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Commentary

Becoming culturally sensitive: A painful process?

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ABSTRACT

Objective: to discuss how midwifery students develop cultural sensitivity.
Design: students carried out international observational elective placements and 13 matched self-assessments from before and after a Global Midwifery Module were compared. The module is based around a model of immersion and permitted measured responses and qualitative evaluation to be explored.
Settings: observational placements occurred in the UK, America, Canada, and Gutamala.
Participants: seventeen year 3 midwifery students.
Findings: raised awareness about international midwifery was identified; the module contributed to enhancement of practice, confidence about caring for those from a different culture varied, the process of critical reflection was uncomfortable for some.
Key conclusions: critical reflection facilitated in a safe place may support individuals to transform their way of thinking.
Implications for practice: responsibility for developing cultural sensitivity should lie with the individual. However, leaders need to facilitate space for critical reflection. Critical self-assessment and reflection about cultural sensitivity should be part of a life long learning approach.

Introduction

Respect for cultures and traditions remains a fundamental requirement for midwifery (NMC, 2009; WHO, 2009) stipulating that midwives should not discriminate (NMC, 2008). However, evidence suggests that discrimination does exist during episodes of midwifery care (Harper-Bulman and McCourt, 2002; Ali and Burchett, 2004; Pollock, 2005), and highlights that partnership with women from multiethnic cultures may be more difficult to develop. Partnership development may be hindered by a lack of confidence when managing complex issues (Drennan and Joseph, 2005) and disparity may grow further when there is miscommunication, potentially affecting maternal and neonatal outcome directly (Doorenbos et al., 2005; Lewis, 2007; CMACE, 2010). Communicating, when individuals are from different cultures can become complex and the ideal that both parties reach full understanding may never be achieved (Habermas, 1984). One explanation of why complete understanding remains difficult to achieve may be related to how language barriers encourage subtle interaction that permits individual assumptions to be made (Briscoe and Lavender, 2009; Briscoe, 2009). Professionals who speak the same language as their clients provide an important service; however, Kim-Godwin et al. (2006) identified that a caring attitude was more important to clients than language. This small Delphi study (n=93 round 1; n=142 round 2) (Kim-Godwin et al., 2006) involved a convenience sample and was set in Mexico and it would be interesting to explore how transferable the findings are in the UK.

Culturally sensitive health care occurs when client expectations are aligned with health-care provider's knowledge, attitude, and behaviour (Doorenbos et al., 2005). For organisations, aligning knowledge, attitude, and behaviour about culturally sensitive concepts remains difficult (Weiss, 1996; Cummings and Worley, 2009). Additionally, in service training about minority ethnic groups may rely on generalised concepts that are difficult to apply to individual people and may contribute to stereotype (Schim et al., 2007).

Individuals who have experienced being with and supporting clients from different cultures may have greater sensitivity because exposure helps individuals to internalise awareness of how other people live (Hogg cited in Burke, 2006, p. 111). However, working in a multiethnic environment does not mean that the carer has implicit cultural sensitivity and competence (Pope-Davis et al., 1994), and it is important to consider how individuals and not systems create the caring environment. Individuals hold the power to influence the client experience, as Reimer-Kirkham (2000, p. 352) comments:

> It is not the culture that shapes the health care experiences of individuals. It is the extent to which they are stereotyped, rendered voiceless, silenced, not taken seriously, peripheralised, homogenised, ignored, dehumanised, and ordered around.

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For individuals, there is a suggestion that the process of developing cultural sensitivity needs to be pre-empted by a desire within professionals to become culturally sensitive (Campinah-Bacote, 1999, 2003). However, the provision of culturally sensitive care is a professional standard (NMC, 2004, 2009) that should not depend on whether individuals choose to become culturally sensitive. Constructive development theory (Comings et al., 2004) helps to identify that knowledge is constructed within the individual and holds individual meaning, and therefore, providing and engaging in care for individuals from other cultures will hold a different meaning for each professional.

Developing self-awareness becomes the first step (Campinah-Bacote, 1999; Krainovich-Miller et al., 2008) for professionals who desire to become culturally sensitive and Midwives may have learnt how raised self-awareness assists communication (Hunter, 2005). Critical reflection provides a framework to support learners to become self-aware (Schon, 1983, 1987; Boud et al., 1985; Gibbs, 1988; Quinn, 2000; Johns, 2004). However, critical reflection is not simply assessment and reassessment of assumptions (Williams, 2001). After reviewing theories of reflective process (Mezirow, 1990; 1998 cited in Williams, 2001, p. 30; Brookfield, 1987 cited in Williams, 2001, p. 30; Schon, 1995 cited in Williams, 2001, p. 30), Williams (2001, p. 30) states, 'critical reflection occurs whenever underlying premises are being questioned' and Brookfield (2000) relates how ideology critique that promises social transformation helps people to lean to recognise how dominant ideologies pervade everyday events and practices (Brookfield, cited in Mezirow and Associates, 2000, p. 128).

The process of becoming self-aware can be allied to theory associated with transformational learning, when a real life dilemma is followed by a self-examination based around critical reflection that aims to explore new roles, negotiate relationships, build confidence, and develop a more inclusive and discriminating perspective (Mezirow, 1990; Mezirow cited in Taylor, 1997, p. 3; Mezirow et al., 2000). Importantly, development linked to cultural sensitivity may become uncomfortable because critical reflection that recognises personal limitation can be a surprising and uncomfortable journey, which is best facilitated in a safe space (Lyons,1999; Iedema et al., 2006).

Opportunity for student midwives to develop cultural sensitivity has been provided using the vehicle of a Global Midwifery Module within a 3 year BSc Midwifery programme, in North West England. A safe environment in a university setting was provided, where exploration was underpinned by a transformative philosophical base (Mezirow, 1990; Taylor, 1997; Mezirow et al., 2000; Johnson-Bailey and Alfred, 2006). However, in order for a transformation to be visible it was important that level of change was assessed and the findings from evaluations are presented in this paper.

Methods

Opportunity to observe midwifery practice in any part of the world is presented at the beginning of the midwifery programme and students plan their elective placement from the beginning of year 2 onwards. The rationale for the module aims to develop cultural awareness and sensitivity and encourage students to gain transferable skills associated with planning and organising their work load. The students are advised to develop a broad aim, which is later honed once the placement has been confirmed by the host. The elective placement is purely observational and there is recognition that the placement is self-funded. However, students are supported and encouraged to apply for funding and in 2006 student midwives achieved a Student Vision Award (RCM, 2006). Later, in 2011 students were awarded the prestigious Iolanthe Student Award (2011) and The Royal College of Obstetricians Wellbeing of Women Student Bursary (2011). Additionally, students are supported to disseminate their work in local, national, and international settings (Bond, 2008; Briscoe and Cohort-32 Student Midwives, 2008; McEvilly et al., 2008; Partridge et al., 2008; Squires et al., 2008; Dee, 2009).

Students search for their elective placement by contacting professional midwifery colleges within individual countries and permission is sought to observe practice. Usually hosts welcome students and plan time when student midwives are able to observe midwives working. However, some applications are declined because host placement areas are oversubscribed. Prior to travel, risk assessment will be carried out and approval for travel is ratified by the Head of Midwifery, Dean of Faculty and university compliance department. To date, students have been facilitated to visit placements in Africa, America, North America, South America, Asia, Australia, Europe, Middle East, and Oceania.

Prior to the visit, a literature search aims to develop awareness about the new culture and the topic of interest. During elective placements students' communicated with the module leader by telephone, e-mail and an eblogger. On return, students were supported to critically analyse and reflect upon their experience by linking theory to their observations within summative assessments of a poster and supportive paper. Prior to and after attending elective placements students are invited to complete a specifically designed self-assessment questionnaire. Additionally, the module is evaluated as part of the university evaluation process. Furthermore, students are provided with the opportunity to reflect in a group or a one tutorial.

Findings

Ethical approval was sort from Edge Hill University's Ethics Committee, which concurred that because this discussion paper involved service evaluation, formal approval was not required. Therefore, out of courtesy, permission was sought from September 2008 cohort who experienced their elective placement in 2011. Eighteen students began the module, however, one student needed to step off the programme during the module leaving the maximum number of matched responses associated with before and after the module of 17. There were 13 matched responses where attrition lost 4 student responses. Comments collected from eblogger reflection and module evaluations help to contextualise student self-assessment. The idea for using an 'eblogger' in a virtual learning environment for group communication rests with one innovative student and provided a real time online discussion secured by the University's Technology Department.

Students were asked to identify if they were aware of international issues related to midwifery. Ten of the matched paired students identified an increase in their awareness after the module, 2 responses remained the same and one student (Student 11) identified less knowledge in the after questionnaire (Fig. 1). Concepts such as post partum haemorrhage, infection control, maternal and infant mortality, and Female Genital Mutilation were evident. Individual students mentioned skilled trained attendants, HIV, wearing veils, sickle cell, and Thalassaemia after the experience. Comments from self-assessment supported an increased awareness:

> International issues in midwifery are vast. This module has enhanced my understanding of global issues related to midwifery and allowed me to develop my awareness of this. Key international issues I am aware of are FGM, inequalities in care provided, reasons for global maternal death (e.g. PPH) (Student 15: Self-Assessment: After).

Anonymous module evaluations were submitted by 9 students, eight of whom identified that the module had contributed to