discussing how she feels that the part of the population who are Aboriginal are in their ‘adolescent stage’, in regard to following the behaviours and norms of the population who are ‘white’, the dominant sector of the population.

*I sort of think that Aboriginal people as a group as a culture are sort of like at the puberty stage and in a person’s sort of development. They are sort of getting some white ways but their still got some of their own ways and as an adolescent their sort of making, this probably sounds stupid but this is how I believe it. It’s like starting to making their demands and some are coming through and starting to become more sort of self sufficient as adults. Coming into hospital and bringing their supplies and what not and just fitting into um more of a, not necessarily white women’s ways, but just becoming more sort of self sufficient to themselves.*

The midwife is inferring that the people who are Aboriginal were not self sufficient before, but she is judging this on their lack of material possessions. It does not appear that she understands the effect that colonisation had and continues to have on people who are Aboriginal. See my thoughts under ‘low socio economic memo’ regarding standard of
living and how this midwife does not relate this to colonisation. Whereas I think it is a result of the effect of colonisation.

The midwife also comments that people who are Aboriginal receive more benefits. However she does not seem to see the relationship of colonisation to poverty. *It just seems in lots of ways that the Aboriginal, I think a lot of white people think the Aboriginal people get it, they have more sort of more things going for them in terms of more benefits and what not.*

**Interview 17AMS (rural)**

Her comments are interesting as she states that people with 'Anglo-Saxon' backgrounds expect people to be the same. *I come from an Anglo-Saxon background we presume what we think is right. Everyone should be should do the same.*

**Interview 18 (rural)**

The midwife in this interview does not appear to understand the effect that colonisation has had on the aboriginal population. *I suppose the only thing that’s sort of differently is they get more from us than what the white ladies will. People that come from (town) most times don’t bring anything with them and we have to supply their pads and if they’re going to artificially feed, we supply the formula, we supply everything I suppose to those ladies the ones from (another town). They usually bring everything, well prepared and most that are here in town are O.K. It’s just the different areas, some from (town) don’t (I shouldn’t be prejudging (town)).*

*No that’s fine.*

*But that’s what we find sometimes we actually give more to them.*

**Do you find that frustrating on a personal level, or?**

*Sometimes it is, sometimes, yes.*

**Frustrating because they’re not prepared and or frustrating because you feel you are giving out things and no one else is getting that?**

Well I suppose it’s frustrating because of that, there’s other instances: they get flown in by the Flying Doctor Service because they are queried in labour and if they’re not in labour they made to go, and you some of us just look at the money and occasionally you think the white girls, well are coming to town we have to stay somewhere and these people get flown in. For instance, last week a lady was in town, her baby was due, her child was in the Children’s’ Ward, she was due any day and they asked her about staying and she said, *“no, I’ll be back when I have my baby”.* She got back to, back to (town) that day and had to be flown back in, in labour. And it’s just annoying sometimes, little things like that.

**Yes because**

*Its just added expense and sometimes you think, why can’t everybody have it …..*
This midwife is also (like interview 14) talking about a cultural awareness day that the area health service runs. She does not appear to relate the stolen generation and the change in Aboriginal living conditions to colonisation.

…they showed a video on the Lost Generation, basically how the children were taken and why and how actually their cultures have been mixed, like the cultures within a different area, say along the river edge, each tribe and when they were taken and put in Missions they were mixed together, so they also got a cross-cultural ... as well, that was one of the issues to talk about. They talked about housing, what they’re actually doing in (town). What they were doing in (town) which isn’t viable anymore, building bricks and making their own houses. Then we just had to talk about aspects of how their stories and cultures have been carried through and a lot of it isn’t anymore where culture is written down and it’s in stories and how everything we do is written and kept in books and other things like that, where theirs is actually talk, stories and paintings.

**Interview 24 (regional)**

This midwife is discussing the history of colonisation but she in my opinion lacks insight in to the continuing effect this has had on the Aboriginal population. She states that they should get over it and move on.

**So your not sure how that’s come about or do you have an idea of why they might distrust us?**

Well I think the history of, you know, the Aboriginal Australians and the way that our ancestors, the way they were treated when they came out to Australia was very poor indeed. But I certainly don’t think that the history, but I mean, it’s certainly impacts how people think and act and behave and everything, but, I certainly don’t think that we currently should be responsible for what for what happened in the past. It was appalling what happened in the past but I don’t know, in some ways I think everyone should get over it, move on. It’s a new era and you know, deal with it and move on rather than kind of. There seems to be resentment sometimes.

**Interview 30 (urban)**

Although the midwife is not directly discussing colonisation, they are discussing the effect that history has had on the Aboriginal population. This has an impact on their practice as this midwife approaches people who are Aboriginal with a heighten awareness of the impact of history on their wellbeing. This midwife is more cautious in their approach.

**I think it’s doing do anything differently maybe not but we do it with, I do it with a heightened sense of awareness I guess that given their position in Australian society that I’m a little bit more cautious I guess of trying not to offend...**

Because of their history and because of the negative generalisations that people throw on Aboriginal women especially in the inner city. Why, I guess it’s no different but the perception of high drug use and low education; it is definitely not always the case...
**Interview 31 (urban)**

This midwife is not discussing the stolen generation directly but is referring to the distrust that Aboriginal people have of anyone in uniform, any one who represents hierarchal systems. It could be seen as an effect of colonisation.

*It probably can reflect on really what has happened to previous family members, previous hospital admissions for other family members. Anything in a uniform maybe. It’s quite often it doesn’t matter that the fact that they might be Aboriginal Islander Strait ..., they’ll be the first one to get harassed or told to leave or whatever purely because of on the history of maybe potentially someone in the area who’d be not, law abiding or whatever. So I think that follows through here. We all wear uniforms. There’s that hierarchy thing.*

**Interview 32 (urban)**

This midwife is discussing why she believes Aboriginal people distrust health professionals. She in my opinion has a good insight into why they distrust the health system. She relates this to power. This would be a good example to relate to Fahy (2002) article where she discusses Foucault view about power and she discusses medical power and midwives role in this. Clare and Hamilton (2003) also discuss power and how it affects care. Interestingly, Danaher et al. (2000 pp.105-115) state that although Foucault did not discuss colonisation directly, his theory of power relates well to colonisation.

*Well we have power, we have power by basically the premise that they need to come here for their delivery. We have power in that they don’t know me behind a desk. They don’t know me from even like an interview like this. So that they really don’t know what. You are. So they don’t know what and who you are and what you’re likely to do. Yes.*

*But what makes Aboriginal people distrust you and others wouldn’t. What happened to them do you think? Certainly you only have to look at their history in the society. Within our Australian population I worked in a country hospital, certainly back in the 60s, you know, early 70s, not in the 60s or 70s where they weren’t even admitted to our hospital. They had an outside section in our hospital. They were only given rights to vote in 68. So, I mean, everyone’s got to look at cultural history in terms of what’s happening in our society that impacts on their views, opinions, attitudes towards um any authority, any authority.*
Abstract 1:

CONFERENCE:

TITLE OF PRESENTATION:
Dealing with Diversity: Incorporating Cultural Sensitivity into Professional Midwifery Practice.

ABSTRACT:
This paper presents some of the preliminary results of a qualitative study into how midwives’ incorporate cultural sensitivity into their professional midwifery practice. The aim of the study was to gain understanding of midwives’ concepts of culture and cultural diversity and to explore midwives strategies to incorporate cultural sensitivity into professional practice, especially in relation to Aboriginal women. The study involved in-depth interviews 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 involved accessing midwives from three different geography (urban, regional and rural) locations within NSW.

Abstract 2:

CONFERENCE:

International Confederation of Midwives, 26th Triennial Congress
April 14 -18, 2002, Vienna Austria Center; Midwives and Women
together for the family of the world.

TITLE OF PRESENTATION:

How do Australian Midwives Deal with Cultural Diversity?

ABSTRACT:

This paper will discuss how midwives Incorporate Cultural Sensitivity into Professional Midwifery Practice. A study is in progress to gain understanding of midwives concepts of culture and cultural diversity. This study has explored midwifery strategies used to incorporate cultural sensitivity into professional practice, especially in relation to Aboriginal women. Some of the preliminary results of this qualitative study will be presented. The study has involved in-depth interviews 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 has involved accessing midwives from three different demographic (urban, regional and rural) locations within New South Wales, Australia. The study will in future be also used to explore midwives educational needs in relation to cultural sensitivity.

Abstract 3:

CONFERENCE:
International Confederation of Midwives, 26th Triennial Congress April 14-18, 2002, Vienna Austria Center; Midwives and Women together for the family of the world.

TITLE OF PRESENTATION:
What is Cultural Sensitivity?

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.

Abstract 4:

**CONFERENCE:**

**TITLE OF PRESENTATION:**
How Midwives Perceive Themselves and their Practice.

**ABSTRACT:**
As part of a qualitative study looking at how midwives incorporate cultural sensitivity into their practice, participants were asked why they became midwives and why they remain in the profession. Their reasons, and their perceptions of midwifery, provide ‘food for thought’ for midwifery managers who wish to retain their staff.

Abstract 5:

CONFERENCE:

TITLE OF PRESENTATION:
The Impact of Environment on Practice.

ABSTRACT:

This paper discusses some findings from a qualitative study looking at how midwives incorporate cultural sensitivity into their practice especially when caring for Aboriginal women. The study involved 30 midwives from a variety of clinical settings in different geographical areas in New South Wales and included midwives whose practice is specifically with Aboriginal women as well as ‘mainstream’ practitioners. The research shows that context and setting impact strongly on practice. It is suggested that contemporary hospital practice is antithetical to developing sensitive care instead resulting in an emphasis in control and efficiency.

Abstract 6:

**CONFERENCE:**

27th Congress of the International Confederation of Midwives
Midwifery: Pathways to Healthy Nations Australia, Brisbane
September 2005

**TITLE OF PRESENTATION:**

Current Ways of Knowing; Colonial Discourse and Indigenous Australians

**ABSTRACT:**

Discourse is pivotal to the understanding of how the concept of culture is constructed, the discourse relating to culture has been shaped and maintained by power relationships that construct the various discourses and those with power often use these discourses to their advantage. The use of power is also reflected in colonial studies, this paper will introduce the literature in relation to colonisation, in particular colonial discourse. Following, this review it will be shown that the discourse in relation to the colonisation of Australia was often discriminating towards the indigenous Aboriginal population and that this discourse still prevails today.

The work of Michelle Foucault will be discussed as a means by which the various discourses relating to culture and power can be linked and used to identify the various discursive frameworks which underpin how mainstream Australians view Aboriginal Australians and in-turn how this impacts on individual Aboriginal Australian’s.

The history of the colonisation of Australia will be described and the ongoing impact of this process on the well being of the Australian Aboriginal population will be portrayed as one in which the Australian Aboriginal population as been excluded and hidden from the mainstream Australian population. The legacy of this exclusion has had far reaching implications for the economic and health status of the majority of the Australian Aboriginal population particular for Aboriginal Maternal and Neonatal morbidity and mortality.

This paper discusses these issues, utilising empirical data from a larger qualitative study, which explores how midwives incorporate cultural sensitivity into their practice when caring for Aboriginal women and their families.

## Abstract 7:

### CONFERENCE:
The Australian Association for Infant Mental Health: Old Families New Beginnings. Sydney, Australia May 2006:

### TITLE OF PRESENTATION:
**Working with the ‘Ghosts in the Nursery’- the Impact on Midwifery Practice**

### ABSTRACT:
This paper presents some of the results of a qualitative study into how midwives’ incorporate cultural sensitivity into their professional midwifery practice. The aim of the study was to gain understanding of midwives’ concepts of culture and cultural diversity and to explore midwives’ strategies to incorporate cultural sensitivity into professional practice, especially in relation to Aboriginal women. The study consisted of in-depth interviews with midwives employed in a variety of settings including the mainstream clinical setting, as well as with midwives whose dedicated midwifery practice is specifically with Aboriginal women. This involved accessing midwives from three different geography (urban, regional and rural) locations within NSW.

Midwives talked about the impact of the ‘stolen generation’ in providing care to Aboriginal and Torres Strait Islander women. Some felt that these past experiences have caused some Aboriginal women to mistrust those in authority, such as health professionals. Further, mandatory regulations and the context of care, especially in hospitals, limits the midwives’ ability to tailor their practice as they might wish. This paper discusses these issues.

Abstract 8:

**CONFERENCE:**


**TITLE OF PRESENTATION:**

‘Midwifery Practice’ and the ‘Context of Care’

**ABSTRACT:**

This presentation will discuss the authors learning journey and experiences while undertaking a qualitative study which focused on how midwives incorporate cultural sensitivity into their practice, especially when caring for Indigenous women. This study was undertaken as there was little information available on how cultural sensitivity was incorporated into midwifery practice. The research found that cultural ‘recipes of care’ are predominant, as the context of care is prescriptive and does not allow for more creative practice. This paper discusses these issues.

Abstract 9:

**CONFERENCE:**
Big Bold and Beautiful: 15th National Conference Australian College of Midwives. Canberra, Australia September 2007

**TITLE OF PRESENTATION:**
Bold; Cultural Safety and Midwifery Practice in an Australian Context.

**ABSTRACT:**

This presentation will explore the concept of ‘cultural safety’ and its recent endorsement by the Australian Nursing and Midwifery Council, within the National Competency Standards for the Midwife. Discussion will focus on the impact of colonisation on the Australian Indigenous population and outline the subsequent implications for midwifery practice. This discussion will be illuminated by data from a study that explored how midwives currently incorporate cultural sensitivity into their practice.

### Abstract 10:

**CONFERENCE:**


**TITLE OF PRESENTATION:**

**ACCEPTED ABSTRACT:**

This paper discusses findings from a study undertaken to explore how midwives provide culturally sensitive care for women from culturally and linguistically diverse (CALD) backgrounds, particularly focusing on the care provided to Australian Indigenous women. Following ethics approval, a qualitative study was undertaken, utilising a modified grounded theory approach for the data collection and analysis. Thirty-two midwives were interviewed in the different geographical locations within New South Wales, Australia. The study used insights from colonial and postcolonial discourse theory to explore and interpret the perspectives of the participants.

When discussing the concept of ‘culture’, most participants referred to ‘customs and traditions’, a perspective which tends to see culture as static and unchanging. They had been encouraged to view culture in this way by their educational preparation, reinforced by much of the nursing literature. As a result, participants tended to expect CALD women to conform to what they themselves believed were cultural norms. Some were challenged in this view during their practice with CALD women but, for many, the routines of busy hospitals allowed little time for reflection. More recent approaches in the literature have emphasized ‘cultural safety’, which advocates being aware of the social, political and economic factors which impact on clients, but it is still unclear how this concept may be operationalised in practice.

These findings question the utility of using the concept of culture in midwifery education. The challenge is to encourage midwives to value the uniqueness of each individual woman, appreciating broader factors which impact on her life, but not stereotyping. Is ‘culture’ the right concept for the job? If we decide it is, perhaps we can learn from other disciplines such as anthropology and cultural studies to take a more nuanced and insightful view than this study suggests is presently the case.