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Culture and Communication in Ethically Appropriate Care

This article considers the difficulties with using Gillon's model for health care ethics in the context of clinical practice. Everyday difficulties can arise when caring for people from different ethnic and cultural backgrounds, especially when they speak little or no English. A case is presented that establishes, owing to language and cultural barriers, that midwives may have difficulty in providing ethically appropriate care to women of Pakistani Muslim origin in the UK. The use of interpreters is discussed; however, there are limitations and counter arguments to their use. Training is identified as needed to prepare service providers and midwives for meeting the needs of a culturally diverse maternity population.

Introduction

When undertaking research across cultural boundaries, previous work has highlighted the difficulties that can arise in applying western ethical principles.¹ Standard codes of ethics cannot be applied when using research participants from other cultural backgrounds than the one where the research is undertaken. Codes must be flexible in order to respect the cultural differences of research participants.¹ In this article we originally intended to use Gillon's (four principles plus scope) model² to demonstrate the difficulties in providing ethically appropriate midwifery care to women whose ethnic, cultural and language backgrounds are different to those of their carers. However, in the course of writing, an argument evolved questioning the application of Gillon's model in this context, supporting the claims that difficulties can arise in applying western ethical principles.¹ We therefore explore the two issues of the ethical appropriateness of care and the appropriateness of Gillon's model² in critiquing care.

The UK is today a multicultural, multi ethnic and multiple language society. It is within this milieu that health care needs to analyse practice from an ethical perspective. During 2003 it was reported that 48% of the total population requiring maternity care in Bradford (a city located in the industrialized part of northern England) were of Southeast Asian origin.³ The majority of the women were of Pakistani Muslim descent. A significant number had not been born in the UK⁴ and were therefore of different ethnic, cultural and language backgrounds. To practise as prescribed by the Nursing and Midwifery Council⁵ midwives must develop an awareness and understanding of ethnic, cultural and language differences between themselves as carers and those for whom they are caring. It is, however, well documented that women born elsewhere experience greater difficulties because of their backgrounds when receiving maternity care than British-born minority ethnic clients.^{6,7}

Gillon² adapted the original ethical principles proposed by Beauchamp and Childress⁸ developing what he described as a 'culturally neutral' model. He considers his approach neutral in that health care workers can share a common moral commitment despite originating from disparate moral cultures. This neutrality is impartial to competing theories, including those of religion and culture. Cultural neutrality supposes that carers can ignore their own perspectives shaped by their particular living and working contexts and by any religious beliefs they may hold. This enables the adoption of a 'neutral' outlook about clients. The contention is that, in this new state, carers will not use any of their previous feelings or awareness to inform their approach to providing care (maternity care in this instance). Adopting a

culturally neutral approach to care should also mean that carers do not take account of the culture of their clients. However, using Gillon's model 2 we will now discuss the importance of health care workers' background when considering ethical issues in clinical practice. Indeed, it is important to consider the background of the client who is at the receiving end of ethical clinical decisions. We will focus on the context of midwives providing care to pregnant women of Pakistani Muslim origin, who may not share the same ethnic, cultural or language backgrounds as their carers. Beneficence and non-maleficence will be considered together because these two concepts are acknowledged jointly by health care professionals

Autonomy

Gillon 2 defines autonomy as deliberated self-rule and considers that, to respect autonomy in health care ethics, informed consent should be acquired before undertaking procedures. He suggests that effective communication is essential for this. Indeed, the Department of Health 9 states that the fundamental principle for establishing the ability to consent to procedures is effective communication. A survey of people from minority ethnic groups 10 showed that 28% of Pakistani people were not able to speak any English. Many of these were uneducated women who had recently immigrated to the UK. They did not work outside the home and had limited contact with non-Asian British people.11. Some of these women may be reasonably fluent in English for everyday activities, but they may not have acquired the language to make sense of health care 7,12. In view of this, one could question how midwives can communicate effectively with these women. To gain informed consent, midwives should assess whether a woman has a full understanding of the choices available. Surely this is impossible when the woman speaks little or no English? The ethical and legal ramifications of not obtaining informed consent from pregnant women are profound. If midwives continue with care, in addition to not respecting the woman's autonomy, they could be deemed to have undertaken a physical assault against the person, particularly when it may involve intimate examinations.13

The cultural context of communication is a poorly researched area of health care,14 yet midwives are instructed to consider this within their daily practice.5 Childbirth is a time when a number of cultural traditions come to the fore. Where incongruence exists between the woman's and the midwife's cultural beliefs about childbirth, one could argue that the foundations of the relationship could be distorted by a lack of common ground. In contrast, Gillon 2 suggests that health care workers' background does not influence the concept of cultural common ground because carers adopt a culturally neutral approach. A lack of commonality (due to cultural disparity) will, however, influence the type of information that the midwife presents, thus affecting the woman's ability to provide informed consent. The concept of existential autonomy supports this argument;15 therefore a midwife must endeavour to develop an understanding of women's cultural perspective of the world because this may directly impact on the choices and decisions made by the women in the midwife's care. If the midwife has little comprehension of a woman's beliefs about childbirth then one could argue that she cannot provide information appropriate to respecting the woman's existential autonomy.

When considering the broader context, a society's cultural beliefs will impact on an individual's interpretation of the world. In turn, how society views autonomy will become significant when an individual is faced with making personal decisions. In an

Egyptian, mainly Muslim, society, paternalism is the accepted norm in health care practice.¹ Consequently, the importance of respecting a woman's autonomy (from a western understanding of the term) is not considered relevant because health care practitioners take on the role of decision makers for their clients. This may be similar in a British Muslim Pakistani society. Midwives could experience comparable difficulties to the Egyptian researcher when caring for women who have originated from Pakistan.¹ Women could look up to them as being superior and therefore not value their own ability to make decisions around their care, expecting midwives to take on this role. This demonstrates the different cultural interpretations of the concept of autonomy, and, although Gillon ² acknowledges that people may want varying degrees of autonomy, this is not within a cultural context. This cultural disparity will have an influence on midwives' ability to gain informed consent for procedures and therefore respect autonomy. To be able to gain informed consent, midwives (or indeed any other health care professionals) need to engage women fully, understanding their 'hopes, fears, physical condition and limits of intellectual understanding' (p. 174),¹⁶ employing a language in which the women can interact. Once this is achieved, information can then be tailored to match recipients' needs, thus providing ethically and culturally sensitive care. It can therefore be seen that true informed consent cannot be achieved in a culturally neutral way. If consent is gained in the absence of these conditions, it could be said to have disrespected the ethical principle of autonomy.

Beneficence and non-maleficence

It is generally agreed in health care that professionals should act in a way to do good and not to harm their clients. Gillon ² discusses this with the aim of providing net benefit over harm. In relation to caring for pregnant women of Pakistani Muslim origin, it could be argued that, if the midwife cannot communicate with a woman, then she cannot assess whether her care is indeed respecting these principles. It is alarming that the most recent Confidential Enquiries into Maternal Deaths ¹⁷ demonstrated that women from minority ethnic groups who spoke little or no English were twice as likely to die in childbirth than women whose first language was English. This was because these women could not communicate their needs and therefore the professionals missed important symptoms of life-threatening conditions. In such cases professionals have failed in their duty of care and thus increased the potential of harm to their clients.

Studies have demonstrated more subtle examples of how communication difficulties can impact on the care women receive. Midwives could fail to provide psychological support to women whose first language is not English.^{18,19} They may focus only on the physical aspects of caring for these women owing to their difficulties in communicating with them.²⁰ Consequently, there is a potential to cause psychological harm by the non-acknowledgement of emotional issues. There is evidence to suggest that, when health care professionals cannot communicate effectively with their clients, they may become angry and frustrated, which can be manifest in their non verbal cues. The client may sense this and feel vulnerable and inadequate.⁷ This in turn could exacerbate psychological harm, thereby not respecting the ethical principles of beneficence and non-maleficence. Midwives may also stereotype and categorize women who speak little or no English.¹² Women may be labelled as 'unresponsive, rude and unintelligent', which may lead midwives to hold preconceived expectations of women's behaviour and cultural values.¹²

Ineffective communication coupled with a lack of common ground and understanding of cultural issues will exacerbate this concern. Consequently, inappropriate demeanour on the part of midwives may lead to women become uncooperative, thus exacerbating the stereotype.²¹ In Bowler's study 12 midwives perceived that it was normal for women of Pakistani origin to express their pain in labour vocally. In reality this stereotype could detract from midwives exploring other potential reasons for this behaviour. If, for example, a woman was in severe pain but could not communicate this, then she would not receive the appropriate care and could ultimately be harmed. In this situation, midwives' lack of knowledge of cultural issues therefore leads to a failure in respecting the principles of beneficence and non maleficence. This suggests that it is important to consider the cultural context when applying these principles. This is a position not explored by Gillon.²

Justice

Gillon 2 explores the principle of justice in relation to health care ethics. Within this milieu he contends that, although people appear to be treated equally, they can be treated unjustly. An example of this is in accessing health services, which, in the UK, are free to everyone. However, in reality, being able to read and write in the majority language is an important facet in enabling users to learn about and then access health services.²² For example, in the maternity services, telephone triage is commonly used to access care. Utilization of such a service demands a reasonable command of the English language, including the understanding of and ability to communicate descriptive words and some medical terminology. Without this, one could argue that these women's rights of access to this service are not being respected and therefore they are being treated unjustly.

Health services do not take into account the cultural needs of people from different ethnic groups.²³ Non-acknowledgement of cultural diversity within communities can exacerbate problems in accessing health services for women whose first language is not English. This is reflected in research that found that non-English speaking women were deterred from attending for cervical screening owing to a lack of understanding about the importance of the test, and not wanting to expose themselves to male doctors for the procedure to be undertaken.²⁴ Therefore, despite the service being available, women's rights to access a culturally sensitive service was not considered important in this instance.

Another issue related to justice is the need to evaluate existing services to ensure equity in the quality of care provided to the target population. A legal requirement under the 2001 Race Relations (Amendment) Act ²⁵ is that the standard of care provided to people from minority ethnic groups is equal to that provided to the indigenous population. When establishing a service it is also necessary to take into account cultural sensitivity. In the absence of effective communication there is little hope of establishing whether the quality of care provided for Pakistani Muslim pregnant women is of the same standard as that provided to other maternity service users. However, establishing the quality of a service is often judged by the number and type of complaints received, and it is these that can influence enhancements or changes services. Owing to language barriers, Pakistani women are unlikely to use the complaints procedure effectively.⁷ It is therefore difficult to ascertain whether they are being treated equally and therefore justly. Gillon 2 discusses justice in

relation to both the rights of people to access health services and also the fair distribution of these services. However, he does not acknowledge the need for cultural sensitivity in relation to these services and the fact that culturally insensitive services do not respect the principle of justice

Discussion

Owing to language and cultural barriers midwives in Bradford have difficulty in providing ethically appropriate care to Pakistani Muslim women who may be of a different ethnic and cultural background to themselves. We have highlighted the difficulties in applying Gillon's model of health care ethics in this context. We will now explore how these key concerns can be addressed.

Traditionally, when communication with women has been problematic in the health care setting, family members have been used to interpret. However, this practice is ethically questionable. As well as encouraging breaches in confidentiality, the women's autonomy is being undermined because they have no control over the message being communicated on their behalf. Untrained interpreters have been known to omit, add, condense, simplify and substitute facts.²⁶ This has a bearing on the accuracy of the information exchanged and the subsequent maternity care provision.

There has been a national push to employ bilingual staff, who, as well as providing culturally appropriate care, are expected to meet the translation needs of users of the maternity services.²⁷ Although initially this appears to be ethically more acceptable, these individuals tend to be untrained and do not always have the required fluency level to bridge the gap. In addition, bilingual staff with no medical knowledge may be coerced to go beyond their capabilities in some situations.²⁸ This can impact on the type and amount of information transmitted between the woman and the midwife. For effective communication, an interpreter requires an understanding of the needs of the woman and the objective of the communication. The difficulty lies in knowing whether bilingual staff have the appropriate knowledge and linguistic skills to translate beyond the simple and informal language used among family members.²⁸

The use of a professional interpreting service is one solution that has been implemented to overcome these possible problems. However, this service is limited.²⁹ It is often provided in office hours only, not taking into account the 24-hour nature of maternity care provision. In addition, there may be inadequate numbers of personnel speaking a specific language to meet the needs of women all requiring the service at the same time. It is interesting to note that some health care staff have been known to criticize the provision of these services from an ethical perspective.⁷ They believe that the use of interpreters is unjust to English-speaking service users because the money used to provide the service could be diverted into other areas of health care, benefiting everyone instead of wasting scarce resources. They consider learning English as a simple moral duty for immigrants. This perspective could be viewed as paternalistic and, in reality, if we are to respect a person's autonomy then there should be no obligation that immigrants should learn to speak the majority language. Indeed, people who do attempt to speak some English have encountered hostility, racism and impatience when trying to communicate.⁷ This can destroy their confidence and their wish to speak English, regardless of their ability.

The concept of a tiered structure of language support sees the need for communication being on a continuum.²⁸ Health care and indeed maternity clients require not only obstetric-based information but also social interaction. The use of a tiered system of language support, where workers with different skills would fulfil different roles, would mean that those with basic skills could fulfil the role of enabling social engagement in the maternity context; this could include basic day to day neonatal care. Those with more sophisticated language skills could enable the transfer of more complex technical information, such as antenatal or postnatal investigations, including neonatal screening. The notions of a tiered system of language support could be viewed as a hierarchical intervention where a trained interpreter transfers the most important information. The potential for such a system to provide social support to influence the development of mutual trust and cultural understanding as a prelude to the development of a relationship is of immeasurable benefit to women and midwives.³⁰ Ledger ³¹ believes that improvements in work and job satisfaction are to be gained by those who learn a few basic terms and phrases of the majority languages and would enable basic interaction and the exchange of social pleasantries. This is supported by Cioffi,³² who identified that just being able to speak to someone has the potential to reduce clients' anxiety. In the maternity context, midwives have gained a plethora of knowledge about the types of information that women in their care require and about the types of reaction these women can potentially have to situations that arise. This provides midwives with a good foundation on which to build a potential basic stock of phrases that will enable some essential interaction to be undertaken. The potential to build unit resources, for use on a day to day basis, which could include a list of simple terms/phrases (including the phonetic pronunciation) to support all staff working in a particular area, has been recently demonstrated.³³ No such tiered language support system could be implemented without due care and attention to the provision of equal employment rights to participants wherever they are in the hierarchical language support continuum. This should include basic rights to pay, conditions of service, access to training etc. Investment in the development of such a system should eventually lead to the provision of a reliable, effective and culturally acceptable translation and interpretation service.

The Department of Health publication *Vital connections* ²⁶ has a number of goals, one of which is to achieve a health service free from stereotyping and discrimination. Considering this from a macro perspective, cultural differences need to be central to the development of health services. Such emphasis will ensure that provision is much more likely to be culturally acceptable and therefore accessed equally by diverse local populations. It is vital that service providers receive adequate training and education in cultural diversity and the health needs constituting their local population, thus ensuring justice in the provision and execution of services.

To improve maternity care provision there is a need for staff training to increase their knowledge of the cultural diversity of the women for whom they care. Midwives require greater comprehension of the cultural dichotomy between traditional birth customs and western medical management of pregnancy and childbirth in order to understand women's experiences of maternity care.³² With increased knowledge, midwives would be better equipped to respect women's autonomy, as well as able to ensure that care provision does good not harm.

Gillon's model of health care ethics² is widely used in education for health professionals as a way of encouraging them to analyse and prioritize their thoughts when ethical issues occur in clinical practice. We have demonstrated difficulties with using this 'culturally neutral' approach in this context. One such difficulty is that Pakistani Muslim women's understanding of the term autonomy differs from the western understanding. Care providers acknowledge that people from different ethnic and cultural backgrounds may understand the term in different ways and therefore when an ethical issue arises in practice it is important to imagine oneself in the client's shoes, looking at the world from their perspective and understanding that their decision-making approach may be different. This would be to work in a culturally 'non-neutral' way.

Feminist ethicists would argue that, in order to improve care for women (in this case Pakistani Muslim women) a fundamental change is required to the way in which services are structured.¹⁵ Indeed, Gurdorf¹⁶ goes so far as to say that the ethical principles that we hold as *prima facie* are appropriate only for people who hold power (or who are dominant); autonomy is then perhaps a concept only for people who are able to exercise it. Less powerful people (women, and therefore midwives) should consider other non-*prima facie* principles and values such as nurturance, mutuality, empathy, community etc. as being more important. In order to provide ethically sensitive and culturally appropriate care to women, health care professionals, including midwives need also to consider some of these values, which may aid the structuring of care to meet the needs of recipients. Indeed it appears that Gillon's model in isolation is insufficient to enable the provision of ethically sensitive and woman-centred care. In order to do this, education and training is required concerning different cultural belief systems and how these may inform individual decision making.

When using Gillon's² ethical principles as a framework there are elements that can be expanded to include the cultural context. An example is Gillon's discussion regarding respecting patients' rights in relation to not allowing disapproval of a patient's lifestyle to influence decision making regarding their care. If taking Gillon's assertion further, one could argue that the cultural context of a patient's lifestyle should be considered important in ethical decision making. It can therefore be seen that the four principles should be viewed as an outline 'sketch' rather than the completed work in relation to the provision of ethical health care. Even Childress³⁴ asserts that, rather than see the four principles as a number of rules, they should be used only as a guide. The provision of ethically sensitive care to Pakistani Muslim women is one such situation when the 'sketch' would require enhancement to include cultural 'non-neutrality'. Respect for other non-*prima facie* principles such as empathy and solidarity would be inherent.

Conclusions

Rather than remaining 'culturally neutral' when providing midwifery care to women of Pakistani Muslim origin, it is essential to be culturally sensitive to meet their needs. These women may require both language support and culturally appropriate care. To facilitate this, the use of interpreters has been discussed; however, there are limitations and counterarguments to their use. We acknowledge that training is required to prepare service providers and midwives for meeting the needs of a culturally diverse maternity population. Educational institutions must develop

curricula that meet the needs of these professionals in order that they can address the two concerns identified. Providing effective care through an interpreter has not previously been identified as being a necessity, but, in consideration of the complexities of communication through a third party, this would seem to be the conduit to assisting in the appropriate use of resources. Training in interpreter use would ensure that midwives are able to consider the cultural context within which they are providing care. This is identified as an important aspect of providing ethically appropriate care and would help to address some of the issues in practice. The fundamental issue that has come to the fore is the need for effective communication for a number of different reasons. Gillon 2 identifies this as being essential for respecting autonomy. We have identified the importance of communication in also respecting beneficence, non-maleficence and justice.

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