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RESEARCH

Cultural Competence and Ethnic Attitudes of Midwives Concerning Jewish Couples

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ABSTRACT

Objective: To examine nurse-midwives' general cultural competence and ethnic attitudes toward Jewish couples of varying degrees of religious identification during the birth process and the relationship between background data, ethnic attitudes, and cultural competence.

Design: Descriptive, correlational study.

Setting: Academic tertiary care health facility.

Participants: Thirty staff nurse-midwives employed at a university hospital in Israel.

Methods: Participants completed Campinha-Bacote's Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals-Revised, Ethnic Attitude Scale-Adapted, and a midwifery demographic survey.

Results: General cultural competence scores were consistent with previous studies of nurses who did not receive formal cultural education. Midwives' ethnic attitude differed significantly among Secular, Traditional, Religious, and Ultra-Orthodox Jewish patient scenarios. The most positive attitudes and lowest bias scores occurred for midwives when the patient scenarios were similar to or congruent with their religious identification.

Conclusions: The results of this study indicate a need to establish educational and practice content with clinical experiences to improve midwives' cultural competence and ethnic attitudes toward women and their families with dissimilar cultural backgrounds. These results have global implications for nursing/midwifery care considering patients' varying degrees of religious adherence.

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Childbearing practices are highly influenced by cultural values and beliefs (Andrews & Boyle, 2003; Callister, Khalaf, Semenic, Kartchner, & Vehvilainen-Julkunen, 2003; Campinha-Bacote, 2003, 2007; Galanti, 1997; Leininger & McFarland, 2002; Mattson, 2000; Purnell & Paulanka, 2003; Schuiling & Sampselle, 1999; Weber, 1996). Many cultures with various religious practices incorporate their cultural beliefs, values, and practices into the childbirth experience. The labor and delivery unit is a prime example where culturally diverse women and their families may clash with the westernized health care system. Caring for laboring couples necessitates that culturally competent midwives and nurses recognize culturally related responses in order to appropriately care for women and their families (Callister et al.). Spector (2009) has written extensively on the issue of cultural diversity and cultural conflict in the provision of health care. Health care providers need to understand and respond effectively to the cultural needs brought to the health care experience. There is limited research available in understanding the interface experience between health professionals and the culturally diverse population.

Presently, there are approximately 12 to 14 million Jews in the world with the greatest concentrations being in the United States and Israel. In a published report by The Jewish People Policy Planning Institute (2007), the four top centers of the Jewish population include North America (5,649,000), Israel (5,393,000), Europe/non-Former Soviet Union (non-FSU) (1,155,000), and the FSU (357,000). Births in Israel occur mainly in hospitals with most babies delivered by midwives. In general, the health care personnel are Jewish and secular, reflecting the Israeli Jewish population as a whole. In contrast, the

majority of Jewish women giving birth are Ultra-Orthodox (Choshen, Korach, & Diskin, 2006). This phenomenon has the potential to create a situation whereby many of the health care personnel do not share the same religious identification as their clientele. Dissimilarities like these can be the source of a potential challenge to the patient-provider encounter. In addition, nursing and midwifery education has not yet fully integrated formal cultural competence modules into their professional curricula.

Internationally, the Jewish culture can be found in many countries with differences between the various religious subcultures present within the Jewish population worldwide. This study provides a template for studying subcultures within a heterogeneous population for the purpose of ultimately providing culturally competent health care.

Conceptual Model

For over 40 years, nursing scholars have examined the subject of transcultural nursing via model, theory, and framework development (Andrews & Boyle, 2003; Campinha-Bacote, 2007; Giger & Davidhizar, 2004; Leininger & McFarland, 2002; Purnell & Paulanka, 2003; Spector, 2009). Culture influences the way that people confront their beliefs, attitudes, and practices (Leininger & McFarland; Rooda, 1992). Internationally, health care professionals recognize that culture is a strong factor in the way that people conduct themselves concerning lifestyle, and health care in particular.

The study employed Campinha-Bacote's "The Process of Cultural Competence: A Culturally Competent Model of Care" originally developed in 1991 (2007). The model presently contains five process-oriented concepts including cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters.

Cultural desire is the personal motivation of a health care professional to become culturally competent. Cultural awareness is a process of self-examination and exploration of one's personal cultural background. Without cultural awareness, the health care professional would be unaware of his/her attitudes, biases, and prejudices toward individuals who are different from themselves. This personal assessment phase may reveal a cultural imposition defined as "tendency of an individual or group to impose their beliefs, values, and patterns of behavior on another culture for varied reasons (p. 51)" as "the" correct view and belief (Leininger & McFarland, 2002).

Cultural desire is the personal motivation of a health care professional to become culturally competent.

Following cultural awareness, there is a demand for cultural knowledge that allows the health care professional to view the client's beliefs and values from within the client's worldview as it affects their health and illness. Cultural skill is "the ability to collect relevant cultural data regarding the client's presenting problem, as well as accurately performing a culturally based, physical assessment in a culturally sensitive manner" (Campinha-Bacote, 2007, p. 49). Finally, Campinha-Bacote defines cultural encounters as "the act of directly interacting with clients from culturally diverse backgrounds" (p. 71). She stresses the importance of multiple cultural encounters to avoid pitfalls or assumptions through exposure to only three or four individuals from a particular ethnic group.

Prior research by Rooda (1992) demonstrated that ethnic attitude has been linked to cultural competence. Background data may significantly influence ethnic attitudes and affect cultural competence. She based her study on Allport's (1979) Social Contact Theory, whose classic study of prejudice in 1954 hypothesized that increased social contact between people in majority and minority groups, within certain conditions, had the potential to reduce prejudice. Rooda (1992) highlighted the influence of ethnic attitudes toward diverse cultures through her findings that White nurses, working at an inner city campus, with increased contact with African American patients, were significantly less biased toward African Americans than their suburban campus counterparts.

Background

Israel is a westernized country composed of immense cultural diversity. In 2006, Israel's population was approximately 7.1 million people representing different religions (Jewish, Moslem, Christian, Druze, and other) and ethnic backgrounds (Jewish and Arab; Central Bureau of Statistics, 2007a; Central Bureau of Statistics, 2007b). The Jewish culture accounts for 76% of the population within Israel. Among the Jewish population, various identification groups exist pertaining to religious observance and affiliation. One mode of categorizing these groups is Ultra-Orthodox (Haredi), Religious, Traditional, and