Reflective report on experiences working as a midwife

While I was on my first placement in semester one as a student midwife, I met many pregnant women, both within the community and in the hospital with different cultural backgrounds. For this essay which is a reflective essay, I have chosen to write about a pregnant lady and, in order to protect her confidentiality, according to the Nursing and Midwifery's Code of Conduct (NMC 2008), I will refer to her as ' Zara'. In this reflection, I am going to use Gibbs (1988) reflective cycle. This encourages a clear description of the situation, analysis of feelings, evaluation of the experience, and analysis to make sense of the experience and an action plan to examine what to be done if the situation arose again.

Description of the event:

My placement at the time was on the midwifery led unit in the hospital of my Trust, and on the day in question, I was on an early shift and, when I arrived, my mentor and I went in to Zara's room and introduced ourselves. Zara was in pain and her husband was also present in the room. My mentor tried to placate her down by talking to her but, because Zara did not understand English, she looked more worried and was looking at her husband to explain it to her. Her husband did not understand much either so my mentor suggested a translator but they refused it. We took her notes away, went in to the office and read through them so that we could plan her care according to her needs. Zara was in her early thirties and unemployed. This was her twelfth pregnancy, she has had six miscarriages, two stillbirths and three live children. All of her births were done by caesarean section including this one . This was because Zara was unable to give birth naturally due to her being a victim of female genital mutilation (FGM). They were also requesting female

only care providers and doctors due to them being Muslims. Zara had also not attended many of her antenatal appointments because according to Currer (1991) antenatal care among Muslim mothers was not seeing important they view pregnancy as a normal condition.

Prior taking Zara into the theatre to have her caesarean, my mentor explained the procedure to the husband and he translated to the wife. They signed all the relevant papers but Zara looked worried. I could tell they did not understand everything but to my surprise, they did not ask any questions, but they did not want a translator. After a while the anaesthetist came to give Zara the epidural, and it was a male. As soon as Zara's husband saw that, he placed his hand on Zara's shoulder and did not want it to let go. The staff was becoming very annoyed and frustrated because they kept telling him ' do not put your hand there, the procedure of the epidural has to be 100% sterile' but he did not understand that. I stepped in because I still remembered when I had to learn English and I knew the word choice was difficult for them and it has to be relevant to their knowledge of English. I said to Zara's husband ' no hand, bacteria, no good for Zara' and I was also demonstrated it with my hands and face. He understood and said ' ok' but I could still see that he was not comfortable. Finally the anaesthetist got the epidural in and we took Zara to theatre to deliver her baby along with her husband. When arriving to theatre, I tried to catheterise Zara but could not do it due to her genital area being completely sawn up, so the doctor had to intervene. Zara's husband was standing by her legs and the staff tried to move him to top of the bed but said that he wanted to see what we were doing to Zara and that he was going to stay there. After a long discussion

and explanations, he finally moved. Zara and baby were being monitored and by this time the baby's heart was not picking up and we had to act fast. The doctor then cut Zara's abdominal to deliver the baby but meconium was gushing out instead. I run to call the paediatrician. The baby was floppy and there were no sign of life. Zara was asking why the baby was not crying and the husband looked very worried. Reassured them and explained that, when babies are born in meconium, they will need extra care and attention. The baby was now on the resuscitaire and the doctors was doing all they could to take out the meconium from the baby's mouth and nose, and rubbing the baby to promote. After a little while, the baby started to cry and we all let a relieved breath out. I took the baby and showed it to the parents and explained that the baby had to go to special care unit to ensure that everything was fine. Zara was doing well, and after a couple hours we transferred her and her husband to the postnatal ward.

Feelings:

In this paragraph, I will discuss my feelings and thinking surrounding Zara's situation and the care she received from the medical staff. I empathized with Zara and her husband because they could not speak English, Zara endured many pregnancies and which of some had ended up in miscarriages and stillbirths and was naturally worried about the wellbeing of this baby. Because of Zara's and her husband's limited English and their cultural background, caring for them was more difficult and the medical staff was getting very impatient and irritated with them. I knew I could help both the staff and Zara and her husband. I tried to build up a good relationship with them by doing a proper introduction of myself, where I was from and to try

to put them at ease. I still remember how difficult it was being in a new country with different cultures. My first attempt was to ask if necessary, whether it will be acceptable if the doctor were male and I explained the procedure in a way they could understand, I was acting as an intermediary between them and the medical staff throughout. I did not speak their language but because I was explaining as simply as possible, they became very comfortable with me and trusted me. I really felt useful and helpful as they responded to me as I put myself in their shoes and remembered how it was when I was new in this country. According to Wold (2004) the empathetic listening is in relation to the willingness to know the other individual not just judging the person's statement. I then stood by Zara's bed and when needed, I used some facial expressions and hand gestures which could be translated to if she were still feeling pain in her tummy and if felt sensation in her legs. I was also using simple words. She looked at me and smiled and point where she could still feel. I was unsure whether to continue or not because I felt the medical staff might think I was not being professional, but according to Funnell et al, (2005) body gestures and facial expressions are referred as a non-verbal communicating. So I continued because I knew that would help Zara's family. The language and cultural barrier affected the care Zara was receiving because the staff was not communicating with them and did not appreciate that good explanation were essential for this family with their particular circumstances of limited English and understanding. During the procedure, I stayed by Zara and kept my eye contact with her because according to Wilma (1999) direct eye contact could express a sense of interest in the other person. Zara was holding my hands and I was updating her whenever she was asking for it.

Evaluation:

I feel I made the right decision to accompany Zara. Furthermore, I could develop my caring role for clients by understanding that they all will have different needs and will require different care. I think my approach with Zara and her husband was a good approach. The staff and Zara did benefit from my effort. It was also my responsibility to care for her so that she was getting the best care and understood what was done to her. I was able to improve my non-verbal communication skills in my conversation with Zara and her husband during my time with them and I know they were now getting the necessary information that they wanted and needed in this challenging situation.

According to O'Hagan (2001) issues such as cultural diversity, cultural sensitivity and cultural competence had no place in the training of care professionals. To enable this vision to be implemented, it is significant that health care professionals have the adequate educational preparation to provide culturally sensitive care to those who have a diversity of health beliefs and practices (Aziz et al. 2000). Promoting cultural awareness among health care professionals is believed to improve their confidence and skills in providing holistic care for patients with different cultural backgrounds Also, culturally sensitive attitudes and practices, rather than simple knowledge, are likely to contribute much toward achieving the ultimate goal of providing quality care to the patients and their families. (Murphy & Clark, 1993, cited Zafir 2002).

There are many implications that should be well thought-out when caring for Muslim patients.

All procedures, decisions and judgments must to be family orientated and culturally derived. Religious and cultural frameworks give the most complete and holistic perspective for caring and understanding the patient population of Muslim denomination. Practices need to take into account the care constructs of presence, participation and support. In addition, the policies and philosophies of the hospitals and other institutions needs to reflect the cultural practices related the specific care, communication and spirituality. Also, where language is a problem, it is important to have access to interpreters in order to provide culturally competent care for Muslims. Secondly, there are differences in the cultural and psychosocial forms of expression of the Muslim patients and their families and those of the caress. The process of reflection and clinical supervision could assist care givers in identifying their own cultural barriers, stereotyping, and ethnocentricity, thus, ultimately improving care. Finally, the management should continually assess whether the staff have the appropriate knowledge and skills to handle the particular ethical situations involved in caring for the patient and his/her family of Muslim denomination and, with the aim of reducing emotional labour, provide a mechanism, which would assist the staff in becoming more competent. Halligan (2005)

Zara was also a victim of FGM which is defined by the World Health Organization (WHO 2006) as procedures that involve partial or total removal of the female external genitalia and or injury to the female genital organs for cultural or any other non-therapeutic reasons. Zara had Type IV which includes pricking, incising or piercing of the external genitalia, stretching of the clitoris and or labia, cauterization by burning of the clitoris and

surrounding tissue or any other procedure that is performed to cause vaginal narrowing or tightening, and this was why she could not give birth naturally. According to the National Institute of Clinical Excellence (NICE 2008) guidelines suggest that women who have experienced FGM should be identified early in the antenatal period through sensitive enquiry. I read through Zara's note but it was not recorded that she was a victim of FGM and the special care that she needed was not given.

Analysis:

My communication skills were very important when I was providing care for Zara. I noticed that my non-verbal communication skills helped enormously while caring for Zara. She could understand a few words when I was asking her questions but the lack of language hindered good communication. As the patient was not using her first or second language, I tried to communicate in a way she could understand. I still could manage to communicate in a way the other staff members could not because they had not the knowledge how to communicate with someone that does not speak English. White (2005) recommended that a care provider should learn a few words or phrases in the predominant second language to put a patient at ease for better understanding. Although, it was quite difficult to demonstrate certain things, Zara managed to understand and she was answering me by nodding her head when she was understood and also by her body gestures and her eye movement. Zara's husband was also asking me questions that I had to make the staff aware of

According to Zafir et al (2000), Muslim patients should have a healthcare provider of the same sex. Exposure of the patient's body parts should be

limited to the minimum necessary, and permission should be asked before gently uncovering any part of the body. Even more care should be taken when exposing private parts, and attempts should be made to avoid such exposures unless absolutely necessary. Zara’s husband did ask for a female doctor but his request was declined because the ward was very busy and it was not possible. I think if this had been included her birth plan, it would have been arranged for them Zara and her husband may have felt discriminated . If communication is a problem for one or both parties in an exchange, they will have an interest in improving it In Zara’s case, the lack of time, did not permitted this. Discrimination is usually due to miscommunication however this should be lower in hospitals especially when the relationship between the medical staff and patients has been sustained for a longer period. Furthermore, the gap will be even more difficult to bridge since learning and communication are can be more costly for the hospital such as when providing a translator. Balsa et al (2003)

Conclusion:

Writing this reflection has made me aware of my approach to car for clients who have language difficulties and have a different cultural background. Zara needed a lot of support and personalised care. It was vital to deliver this baby in a good condition due to her previous stillbirths and also, it was important to recognise that Zara and her husband came form a different culture and their values and belief were different to us.

The beliefs and practices of Islamic patients may have an effect on the patient’s health care in ways that are not apparent to many health-care professionals and policy makers internationally. Intercultural misconceptions

and misunderstandings of many healthcare professionals have potential consequences. Therefore, health-care professionals need to be better equipped to meet the needs of their patients and Interpreter should always be available when knowing the patient does not understand. Halligan (2005).

Action Plan:

My plan for my future role as a midwife, if I ever come across a client like Zara who was not speaking English, had dramatic birth experience and had different cultural background, I would know how to deal with it. I would prepare my self better, I would try to learn some word in her language and doing some reading regarding her culture and write down her expectations. I know that communication is a very important part to build up a good relationship. According to Payne (2007) communication and information provision play key roles in determining whether people engage in recommended health behaviors and whether the behaviors have a positive outcome. Health communicators may want to achieve any of a number of goals, including providing information, instruction or reassurance, influencing opinions and attitudes, and changing behavior. So an excellent communication is necessary in order to identify the patient’s wellbeing. I should not pre-judge my client by first assumption and impressions but I have to make her feel appreciated as an individual. I have also learned the importance of listening because when I was listening to Zara, I was watching her gestures as the same time, even though I did not understand when she was talking, I could read her gestures. I should also able to respect their basic principles, beliefs, culture and individual means of communication.

In conclusion:

I have used Gibbs (1998) Reflective Cycle as my support for this essay and I was able to discuss every stage in the Gibbs (1998) Reflective Cycle.

REFRENCES:

Ana I. Balsa a, Thomas G. McGuireb. (2003). Prejudice, clinical uncertainty and stereotyping. Journal of Health Economics. 22, 89-116.

Aziz S. & Abdul R. G. (2000). Caring for Muslim Patients. Radcliffe Medical Press Limited, Oxford.

Currer, C (1991). Understanding the mother’s viewpoint. Buckingham, Open University Press.

Funnel, R Koutoukidis, G and Lawrence, K (2005) Tabbner’s Nursing Care 4E: Theory& Practice, Australia: Churchill Livingstone.

Gibbs G. (1988). Learning by Doing: A Guide to Teaching and Learning Methods. Oxford Further Education Unit, Oxford Polytechnic.

Halligan, Phil, (July 2005) Caring for patients of Islamic denomination School of Nursing & Midwifery and Health Sciences, College of Life Sciences, University College Dublin

National Institute for Health and Clinical Excellence (NICE, August, 2008) FGM, F

Nursing & Midwifery Council (2008) the Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives

O'Hagan, Kieran. (2001). Cultural competence in the caring professions. London: Jessica Kingsley Publisher

Payne, S (2007) Psychology for Nurses and the Caring Professions 3rd Ed. McGraw-Hill

White, L (2005) Foundation of Basic Nursing 2nd ed. USA: Thomson Delmar Learning.

Wilma M. C. M. – Kerkstra, Ada – Bensing, Jozien M, Caris-Verhallen. (1999) Non-verbal behavior in nurse-elderly patient communication. Journal of Advanced Nursing 29(4), 808-818

Wold, G. H. (2005) Foundation of Basic Nursing. 3rd ed. USA: Mosby.

World Health organization (WHO2006) New study shows female genital mutilation exposes women and babies to significant risk at childbirth, Published in The Lancet

Zafir al-Shahri. (2002). Culturally Sensitive Caring, Journal of Transcultural Nursing. 13, 133.