

Institutional Policies, Values and Practices that Guide Health Care Providers
in the Provision of Patient and Family Centered and Culturally Safe
Reproductive Health Care to Women from Somalia

Robin Ann Narruhn

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Reading Committee:

Marcia Killien Chair

Michelle Andrasik

Bonnie Duran

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Robin Ann Narruhn

University of Washington

Abstract

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Chair of the Supervisory Committee:

Marcia Killien PhD

Family & Child Nursing

The purpose of this study was to identify the policies, values and practices in a major medical center regarding the Patient and Family Centered and Culturally Safe reproductive care for women from Somalia. The aims were to identify the policies, values and practices as well as limitations and recommendations that informed care from the perspective of administrators. The design was a single case study. Data sources were interviews and institutional documents. Content analysis and Atlas.ti were used to analyze the data. The major findings were that while Patient and Family Centered Care were endorsed and valued by the institution it did not sufficiently assist health care providers in navigating a conflicted multicultural clinical encounter. Limitations included lack of early engagement and specific policy to guide providers in this specific scenario, a gap in policy regarding the cultural care of individuals and communities, the emergent nature of the scenario, assumptions and dominance of the biomedical culture. Recommendations included pragmatic strategies to manage the emergent nature of this scenario and paradigm changing recommendations. The culture of biomedicine was acknowledged as having influence on this clinical scenario. Conflicting cultural values may contribute to emotional and moral distress in health care providers. Health care providers may be better able to navigate this complex encounter if there are specific policies, practices and trainings designed to assist them.

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DEDICATION

FOR MY FATHER, ROBERT AND DAUGHTER, MAIANA

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Chapter 1: Introduction

My social location

I have learned in my life that transparency is nearly always better than obscurity. It is with this in mind that I reveal my social location here. This research came out of a critical event in my career as a high risk labor and delivery nurse that eventually led to a malpractice suit. My role in that case was as a primary nurse, witness and detailed scribe of the event. Although my role as a technically proficient high risk labor and delivery nurse was not in dispute, privately, I wondered what I, we (the patient's obstetrical team) could have done better. The outcome was a tragically, neurologically impaired Somali infant and while I believe that, using a biomedical framework of care, there was nothing we should have done differently, I knew that if we had evaluated our care using a socially just paradigm, we would have been found to be lacking.

When I started my research I wanted to ask health care providers about their experiences, thoughts, beliefs and strategies regarding the specific scenario of providing reproductive care to a woman from Somalia. I aspire to provide care that is both patient and family centered as well as culturally safe and I wondered what strategies and limitations existed to this specific type of reproductive care from the providers' point of view. I encountered difficulties in recruiting physicians despite my outreach by attempting to contact physicians who were in leadership positions and the use of flyers and brief presentations at didactic meetings. My attempts were unsuccessful. My research necessarily changed the approach to the perspective of administrators. I believe that our preponderance of power, privilege and agency, as well as our obligation to be accountable in the face of unjust outcomes must compel us to understand and mitigate injustice.

I have considered my privileged social location as a person who works in health care and I consider it critical to exercise my agency to address my accountability. If I have appeared critical at times it is because I hold us all to a high level of accountability. From the patient's perspective, it is devastating to have an adverse outcome, and it is salt to a wound to believe your health care providers did not care. It is with this in mind that I have pursued this research: in the hopes of improving outcomes for this Somali immigrant community: teaching clinicians how to keep the inherent humanity in health care despite an objective rationale paradigm and to proceed always in the spirit of compassion and social justice.

Context

The purpose of this background section on the Somali diaspora and the perspective of health care providers are to give the reader an idea of the different context and cultures the primary stakeholders in this clinical encounter have experienced. A hypothetical and prototypical case study is provided so that the reader can imagine how vastly diverse the perspectives are of the health care and provider. The theoretical background is the theory of Patient and Family Centered Care and Cultural Safety which are frameworks I have imposed on this study in my attempt to understand the successes, limitations and strategies in the provision of socially just reproductive care for this community. A prototypical case study will illustrate the scenario many health care providers find difficult to navigate. This case study was read to every participant at the commencement of the interview so that a common understanding of the clinical scenario could be established.

Case Study The fictitious case is a 26-year-old pregnant woman, Amina, of Somali descent. Amina is a refugee, most recently from Dadaab, a refugee camp in Kenya, where she lived for the previous 5 years. This is her third pregnancy. Her first child is 7 years old and was born by vaginal delivery in Somalia and now resides in Seattle with his mother. Her second pregnancy was a miscarriage in Dadaab refugee camp 3 years ago. Amina is pleased with this pregnancy. She lives with her aunt and a cousin who has two children. The father of the baby is involved, though currently out of state. Amina states that he is working and she expects him to return in the near future. Although Amina speaks some English, a certified interpreter is used for her prenatal visits and childbirth hospitalization. Amina is seeing a midwife because she has heard that midwives give the mother more time to labor without intervening. Her gestational age is 41 weeks and 4 days. Postdatism (pregnancy going past 41 weeks of gestation, which leads to an aging placenta and at times fetal hypoxia) is common in this community (Johnson, Reed, Hitti & Batra, 2005). Her cervix on admit, 11 a.m., was 2 cm, 50% effaced, and -2 station. It is well known by the health care staff that many members of the Somali community have a profound fear of cesarean delivery (C-delivery) possibly due to the high maternal mortality rate in Somalia (Brown, Carroll, Fogarty, et al. 2010; Ameresekere, Borg, Frederick, et al. 2011; Borkan, 2010) and beliefs about decreased fertility after a C delivery, which have been empirically confirmed (Salem, Flynn, Weaver, et al, 2011). Additionally, many members of this community believe that the residents are merely practicing or gaining financial incentives when they recommend a cesarean birth (Turnbull 2006). Amina has been in latent labor for 6 hours. Her cervix is 4 cm, fully effaced, and -1 station. Her contractions are every 2–5 min, spontaneous, and of moderate strength. It is now 5 p.m. The external fetal monitoring (EFM) indicates a fetal heart rate (FHR) baseline of 130, with minimal long-term variability and the FHR now indicates late decelerations, which were intermittent are now becoming more frequent. The midwife has requested an obstetrical consult in view of the increasing signs of fetal distress. Obstetricians are obligated by their training to recommend a C-delivery when one is indicated—even if it is likely that a recommendation for a cesarean delivery will be met with dismay or outright refusal. The obstetrical resident on staff makes the recommendation accordingly, and Amina is visibly upset. She declines a C-delivery saying that she needs more time to labor. She begins to pray out loud in Somali as the FHR continues its decelerations (Naruhn & Schellenberg, 2013).

Background of the Somali Diaspora

Since the early 1990s, due to the civil war in Somalia, an increasing number of Somali refugees have relocated to the United States. Many refugees are of childbearing age and are experiencing childbirth in the unfamiliarity of Western biomedical settings. A body of scholarly literature describes the experiences, reproductive inequities, challenges and perspectives of the Somali women receiving health care in Western biomedical systems. The research indicates health care providers are challenged to provide reproductive care that is patient centered and culturally safe for this population (Ameresekere, Borg, Frederick, Vragovic, Saia, & Raj; 2011, Borkan, 2010, Brown, Carroll, Fogarty, & Holt, 2010; Carroll, Epstein, Fiscella, Gipson, Volpe, & Jean-Pierre, 2007; Degni, Suominen, Essén, El Ansari, & Vehviläinen-Julkunen, 2012; Essén, Binder, & Johnsdotter, 2011; Hill, Hunt, & Hyrkäs 2012; Pavlish, Noor, & Brandt, 2010). For example, such challenges manifest when women from Somalia decline interventions prescribed by health care providers such as induction of labor or cesarean delivery and can be particularly perplexing and distressing to the health care provider if there is suspicion of fetal distress leading to the recommendation of expedited delivery by cesarean delivery.

Chapter 2: Review of Literature

Women from Somalia's Perspective of Childbirth in Western Settings

Beginning in the mid-1990s a body of qualitative literature has been produced that describes how many women from Somalia experience childbirth, health care or reproductive care in Western settings. The methodologies in these studies are focus groups and interviews and the researchers are primarily non-Somalis who are academics or clinicians native to the countries in which the research takes place. The studies come from diverse locales including Norway, England, Sweden, Canada and several areas in the United States. The chronological range is from 1995 to 2015. The research questions explore how Somali women perceive their health care experiences and what they would like to see in favorable health care settings and providers.

One of the first qualitative studies using focus groups and interviews was published in 1995 and was conducted in San Diego. The findings led to the conclusion that while Somali women were in general pleased with their prenatal care, they wanted gender concordant providers who were familiar with the obstetrical care of women with a female circumcision and who were conservative in their recommendations regarding cesarean deliveries (Beine, Fullerton, Palinkas, Anders 1995).

In 2000, researchers found that Somali couples believed that Swedish customary childbirth practices contributed to a sense that gender norms were being changed by different expectations in this setting (Wiklund, Aden, Hogberg, Wikman, Dahlgren, 2000). For example, in Somalia it is not customary for men to attend births, however, in Sweden there was some pressure for men to remain at the bedside of their birthing partner: traditionally only women and birth attendants provided support to laboring women. Davies and Bath (2001) used focus groups and interviews in the UK and found that Somali women expressed a need for further information about maternity services and recommend an assessment of the level of unmet information need among this community. These participants felt that information may have been withheld based on racial bias on behalf of health care providers and nurses. Swedish researchers found that women from Somalia maintained their culturally specific childbirth survival strategies due to their concerns about high maternal mortality rates in Somalia and were unlikely to change them if health care providers are unaware of their motives for keeping these practices (Essén, Johnsdotter, Hovelius, Gudmundsson, Sjoberg, Friedman, & Ostergren, 2000).

Chalmers and Hashi conducted a similar study in 2002, using focus groups and interviews in Canada and discovered that Somali women were unhappy with their care and wanted fewer interventions and more respectful and culturally congruent care. These women reported being touched roughly during childbirth by hospital staff, insufficient knowledge about the care of a woman with a female circumcision, perceptions that staff thought they were lazy and reluctant to participate and the belief that health care providers preferred to perform a cesarean delivery rather than a vaginal birth (Chalmers and Hashi 2002). Somali women expressed a fear of cesarean birth, the perception of discrimination by nurses and health care providers, dissatisfaction with high cesarean delivery rates and lower utilization of available services.

In 2004, researchers used focus groups to determine how Somali women in Minnesota experienced childbirth and found that participants reported racial stereotyping, apprehension of cesarean births, and concern about the competence of medical interpreters. These participants also wanted more health information, and help with appointments by reminder calls, transportation and childcare assistance (Herrel, Olevitch, DuBois, Terry, Thorp, Kind, et al. 2004).

Interviews were used to explore how Somali women defined favorable reproductive care in New York (Carroll, Epstein, Fiscella, Gipson, Volpe, Jean-Pierre, 2007). The characteristics identified as favorable were effective verbal and nonverbal communication, feeling valued and understood, gender concordance in providers and interpreters and sensitivity to privacy for gynecologic concerns. Adequate transportation and community based programs were also identified as being necessary for favorable care.

Upvall, Mohammed, and Dodge (2009) sought the perspectives of a marginalized group from Somalia –the Somali Bantu refugees who were residing in Pennsylvania -to explore their healthcare perspectives. Using focus groups and interviews these researchers discovered that Bantu women wanted health care providers to shift the focus away from female circumcisions, develop skills in working with interpreters, facilitate trust and understand the contextual and situational life challenges this population has experienced. Female circumcision is often viewed with a Western feminist lens or exoticized with little contextual or cultural understanding.

A study conducted in Minnesota, Pavlish, Noor, and Brandt, (2010) used community-based focus groups and key informants to identify Somali women's experiences of health care. This study identified a foundational difference in Somali women and health care providers' health beliefs that were widely

divergent. Somali women ascribed contextual factors and situational life experiences as important to health and an expectation that providers view health holistically, however; health care in the United States privileges physical health over social and mental health which contributes to discrepant expectations. Findings suggest that there was little time in these settings to clarify or negotiate divergent explanatory models. These researchers recommend awareness of divergent explanatory models and patient centered care.

In Rochester, New York, researchers explored resistance to common obstetrical procedures by Somali women and found that there is a perception that health care providers rush labor and recommend inductions of labor and cesarean deliveries too rapidly and frequently (Brown, Carroll, Fogarty, and Holt 2010). These participants also expressed a profound fear of cesarean births due to fears of death. These researchers recommended that health care providers' address the fears Somali women have about interventions, and promote collaborative community based education programs.

Ameresekere, Borg, Frederickc, Vragovic, Saiad and Raje (2011) conducted interviews with 23 Somali women in Boston to explore their perceptions about cesarean delivery and found that women avoided surgical delivery because of fears about mortality and morbidity. Ameresekere et al. cite studies that indicate providers do not know how to assist birth in women who have a female circumcision thereby contributing to higher cesarean delivery rates in Somali women. All of the participants in this study had female circumcision. These participants felt that labor was rushed and that there was a need for better communication between provider and patient (Ameresekere et al. 2011).

In Minnesota, Missal, Clark and Kovaleva (2015) interviewed 12 Somali mothers and found that Somali mothers want a more relational ontology with their nurses (and presumably their reproductive care providers). These researchers stated, "Culturally competent nursing care depends as much on the nurse's willingness to build a relationship as on the nurse's expertise" (Missal, et al., 2015, p.6). A trusting relationship between nurses/ health care providers with Somali women is important to this community and consistent with other studies.

The profound fear and abhorrence that the Somali community has for cesarean delivery is related to the belief that cesarean delivery may lead to maternal death (Ameresekere et al., 2011; Brown et al., 2010, Missal et al. 2015) a rational belief given that the maternal morbidity rate in Somalia is one of the

highest in the world. The surgical procedure of cesarean delivery is a foreign concept and is not cultural norm for women from Somalia. One in twelve women from Somalia dies from a pregnancy related cause and one in ten children from Somalia dies before their first birthday (UNICEF, 2012). The following facts illustrate why women from Somalia have different perceptions about cesarean delivery than women from the United States. The maternal mortality ratio is: 1,200 per 100,000 the under-five mortality rate UMR: 180 per 1000 live births and the infant mortality rate is 109 per 1000 live births (UNICEF, 2012). Understanding the context that Somali women come from assists the health care provider in understanding the perspective of Somali women.

There are several common themes that run through these research findings and are consistent through geographical and chronological diversity. At the structural level Somali women want assistance with transportation, childcare and reminder calls. Many participants voiced a desire to have more health information and interpretation that was accurate and confidential. Several articles found that Somali women would like providers to shift the focus away from female circumcision while developing competency in the management of childbirth of a woman who has a female circumcision. Participants also expressed a reluctance to have a highly medicalized birth experience and voiced profound fears about cesarean births. Somali women talked about wanting to have more time to progress through the birth process. These are all structural factors that seemingly present ideas for health care provider cultural education interventions that could be implemented with the investment of time, money and will.

In addition to the qualitative literature on the perspective of Somali women regarding childbirth there are several articles documenting the disparate reproductive outcomes in this community that reveal inequities . There are a number of reproductive disparities in the Somali community including a higher cesarean delivery rate, pregnancies that lasted longer (i.e. up to 42+ weeks) and increased neonatal complications (Johnson, Reed, Hitti, & Batra, 2005; Small, Gagnon, Gissler, Zeitlin, Bennis, Glazier, et al. 2008; Salem, Flynn, Weaver & Brost, 2010). These disparities are particularly problematic because the disparities are in the area of increased cesarean delivery rates and decreased fertility; both highly problematic for many Somali community members. Fertility rates were found to be lower for Somali women who had a cesarean delivery than Somali women who had a vaginal birth (Salem, Flynn Weaver & Brost, 2011). "The incidence rate of a delivery after a vaginal delivery was 3.3% (CI: 0-7.8%), 55.4%

(CI: 40.1-66.8%) and 74.4% (CI: 59.0-84.0%) at 1, 2 and 3 years. Cesarean delivery lead to a second delivery incidence rate of 2.9 % (95%CI: 0-8.2%), 25.9 % (95%CI: 9.8-39.2%) and 58.1% (95%CI: 27.0-72.2%) at 1, 2 and 3 years. Somali women delivering vaginally were 1.56 times (95% CI: 0.94-2.57; P = 0.084) more likely to have a subsequent delivery. The likelihood of Somali women having a second child after cesarean delivery is lower at 2 and 3 year follow-up. (Salem et al, 2011, p.494).

Table 1 Somali Reproductive Disparities in Western Settings

Geographical Area	Washington State 579 pregnancies of Somali women compared to 2834 white and 2435 black women in Washington State using birth records	6 Post-Migration Host Countries Meta-analysis of Regional Perinatal Data Bases, compared Somali women immigrants with receiving country born women
Gestational Age Disparities	9 times more likely to deliver after 42 weeks	Less likely to give preterm birth (Pooled OR 0.72 95% CI 0.64-0.81)
Cesarean Delivery Rate Disparities	First time Somali mothers were more likely to have a cesarean delivery than white or black control mothers (OR 0.61 95% CI 1.4-2.8) respectively. More cesarean delivery indicated by fetal distress and failed induction of labor	Excess of cesarean births, particularly in first births. (Pooled OR 1.41 95% CI 1.25-1.91)
Neonatal Disparities	Newborns of Somali mothers were at increased risk for prolonged hospitalization, lower 5 minute Apgar scores, assisted ventilation and meconium aspiration	Excess of stillbirths (Pooled OR 1.86 CI 95% 1.38-2.51)
Citation	Johnson, E.B., Reed, S.D., Hitti, J., & Batra, M. (2005). Increased risk of adverse pregnancy outcome among Somali immigrants in Washington State. <i>American Journal of Obstetrics and Gynecology</i> , 193 (2), 475-482. doi:10.1016/j.ajog.2004.12.003	Small, R., Gagnon, A., Gissler, M., Zeitlin, J., Bennis, M., Glazier, R., & ... Vangen, S. (2008). Somali women and their pregnancy outcomes postmigration: data from six receiving countries. <i>BJOG: An International Journal of Obstetrics & Gynaecology</i> , 115(13), 1630- 1640.

Somali Values. Somali immigrant values, like any community, vary widely. Women from Somalia tend to value a contextualized, holistic and a faith driven epistemology (Pavlish Noor & Brandt, 2010). In general, Somali cultural values tend to be egalitarian and communitarian. Somali cultural values include loyalty, tradition, inter-dependence, relationships, pride, religious faith (Islam), generosity and respect for the elderly (Castel & Kurata, 2004). Ninety nine percent of people in Somalia are Muslim (Pew Research Center, 2012) and most Somali immigrants continue to practice their faith after migrating. The highest authority is the monotheistic god and faith is expressed in the prevalent sense of fatalism regarding destiny, loss and life in general (Castel & Kurata, 2004). Fatalism in part is an expression of faith and is

reflected in the often-heard phrase “Inshallah”, meaning “God Willing” (Oxford Dictionaries). This fatalism and expression “Inshallah” expresses the belief that life and death are in the hands of God. To accept God’s will is a demonstration of profound faith. An adherent of Islam is taught to remain hopeful, even when one is faced with a very stressful life situation as God’s mercy is always present and sufficient. Family is considered one of the most important aspects of life and is a source of security (Castel & Kurata, 2004; Dybdahl & Hundeide, 1998). A strong Somali cultural value is to have many children. For many women from Somalia it is highly important to continue having children throughout their child-bearing years (Malin & Gissler, 2009; Small et al., 2008). Wojnar explains,

One report about birth and infant mortality rates in Somalia (Omar et al, 1994) suggests that over 65% of women over the age of 45 years had six or more births, 33% had at least one miscarriage, and 20% had at least one stillbirth, while 80% of Somali women have experienced the death of at least one child (Omar et al., 1994). In spite the high neonatal mortality rates women in Wojnar’s (2011) study talked about losing their children in pregnancy, childbirth, and infancy calmly explaining that miscarriage, fetal demise, and neonatal death are the will of God. One woman explained: “Children are gift from Allah and Allah can take them if he wishes.” Hence, Somali women typically deal with the loss of a child with stoicism and deep faith that the child is in a better place and that they, as a mother, will be rewarded with more happiness for enduring the pain of losing a child.

(Wojnar & Narruhn in press). Processes that interrupt a woman’s ability to have many children (such as a cesarean section) may bring a great sense of loss to the individual. Clearly then, there is a high regard for children in the Somali culture, making the declination of obstetrical interventions a rational approach if it is believed that the interventions might limit future childbearing. The scenario in which a woman from Somalia would decline a recommended obstetrical intervention such as a cesarean delivery (especially in the situation of fetal distress) is however, bewildering to many Western trained health care providers, who using an ethnocentric view, prioritize the patients in front of them – in this case the woman and her current fetus. This conflict may arise from the unacknowledged divergence of values, beliefs and expectations. These differences in values are often unacknowledged causing cultural conflict and providing little incentive to resolve assumptions and promote understanding.

Most Somali people (99.8%) are Sunni Muslim and faith has a much more central place in life than is typical in the United States (Lewis, 2009). In a study conducted in the United States, Hasnain Connell, Menon & Tranmer, (2011) found that 83.3% of health care providers reported difficulties providing care for Muslim women and 93.8% of Muslim women reported that health care providers did not

understand their religious/cultural needs. These researchers recommended a flexible and collaborative care model that respects and accommodates the needs of patients, provides opportunities for training providers and educating patients, and makes necessary adjustments in the healthcare system in order to provide culturally appropriate, patient-centered healthcare for Muslim individuals in the United States and other Western countries.

At an abstract level Somali women want health care providers to be cognizant of situational and contextual life experiences of Somali refugees. Many participants voiced a perception of discrimination. Xenophobia in the form of Islamophobia is more prevalent in a post 9-11 society (Byng, 2008). Time for the relational aspects of care-giving and the development of trust were identified as favorable characteristics in health care settings. The perception of discrimination and desire to develop trust and rapport and the promotion of understanding of situational and contextual factors requires some political will and a systems approach, to accomplish. These findings taken as a whole suggest that women from Somalia have identified several areas in which health care can be made more accessible and culturally appropriate. The review of these articles demonstrates some of the disparities and concerns women from Somalia have voiced and provides context for the clinical scenario encountered by many health care providers.

Health Care Provider's Perspective on Providing Reproductive Care to Women from Somalia

There are fewer research studies describing the health care provider's perspectives. One study examined the perspectives of health care providers when working with culturally diverse individuals by conducting focus groups (Kai, Beavan, Faull, Dodson, Gill, & Beighton, 2007). In this study it was found that health care providers experienced apprehension and uncertainty when working with culturally diverse individuals and that this contributed to inertia in regards to innovative solutions to health care concerns (Kai, et al., 2007). Another study in Canada, aimed to understand the challenges health care professionals experienced and how it affected the delivery of care to immigrant women including but not limited to Somali women (Ng & Newbold, 2011). These researchers found that language barriers and maintenance of confidentiality when using interpreters were concerns, as well as providing gender concordant health care providers. The unacknowledged cultural beliefs of immigrant women also made provision of care complicated. For immigrant women who did not have experience with medicalized

childbirth, the weekly prenatal visits and the technology were often seen as a stressor (Ng & Newbold, 2011). Health care providers expressed frustration with the common practice of late entry into prenatal care because of the difficulty in providing the indicated screening and interventions in the first trimester (Ng & Newbold, 2011). Ng and Newbold (2011) found three main differences between provider and patient expectations: the ability to have confidential and accurate translation, different expectations regarding cultural competency and knowledge of the immigrants' cultural background, and the diverging beliefs about the type of prenatal care needed especially in relation to the medicalization of pregnancy and childbirth.

There are four articles that address the specific encounter between Western health care providers and women from Somalia from the providers' perspective (Degni, Suominen, Essén, El Ansari, & Vehviläinen-Julkunen, 2012; Essen, Binder & Johnsdotter, 2011; Lazar, Johnson-Agbakwu, Davis & Shipp, 2013; Pavlish et al., 2010). In Finland researchers examined the communication and cultural understanding of Finnish health care providers who provided reproductive health care to Somali women. Data collection was conducted by in depth interviews of the health care providers (Degni, et al., 2012). These researchers found that health care providers were frustrated with communication because of the general lack of professional medical interpreters and the fear that their statements were being translated inaccurately. Some health care providers expressed the view that Somali women maintain ethnocentric views about reproductive health care services which hindered the provision of care (Degni, et al., 2012). Male health care providers cited the common practice of refusing obstetrical or gynecological care by a male provider as offensive and humiliating to the health care provider (Degni, et al., 2012). The cultural practice of hugging between the same gendered Somali patient and midwife or nurse was also viewed as uncomfortable by some of the health care respondents who were not comfortable being hugged by a patient (Degni, et al. 2012). The differences in the view of time were frustrating to health care providers because women from Somalia were often late or missed appointments (Degni, et al., 2012). Providers reported the belief that midwives had improved relational aspects of care because of the consistency of care and increased social interactions that tend to occur more in the midwifery practice than obstetrical practice. Relationships with Somali women were facilitated by listening to these women describe the impact of the war, loss, and historical, religious and cultural aspects of their lives (Degni, et al., 2012).

Communication between Finnish health care providers and women from Somalia was complicated by differing cultural norms. These researchers concluded that “addressing structural barriers to care and demonstrating basic skills in patient centered communication are the bedrock upon which culturally mediated issues can be addressed” (Degni, et al., 2012, p. 341).

Essen, Binder and Johnsdotter (2011) used the anthropological concepts of emic and etic in England to understand the perspectives of women from Somalia and their reproductive health care providers. Similar to previous studies, it was found that Somali women used strategies to avoid cesarean delivery. Health care providers were aware of negative attitudes that Somali women held regarding cesarean delivery and were stressed when cesarean deliveries were declined by individuals in this community. The emic and etic beliefs differed greatly between the women from Somalia and the health care providers; with Somali women believing *declining* a cesarean delivery could save her life while health care providers believed that *accepting* the cesarean delivery could save the life of the fetus (Essen, et.al, 2011). These researchers noted that there was little motivation on behalf of either community to pursue strategies to change this dynamic.

The mistrust and resistance many women from Somalia have regarding the reproductive health care system and medical interventions was reported as contributing to frustration and disappointment in health care providers as well as “sadness/indignation about Somalis' negative perceptions of provider intentions” (Lazar, Johnson-Agbakwu, Davis & Shipp, 2013, p. 8). The frustration health providers feel regarding resistance to obstetrical interventions may contribute to the difficulties in provider patient communication and adversely affect perceived access to care (Lazar et al., 2013).

Divergent Beliefs, Values and Cultures

Research has indicated that health care providers and Somali individuals have divergent beliefs and values about health, health care and reproduction. Using a social action research design with focus groups and interviews to study the beliefs and expectations of health care providers and patients, Pavlish, Noor and Brandt (2010) found that health care providers used a biomedical model whereas Somali women used a contextualized and holistic framework to view health. Pavlish et al. explained that women from Somalia viewed health in a holistic and highly contextualized, communitarian manner while the biomedical health care providers viewed health as biologically mediated and individually based. Somali

women ascribed contextual factors and situational life experiences as important to health and had an expectation that providers view health holistically. In the United States the dominant culture tends to privilege physical health over social and mental health, which contributes to discrepant expectations. Health care providers and Somali women have highly divergent perspectives that may contribute to misunderstandings and opposing expectations (Pavlish et al., 2010). Many women from Somalia also wished to develop relational aspects with their health care providers as was customary in Somalia; these views conflicted with the time constraints and market driven practices of the US health care system (Pavlish et al., 2010). Findings suggested that there was little time in these settings to clarify or negotiate divergent explanatory models. The divergent beliefs the Somali community and biomedical community have regarding appropriate reproductive health care practices are contrary, this in turn influence the expectations of the encounter. These discordant beliefs lead to misunderstandings and divergent expectations regarding prescribed treatments for reproductive care (Pavlish et al., 2010). These researchers recommended awareness of divergent explanatory models and patient centered care as steps toward the navigation of a mutually agreed upon plan of care (Pavlish et al., 2010).

Idealized design of perinatal care

The idealized model of perinatal health care is a model that illustrates the needed components in a model of care that has the potential to be mutually satisfying to both the service provider and recipient. Health care providers are obligated to provide care in multi-cultural settings often with inadequate resources to guide them. In 2005, Cherouny, Federico, Haraden, Leavitt, Gullo and Resar published a white paper for the Institute for Healthcare Improvement on an ideal design of perinatal care. This model has eight components: a prepared and activated mother and family; the mother and family as the source of control (patient preferences); productive conversations between the mother, family, and the care team; high-functioning care teams (prepared and activated); reliable processes used to evaluate and manage labor and delivery (the perinatal care “bundles”); reliable processes to prevent, detect, and mitigate problems; an appropriate infrastructure that underlies the system of care; and a stabilized mother and baby, given into the care of an informed and ready patient care unit. In the model the source of control is clearly with the mother. The mother and the health care provider have productive conversations and both the mother and the health care team is activated in the preparation of childbirth. The health care team is

supported by reliable process and appropriate infrastructure. This design works well with the perspectives of Patient and Family Centered Care and Cultural Safety. This research examines the policies, values, practices, limitations and recommendations that influence provider's ability to be prepared and activated as noted in this model.

The research problem

Clearly, there is a need to assist health care providers in the navigation of this complex clinical scenario; however there is little literature to guide HCPs in navigating this clinical scenario. Essén et al. (2011) explains...

The paucity of advice available to practitioners might be due to the likelihood that qualitative research in this area is in need of much attention. How should the maternal care provider respond to this special situation when a woman has a valid perspective of apprehension based on fear and refuses the treatment, which is, conversely, the treatment most likely to prevent the adverse outcome she fears? (p. 51).

Research exploring the context of care and the perspective of HCPs may inform policy and practice in clinical settings.

Institutional policies, values and practices

Institutional policies, values and practices guide health care providers in the provision of patient and family centered culturally safe provision of health care; however, there is inadequate information on how systems level processes facilitate or impede patient centered and culturally safe care. Patient Centered Care research is supported by Patient Centered Outcomes Research Institute (PCORI) and is funded by the Patient Protection and Affordable Care Act (PPACA) of 2010 to fulfill the mission to facilitate patient centered care by funding and promoting comparative clinical effectiveness. PCORI drafted the new "National Priorities for Research and Research Agenda" in 2012. There are five main research areas:

1. Assessment of Prevention, Diagnosis, and Treatment Options.
2. Improving Healthcare Systems.
3. Communication and Dissemination.
4. Addressing Disparities.
5. Accelerating Patient-Centered and Methodological Research.

Health care systems can be improved when the facilitators and barriers to delivering a specific type of care are identified. Reproductive disparities are well documented in the Somali community (Johnson, Reed, Hitti, & Batra, 2005; Small, Gagnon, Gissler, Zeitlin, Bennis, Glazier, et al. 2008; Salem, Flynn, Weaver, & Brost, 2011). Improving health care services may facilitate access to prenatal care and presumably decrease the occurrence of disparate outcomes. Understanding the impact of culture-clashes is important for achieving this goal (Camphina–Bacote, 2011, Saha et al., 2008).

Culture can be thought of as a common set of beliefs, practices and values of members of a group. An important distinction to be made is the difference between values and beliefs. A belief is “the mental act, condition, or habit of placing trust or confidence in another, a mental acceptance of and conviction in the truth, actuality, or validity of something: or something believed or accepted as true, especially a particular tenet or a body of tenets accepted by a group of persons” (American Heritage Dictionary). A value (as applied to this context) is defined as “a principle, standard, or quality considered worthwhile or desirable” (American Heritage Dictionary). Values are neither right nor wrong -they are simply principles that are considered desirable.

Defining beliefs and values is difficult but essential; in order to provide patient centered care it is necessary for health care providers to understand the patient's values. In addition, an understanding of one's own personal and professional values as a health care provider is required in order to avoid potential phenomena such as miscommunication, cultural misunderstandings, and moral or emotional distress in health care providers. Emphasizing similarities in values, beliefs and aims may assist in finding common ground. Unacknowledged differences in beliefs and values make it difficult to provide patient centered and culturally safe reproductive care and to find a mutually satisfying plan of care. When values between health care providers and patients are in conflict there is nearly always an element of cultural difference according to Camphina–Bacote (2011). Camphina–Bacote maintains that the values of the health care provider need not be abandoned in the clinical encounter and that both the values of the provider and patient can be respected and negotiated using cultural sensitivity skills while using a patient and family centered approach.

Research from Europe and North America demonstrates there are communication difficulties in the encounter between members of the health care system and the Somali community and suggests that

patient and family centered, culturally safe care may help the Somali community. However; the question remains: What guidance is there for health care providers? Health care providers are highly trained experts in Western biomedicine, but divergent cultural values and beliefs in the health care system can be difficult to navigate, especially when fundamental concerns such as life and death are at stake. What are the resources available to health care providers to navigate this encounter in a patient and family centered, culturally safe way? The goal of this study is to identify the existing values, practices and policies of one academic medical institution, as well as identify the limitations and suggested recommendations that can guide health care providers in the provision of Patient and Family Centered, Culturally Safe reproductive care for women from Somalia.

Theoretical perspectives

Health care quality can be improved for patients and communities by the use of patient and family centered care and culturally competent care that share several characteristics (Saha, Beach & Cooper, 2008). The theoretical frameworks for this research are Patient Centered Care and Cultural Safety.

Patient and family centered care. The basic premises of Patient and Family Centered Care (PFCC) are dignity and respect, information sharing, participation, and collaboration. PFCC is a practice that has been defined by the Institute of Medicine (IOM, 2001) as, "Health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care)." PFCC arose out of the growing recognition that involving patients in their care and decision-making led to better outcomes and patient satisfaction. PFCC can be thought of as occurring when the "physician tries to enter the patient's world to see the illness through the patient's eyes" (McWhinney as cited in Saha et al., 2008). The use of PFCC facilitates patient involvement and individualized care (Robinson, Callister, Berry, & Dearing, 2008). The core components of patient centered care are a welcoming environment, respect for patients' values and expressed needs, patient empowerment, socio-cultural competence, coordination and integration of care, comfort and support, access and navigation skills and community outreach (Silow-Carroll, Alteras, & Stepnick, 2006). The most challenging aspect of PFCC as explained by Berwick (2009) is the accepted degree of patient autonomy. The controversy has been framed as a contest between professionalism wherein the physician has decision-making capacity by virtue of their expertise and consumerism wherein the customer (or patient) is always right (Berwick, 2009). Berwick (2009, p. 560) takes a critical stance and defines PFCC as follows.

The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care.

Furthermore, Berwick (2009) states that evidence based medicine should take a back seat in relation to PFCC. Berwick explains that the physician should say when he/she disagrees with the patient in order to provide full consent but ultimately the power in decision-making should be with the patient. It seems that the praxis of PFCC must be variable given the controversy around its definition.

In 2001 the Institute of Medicine released a benchmark report, “Crossing the Quality Chasm” and one of the six foundational aims was to implement Patient Centered Care (six aims for improving health care: i.e., making healthcare more safe, effective, patient-centered, timely, efficient, and equitable). The ten rules to guide the health care reform included:

1. Care based on continuous healing relationships.
2. Customization based on patient needs and values.
3. The patient as the source of control.
4. Shared knowledge and the free-flow of information.
5. Evidence-based decision-making.
6. Safety as a system property.
7. The need for transparency.
8. Anticipation of needs.
9. Continuous decrease in waste.
10. Cooperation among clinicians.

(Committee on Quality of Health Care in America, 2001).

The rules that are most relevant to this research are numbers 1, 2, 3 and 10.

Similar to the health care reform rules by the Committee on Quality of Health Care in America (2001) The Joint Commission (2014) released, “Advancing Effective Communication, Cultural Competence, and Patient-and Family-Centered Care; A Roadmap for Hospitals” in order to advance the issues of effective communication, cultural competence, and patient- and family-centered care. This document contains a “Checklist to Improve Effective Communication, Cultural Competence, and Patient-and Family-Centered Care across the Care Continuum” which can be found on page 5 and 6 at the following URL <http://www.jointcommission.org/assets/1/6/roadmapforhospitalsfinalversion727.pdf> (Joint Commission, 2014) Many of these recommendations are relevant to this research. The Committee on Quality of Health Care in America (2001) and Joint Commission Report of 2014 both call for patient centered care. Patient and Family Centered Care address the personal values of the patient and family. This case scenario is confounded by divergent cultural values which call for examination of cultural theory that may assist in navigating the scenario.

Cultural theory. The operationalization of cultural competency In the United States has been attempted through “Culturally and Linguistic Appropriate Standards of Care” (CLAS Standards of Care) mandated through the Office of Minority Affairs (Saha et al., 2008). Communities are made up of diverse members and factions therefore cultural understandings are critical to successful community engagement (McCloskey, McDonald, Cook, Heurtin-Roberts, Updegrove, Sampson, Gutter, & Eder, 2011). Focusing

on the meanings that individuals share and on the explanatory models they use to discuss their health problems provides a richer understanding of these individuals and can yield a cultural understanding that is rooted in their real lives rather than in stereotypes. This meaning-centered approach can also help reveal how community conditions are determined by social, economic, and political forces rather than simply by individual choices (McCloskey, et al., 2011, p. 11).

There are several different approaches to culture including cultural competency, cultural humility and cultural safety. Defining and providing explanations for why a particular theoretical approach regarding culture is used is pivotal in this study because the clinical scenario between a health care system and Somali community members is confounded by differences in cultural perspectives as explained in the article by Pavlish et al. (2010) that describes how health care providers and members of the Somali community have widely divergent values and beliefs.

Cultural competency. Cultural competency is one of the earliest theories on cultural care. Cultural competence is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations (Cross, Bazron, Dennis, & Isaacs, 1989). Cultural competency efforts have traditionally been one way to address miscommunication and inequities in racial and ethnic groups, however these efforts have been criticized because they have failed to address vague definitions of cultural competency, did not have measurable outcomes, lacked accountability, interventions were considered for visible markers of difference without attention to the effects of intersectionalities, overlooked the culture of biomedicine and the effects of racism and historical trauma, and disregarded the dynamics of power (Drevdahl, Canales, & Dorcy, 2008).

Cultural competency tends to focus on the “Other” by providing a list of practices and beliefs of the exoticized culture that can be included in the plan of care. Cooney (1994) explains that the first theorist of transcultural nursing was Madeline Leininger who was noble in her intent; however, being a member of the dominant social category of whiteness, her theory reflects the perspective of a Western white person. Lo (2010) explained that cultural competency and cultural brokering efforts have been constrained by macro and structural level factors in the health care system and for these reasons previous efforts have been unsuccessful at undoing health disparities. Moving beyond simplistic micro

level cultural conceptualizations of health disparities and examining power dynamics between racialized people and powerful institutions and providers may be a way to better understand the mechanisms of health disparities (Carlson & Chamberlain, 2004). It may be that a conceptualization of culture that addresses the social and political conditions of people's lives is needed. Blanchet Garneau and Pepin (2015) explain that an essentialist view of culture is congruent with cultural competency views of culture, which are focused on the "Other" and is conceptualized by a Western perspective that emphasizes how religion, nationality, and race influence behaviors related to health and disease. An essentialist perspective is defined by a humanist ontology that obscures the social context and the network of power in which it is located (Blanchett et al. 2015). These works view culture as a set of defined values, beliefs, and practices shared by a group, and they associate culture with ethnicity and nationality. The influence of the physical, social, political, and historical contexts in these studies is subtle and is rarely taught. As explained by Blanchett et al. (2015) ignoring the social and historical context risks blaming inequities on cultural practices instead of power differentials. Furthermore, as explained by Blanchett et al. (2015, p. 10) this bias avoids the question of why established practices and norms that contribute to inequities and negative representations of certain cultures continue without critical inquiry. Blanchett et al. (2015) consider it appropriate to integrate the concept of cultural safety into cultural competency. It could be argued that subsuming cultural safety under cultural competency is not appropriate because there are too many areas of difference between cultural competency and cultural safety. Cultural competency has been criticized for its inadequate definitions and confounding themes. Subsuming cultural safety under cultural competency risks co-opting its definitions and utility and further confounds the differences in each of these theories. Blanchett et al. (2015) propose a revised constructivist definition of cultural competency as

"a complex know-act grounded in critical reflection and action, which the health care professional draws upon to provide culturally safe, congruent, and effective care in partnership with individuals, families, and communities living health experiences, and which takes into account the social and political dimensions of care" (Blanchett, 2015, P 12).

Blanchett et al. (2015) highlight some of the difficulties with cultural competency. The problem is that simply acknowledging the dominance of one culture without providing the service provider a way to mediate the effects of dominance reinforces the power imbalance (Cooney, 1994).

Cultural humility. Cultural humility is a theoretical perspective and requires self-evaluation, attention to power differentials and promotes the use of advocacy (Tervalon & Murray-Garcia, 1998). This has been a useful conceptualization of cultural competency but had less uptake in the United States than transcultural conceptualization of cultural care. Cultural Safety is a theory that was conceptualized by Maori nurses in New Zealand and shares some similarities with Cultural Humility (Ramsden, 2002).

Cultural safety. Cultural Safety is a relatively new, innovative and potentially relevant cultural theory. Health care that is deemed Culturally Safe is defined by the individual patient or community and includes partnership, participation and protection (Richardson & Williams, 2007), making it particularly relevant to the clinical concern of this research. Cultural Safety is both a theory and practice which emphasizes the relational aspect between health care provider and individual, and requires the health care provider to be reflective about the way his or her personal history, social location, power dynamics and culture affects the encounter with the recipient of health care (Ramsden, 2002). Irahapeti Ramsden reflects the perspective of the non-dominant majority; here the Maori culture. Cultural safety as originally applied to nursing, is defined by Ramsden (2002, p. 4) as:

The effective nursing of a person or family from another culture by a nurse who has undertaken a process of reflection on own cultural identity and who recognizes the impact of the nurse's own culture on own nursing practice. Unsafe cultural practice is any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual.

Researchers explain how the theory of cultural safety address concerns such as historical trauma, colonialism and bias,

Cultural safety speaks to all of us, but not in terms of static, essentialized, cultural categories. It is constructed in context, and it is a way of bringing postcolonial discourse into clinical practice, not as a set of concrete standards for practice, but as a way of questioning how we are positioned in relation to our patients and in relation to the system of health care delivery in which we practice.

(Anderson, Perry, Blue, Browne, Henderson, Khan, Reimer Kirkham, Lynam, Semeniuk, & Smye 2003, p. 212). Cultural safety arose from the indigenous Maori rights movement in New Zealand in the 1980s and was initially met with great controversy because of the racialized component of the theory (DeSouza, 2008). Initially, Cultural Safety was framed as a theory to attend to the cultural care of the indigenous Maori people by Palangi (White people) but has now been developed to consider the cultural needs of anyone who may be seeking health care (Richardson, 2004). Many women from Somalia have traumatic histories ((Jaranson, Butcher, Halcon, Johnson, Robertson, Savik, Spring, & Westermeyer, 2004).

Cultural Safety is certainly relevant to individuals of the Somali Diaspora because of their traumatic histories of colonization, war, displacement and trauma.

The Nursing Commission of New Zealand has adopted Cultural Safety as a premise of nursing care and it was introduced to nursing and midwifery curriculum in 1992. Richardson explained,

...cultural safety has allowed for a more reflective, critical understanding of the actions of nursing developing. This includes recognition that nurses' attitudes and values have inevitably been influenced by social and political forces, and as such are in part reflective of those within the wider community" (Richardson, 2004, p.35).

There are four main principles of cultural safety:

1. Improving the health of Maori people. It requires the nurse to acknowledge the beliefs and practices of those who differ from them in terms of categories such as ethnicity, race, gender, sexual orientation, occupation, religion, spiritual belief, or disability.
2. Attention to power differentials between nurses and patients. This principle requires the nurse to carefully reflect and analyze the personal and institutional power differential and how it may be affecting access and health care delivery.
3. The recognition of the historical, political and social inequalities and how they have affected health inequities.
4. The nurse needs to reflect on how she brings her own culture, history, attitudes and life experiences, into the encounter (DeSouza, 2008).

As can be seen from these principles, Cultural Safety attends to power dynamics, reflective practice, and relational aspects of the healthcare encounter.

The concept of Cultural Safety is now being used in other disciplines such as medicine and education. Uptake of the framework of Cultural Safety has been greater in New Zealand, Australia and Canada than in the United States. The use of Cultural Safety in the United States has the potential to teach health care providers how to consider the cultural perspective of the individual being given the care, instead of delegitimizing it in favor of the biomedical culture (Doutrich, Arcus, Dekker, Spuck, & Pollock-Robinson, 2012).

The following table explicates some of the differences and similarities of Cultural Competency, Cultural Humility and Cultural Safety.

Table 2 Comparison of Cultural Competency, Cultural Humility and Cultural Safety

Cultural Competency	Cultural Humility	Cultural Safety
<p>Definition</p> <p>“Cultural competence is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations. (Cross, Bazron, Dennis, & Isaacs, 1989).</p>	<p>Definition</p> <p>“Cultural humility is proposed as a more suitable goal in multicultural medical education. Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partner” (Tervalon & Murray- Garcia 1998, p.117)</p>	<p>Definition</p> <p>“The effective nursing practice of a person or family from another culture, and is determined by that person or family. Unsafe cultural practice comprises any action that diminishes, demeans or disempowers the cultural identity and wellbeing of an individual” (New Zealand Council of Nursing, 2011)</p>
<p>Theoretical Perspective</p> <p>Leininger-Anthropology Camphina-Bacote-Biblical Purnell-Holism & Complexity Theory (McEldowney, 2011)</p>	<p>Theoretical Perspective</p> <p>Public Health (?)</p>	<p>Theoretical Perspective</p> <p>Political, Emancipatory (McEldowney, 2011)</p>
<p>Focus</p> <p>On exoticized “Other” group On visible markers of difference (Drevdahl, et al., 2008) Cultural practice of receiver of services Views interaction as objective (Polachek, 1998)</p>	<p>Focus</p> <p>Self-reflection of service provider Acknowledgement of power imbalances between providers and recipients of care Suggests that provider training includes advocacy (Tervalon & Murray- Garcia, 1998)</p>	<p>Focus</p> <p>Self-reflection by service provider Recognizes social positioning of individual or community Acknowledges power imbalances between provider and recipient of care Recognizes that no interaction is truly objective (Polachek, 1998)</p>
<p>Power Analysis</p> <p>Views all cultures as equal thereby ignoring the differences in power (Polachek, 1998)</p>	<p>Power Analysis</p> <p>Requires acknowledgement of power imbalances between providers and recipients of care Suggests community based advocacy is a component of culturally appropriate care (Tervalon & Murray-Garcia, 1998)</p>	<p>Power Analysis</p> <p>Focuses on becoming aware of the relationship between the dominant and oppressed cultures to produce a genuine partnership in which power is shared between groups involved in health care (Ramsden, 2002). It is about setting up systems which enable the less powerful to genuinely monitor the attitudes</p>

		and service of the powerful to comment with safety and ultimately to create useful and positive change... (Ramsden, 2002)
Location/Time of Development 1970s, United States	Location /Time of Development Late 1980s, United States	Location/Time of Development 1980s, New Zealand
Temporal Focus Present	Temporal Focus Present	Temporal Focus Past & Present Considers colonialism & historical trauma
Level of Analysis Individual interaction (Polachek, 1998)	Level of Analysis Individual as well as community and institutional levels (Tervalon& Murray-Garcia, 1998)	Level of Analysis Recognition of the social structures in which all interactions take place. The concept of cultural safety needs to be broadened beyond the attempt at altering personal attitudes to encompass an effort to redesign social structures. (Polachek, 1998)

The theory and practice of Cultural Safety is a philosophical perspective and practice that has the potential to be advantageous in a research program such as this one and is consistent with the premises of Patient Centered Care making Cultural Safety particularly relevant to this research. It is likely that health care institutions and health care providers in the United States conceptualize cultural care in ways that are consistent with cultural competency or transcultural nursing care because that has been the traditional approach to cultural studies in the US. Cultural Safety has theoretical consistency with Patient and Family Centered Care.

Comparison of patient and family centered care and cultural safety

The foundational rules and guidelines support of the Committee on Quality of Health Care in America Report (2001) and the report by the Joint Commission, "Advancing Effective Communication, Cultural Competence, and Patient-and Family-Centered Care; A Roadmap for Hospitals" support the use of patient and family centered care and culturally sensitive care. The use of the frameworks Patient Centered Care and Cultural Safety are related because they both promote relational ontologies and decision-making based on patient centered values. There are similarities between Patient Centered Care

and Cultural Safety. The notion of decision-making that originates with the wishes of the patient, family or community is consistent with theory of Cultural Safety (Ramsden 2002). One of the most significant similarities is that they both have the foundational premise that patients have involvement in their care and power in decision-making. The power to make decisions ultimately is with the patient in both patient and family centered and culturally safe care. The theoretical origin of patient centered care arose from consumer rights in the United States while the theoretical origin of Cultural Safety arose from the indigenous rights movement in New Zealand. Similar to patients and family centered care, cultural safety was conceptualized by the nondominant party in health care – a community of Maori nurses. Patient and family centered care tends to be practiced at the individual level of health care provider –patient and is particularly used in acute care settings. Cultural Safety is practiced at both the patient level and also familial and community level and is used in both acute care and community care settings. Cultural Safety as conceptualized in New Zealand may have focuses at the broader systems level because it was legally mandated in 1990 by the Nursing Council of New Zealand and the New Zealand legislature.

It is one thing to aim to practice Patient and Family Centered and Culturally Safe patient care and another to realistically practice this health care delivery. Health care organizations should adopt and be accountable for both Patient and Family Centered and Culturally Safe care because, although complementary, there are enough differences that the use of both is warranted (Saha, Cooper & Beach 2008).

Table 3 Comparison of Patient and Family Centered Care and Cultural Safety

Patient and Family Centered Care	Cultural Safety
Locus of Control Patient (Feinberg, 2012; Berwick, 2009)	Locus of Control Patient or Cultural Community (Ramsden, 2002)
Country and Decade of Origin United States, 1970s (Feinberg, 2012)	Country and Decade of Origin New Zealand, 1980s (Ramsden, 2002)
Rights Attended To Consumer Rights (Saha, Cooper, & Beach, 2008) Disability Rights (Feinberg, 2012)	Rights Attended To Indigenous Maori Rights (Ramsden, 2002)
System Level Individual	System Level Individual or Community
Orientation Holistic; Whole person (Feinberg, 2012) Person as opposed to disease (Saha, Cooper, & Beach, 2008)	Orientation Social and Political Framework (Richardson, 2004) Culture (Ramsden 2002)
Decision-making Shared Decision-making Model (Feinberg, 2012) Patient (Berwick, 2009)	Decision-making Variable depending on patient preferences
Respect focused on Individual (Feinberg, 2012)	Respect focused on Individual and Culture (Ramsden, 2002)

The practice of patient and family centered care and culturally safe care can be challenging and this research aims to identify both the successes and challenges to this type of care provision.

Adherence and compliance. In both Patient and Family Centered and Culturally Safe care there is an emphasis on providing care that is sensitive to both the personal and cultural values of the person, which by definition is likely to be congruent with the needs of the patient. Examining how Patient and Family Centered Care and Cultural Safety address “non-compliance” demonstrates some similarities. Non-compliance is a term that is not used as much as it once was because of its paternalistic overtones (Bissonnette, 2008). Bissonnette (2008) explains that currently there is little differentiation between compliance and adherence although they are not synonymous. In an analysis of the concept of the compliance Bissonnette explicates that non-compliance was removed from the nursing nomenclature because it has significant paternalistic overtones. As explained by Bissonnette, the World Health Organization introduced the concept of adherence which conveys the notion that the patient approves of

the plan of care. The most common definition of adherence found was as follows. "Adherence can be defined as the extent to which patients follow the instructions they are given for prescribed treatments". No definition of adherence exists that reflects a patient centered approach, the dynamic nature of adherence, behaviour and the power imbalance implied by these terms" (Bissonnette, 2008, p. 634). The next term used was concordance which "implies the development of an alliance between patients and healthcare providers based on realistic expectations as opposed to misunderstanding, distrust and concealment" (Bissonnette, 2008, p.637) although there has not been much uptake of the term concordance.

Non-participation in care can arise from a lack of information and a lack of recognition of patient's values and is more likely to occur in organization-centered rather than patient-centered organizations (Eldh, Ekman, & Ehnfors, 2008). Patient adherence differs from compliance in Patient and Family Centered Care because in compliance there is an underlying notion of control while in adherence the patient has approved of the plan of care; therefore non-adherence can only occur when a patient does not follow recommendations that have been mutually agreed upon (Robinson, Callister, Berry, & Dearing, 2008, p 605). This attention to control is congruent with the philosophy of Patient and Family Centered Care and Cultural Safety. Patient adherence is more in line with Patient and Family Centered Care. Lawn (2011) explains that Patient Centered Care focuses on what the needs of the patient are: "so that whatever treatment is given to the patient by the health care professional it should be suited to the patients' needs and actually ameliorate or cure the health condition for which the patient has come to seek help, while minimizing other unwanted effects as experienced and tolerated by the patient (Lawn, 2011, p.90).

The use of Patient Centered Care may improve communication when problems in communication arise between health care providers and patients due to the biomedical focus on disease management rather than the person and their health problems (Lewin, Skea, Entwistle, Zwarenstein, & Dick, 2001). There is some evidence that Patient Centered Care can lead to greater clinician satisfaction, reduced malpractice claims, and higher clinician loyalty (Silow-Carroll, Alteras, & Stepnick, 2006) all of which are relevant to this clinical scenario.

Indicators of the lack of Cultural Safety include, “low utilization of available services, ‘denial’ of suggestions that there is a problem, ‘non-compliance’ with referrals or prescribed interventions, reticence in interactions with practitioners, anger, low self-worth, and protests about lack of ‘cultural appropriateness’ of tools and interventions transported from dominant culture to minority culture” (Ball, nd). Several of these indicators can be seen in the responses of Somali women to health care provider recommendations to use continuous fetal monitoring, induce labor or accept a cesarean delivery. The unfamiliarity with Somali cultural values may make it difficult to provide Culturally Safe care and contribute to the underutilization of available health care services by the Somali community. Underutilization of existing services is an indicator of culturally unsafe care (Ball, nd) and may contribute to the reproductive inequities in this community. There is a continuing indication for culturally appropriate care for this community. “The cultural competence movement grew out of early efforts to bridge the divide between the largely biomedical, white, middle-class American cultural perspectives of clinicians, and the perspectives of patients, mainly immigrants, whose experiences and language put them at a substantial cultural distance from American healthcare; cultural competence evolved from these efforts into an all-encompassing approach to address interpersonal and institutional sources of racial and ethnic disparities in healthcare” (Saha et al., 2008, p. 6). There is a continuing indication for culturally appropriate care for this community.

Research Question

The overall purpose of this research is to identify the institutional policies, values and practices that exist to inform and guide health care providers in the provision of patient and family centered and culturally safe reproductive health care to women from Somalia. Table 4 documents the definitions of policy, values and practices guiding this study.

Table 4 Definition of Policies, Values, Practices, Limitations and Recommendations

Concept	Definition
Policies	are guidelines for achieving the goals and accepted practices adopted by an institution. https://www.google.com/#q=define+policy
Value	are one's (or an institution's) judgment of what is important. Values are those things we regard as deserving, or useful. https://www.google.com/#q=define+values
Practice	the usual and actual behaviors that represent the application or use of a belief or value. https://www.google.com/#q=define+practice+
Limitations	is a restriction that prevents a person from doing what they intend to do. http://www.merriam-webster.com/dictionary/limitation
Recommendations	A recommendation is a suggestion or proposal as to the best course of action, especially one put forward by an authoritative body https://www.google.com/search?q=define+recommendation&rlz=117NDKB_enUS567&gws_rd=ssl

Limitations in the existing policies and practices that guide the provision of care for the Somali community will be identified, and recommendations for strategies to address these limitations in institutional policies and practices to guide the provision of care will be identified. The research question is, "What are the institutional policies, values and practices that guide health care providers in providing patient and family centered and culturally safe reproductive health care to women from Somalia?"

Research Aims

The aims of the study are:

1. To identify existing institutional policies, values and practices in this health care system that inform the provision of patient and family centered and culturally safe reproductive health care for the Somali community.
2. To identify limitations of existing policies to guide the provision of patient and family centered and culturally safe reproductive health care for the Somali community.
3. To identify administrative recommendations for strategies to address limitations in institutional policies and practices to guide the provision of patient and family centered and culturally safe reproductive health care for the Somali community.

Chapter 3: Methods

Study design

The design is a single case study with the case being defined as a specific health care organization, the ...Medical Center. A single case study is a detailed investigation of a single individual or group and allows the researcher to explore complex situations while taking the context of the situation into account (Casey & Houghton, 2010). Case studies are particularly useful when the phenomenon is complex and highly contextualized (Rosenberg & Yates, 2007), such as exists in this study. An instrumental case study is one in which the case is studied in order to understand the phenomena of interest (Rosenberg & Yates, 2007, p. 449). The researcher chooses the case that will provide the best insight for the research question (Polit & Tatano Beck, 2004). Rosenberg and Yates stated “verification of theoretical propositions that constitutes an integral element of rigor in case study research” and recommend conducting a literature review for case studies because the underlying theories and themes are an important component (Rosenberg & Yates, 2007, p. 448). Case studies are known for being methodologically flexible and for their ability to focus on the particular and specific especially when there is a complex phenomenon with multiple variables that cannot be controlled (Rosenberg & Yates, 2007). One of the advantages of case studies is that they are pragmatic in nature and not dependent on the researcher’s paradigmatic outlook (Casey & Houghton, 2010).

Unit of analysis. The unit of analysis was the health care institution. The relevant parts of this health care institution are comprised administrative offices such as Patient Family Centered Department and the administrative departments of the health care institution.

Case description. The selected case of the Medical Center is an urban academic medical center located on the West Coast of the United States. The Medical Center has sister hospitals in the same city and together they compromise ...Medicine. The Medical Center provides health care at its two leading academic medical centers. Together they have nearly 200 outpatient clinics and seven neighborhood clinics where care is provided by the Medical Center’s physician group. The Medical Center was ranked as one of the best medical centers by U.S News & World Report’s in 2010 and is the first four- time recipient of the Magnet Award. One of the major accomplishments during 2012 was the implementation of “Patients Are First” initiative (...Medical Center, 2012). The city where it is located has one of the most

diverse urban centers in the nation and many of the members of this diverse community receive health care at one of the sites of this Medical Center.

Data sources

The proposed study incorporated two sources of data, interviews with administrators and institutional documents (See Table 5). Using more than one data collection method, data triangulation, can increase the rigor of a study.

Table 5: Aims and Data Collection Sources

Aims	Data Collection	Data Source
<p>Aim 1</p> <p>To identify existing institutional policies, values and practices in this health care system that informs the provision of Patient and Family Centered and Culturally Safe reproductive health care for the Somali community.</p>	<p>Interviews</p> <p>Documents</p>	<p>Administrators</p> <p>Documents</p>
<p>Aim 2</p> <p>To identify limitations of existing policies and practices to guide the provision Patient & Family Centered and Culturally Safe Reproductive care for the Somali community.</p>	<p>Interviews</p>	<p>Administrators</p>
<p>Aim 3</p> <p>To identify administrative recommendations for strategies to address limitations in institutional policies and practices to guide the provision of Patient and Family Centered and Culturally Safe reproductive care for the Somali community.</p>	<p>Interviews</p>	<p>Administrators</p>

Interviews

The central purpose of elite interviewing as described by Hochchild (2009) is to acquire information and context that only that person can provide about some event or process. Interview questions were developed based on the specific aims of the study. A hypothetical case example was used to provide context for the interview. The interview guide is provided in Appendix A. After participants consented to be interviewed I read the case study found on page 2 to each participant. I also provided each with a printed copy of the definitions of Family and Patient Centered Care and Culturally Safety and asked them to read the definitions. In this way I provided the contextual background, definitions of key concepts and the theoretical paradigm for this study.

The initial questions should be neutral, followed by transitional questions and then progress to more sensitive questions. Opening with one broad question followed by three to five transitional questions and then one to three key questions can help the moderator elicit the most meaningful data (Plummer

D'Amato, 2008). The last question should be "Is there anything that I have not asked that you would like to tell me?" This perspective guided the study interviews.

interview participants' eligibility and recruitment. Administrators from the Medical Center who were likely to be familiar with the policies, values and practices that they believe guide personnel in the provision of Patient and Family Centered Culturally Safe reproductive care for women from Somalia were eligible to participate. Participants were identified by review of publicly available organizational charts and by snowballing techniques. Eleven prospective participants were identified. All eligible participants were contacted by a Community Advisory Board Member with a scripted email briefly describing the study and requesting permission for the principal investigator to contact them through email. All but one agreed to be interviewed; that potential candidate stated she did not feel she had the expertise to participate in the interview.

Interviews were conducted with key informants from among administrative personnel from the Medical Center who were familiar with institutional policies, values and practices that are supposed to guide health care providers in the provision of patient and family centered culturally safe reproductive care to women from Somalia. Participants agreed to be interviewed in their private offices or in a private room on campus. All interviews were audio-recorded except that of one participant, who declined to be audiotaped explaining that he never allowed audio-recording. Detailed notes were taken by the investigator during that interview.

Document review.

Official documents contain objective information about the policies, values, and practices of an institution. Document analysis can be used to get the emic perspective of a phenomenon. Three advantages in the method of document analysis are "documents are preserved traces, which persist beyond the local context of their production; second, people do not produce documents as independent personal acts and documents are used to do more than record and reflect social arrangements; according to some authors they also are useful in organizing social life" (Miller & Alvarado, 2005, p. 349). Unlike qualitative methods such as interviewing, document analysis is a post-hoc account of previously generated social data (Miller & Alvarado, 2005). Document analysis can allow a more complete picture of how system (macro) level as well as individual (micro) level factors contributes to outcomes. Research on

institutional norms can be conducted by interviews and observation although Cooren (2004) states that the analysis of texts via document analysis provides data on how an institution guides and directs persons. Cooren's exploration of the agency of textual documents demonstrates how texts can be said to inform, confirm, indicate, say, assert, deny, bemoan suggest, announce, predict, prophesy, tell remind, attest etc. (p 381). Ascribing agency to the text in this way does not disconnect the action of the human actor but simply demonstrates that texts do have agency on institutional guidance, making documents an excellent source of research data.

The data sources for document analysis for this study included the policies, protocols, standards, guidelines, and mission statement. Incorporating document analysis into this research provided a contextualized and historical view of the organization and how the prevailing policies, values and practices facilitate or impede patient and family centered, culturally safe health care. The sampling strategy for document analysis was purposeful. Sampling was dependent on what documents existed and which were accessible. The availability of documents for analysis is a social process and depends on the decisions of the institution and individuals who can allow access. Bias can be introduced when the ability of individuals (or institutions) are denied access to documents (Miller & Alvarado, 2005). Bias can be as subtle as how documents are selected, retained, and cataloged by policies of the institution or which individuals are responsible for preserving the documents. The integrity of the research rests on how well the researcher attends to the possibility of these biases (Miller & Alvarado, 2005).

inclusion criteria. The inclusion criteria for document and policy analysis were 1) the document broadly or specifically delineates values, policies or practices which guide the provision of Patient and Family Centered, Culturally Safe reproductive care to women from Somalia, 2) is currently used and 3) is no older than 25 years. The time frame of 25 years is included because refugees from Somalia began arriving in the United States in the early 1990s. Documents were identified from a review of the medical center's publicly available website and from suggestions from the key informants who were interviewed. Appendix B lists the documents that were included for analysis in this study.

Data Analysis

Interview data were audiotaped and submitted to a professional transcription service with a request for verbatim transcription. After receiving the transcribed document the text was read while

listening to the audio tape and corrections to the transcript were made as needed. Names of people and places were re-dacted. Institutional documents were either copied and pasted into a Word document or saved as a pdf and then the documents and interview transcripts were uploaded into Atlas.ti for coding.

Each transcript and document was then iteratively coded with the deductive structural codes by the primary investigator. Deductive structural coding was conducted staying close to the three research aims thus the deductive structural codes came from the key terms in each aim. For example; Aim 1, "To identify existing institutional policies, values, practices in this health care system that informs the provision of Patient and Family Centered and Culturally Safe reproductive health care for the Somali community", resulted in the following structural codes; values, practices and policies. Accordingly, the key terms in the three aims became codes (Values, Practices, Policy, Limitations and Recommendations). Each document and interview was coded separately for each aim by the principal investigator. The three aims with their corresponding deductive structural codes are listed in Appendix C.

Inductive analysis is the use of the raw data in the reading to derive concepts, themes or models by the researcher (Saldana, 2009). Inductive coding occurs when the codes or themes emerge from the data (Saldana, 2009). For each aim I looked at the words of the participants. I grouped similar words and ideas together and each major group became a theme. I discussed these codes and themes with my committee. One type of inductive coding is descriptive coding which is used to summarize the topic of a passage (Saldana, 2009). Inductive coding was done by using key words of the participants and the documents. These words were highlighted in the documents and interviews using Atlas.ti and then further categorized by similarity into groups and then given labels which became codes. Some codes were combined further if they were enough alike (i.e. alliance, partnership and collaborate became a sub-code of practice). The coding was discussed with two members of the dissertation committee and thus the analysis was done. The inductive findings are categorized by corresponding aim and listed in Appendix D. Inter-coder agreement was assessed by having the chair of the dissertation committee code two interviews. Differences in coding were discussed until agreement was reached.

Using the codebook, the primary researcher read each interview and document, first to deductively code for Aim 1, then to deductively code for Aim 2, followed by deductively coding for Aim 3. Inductive coding was used lastly for themes that were not coded deductively. Each document was read

multiple times. Atlas.ti was used to organize the data. Once the documents were coded Atlas.ti was used to run queries on the codes. Analysis was assisted by running queries to search for themes. Synthesis of findings was done by searching for prominent themes, identifying repeated gaps of information in the text and by identifying opposing statements by the participants.

Protection of Human Subjects

The research procedures were approved by the Institutional Review Board. Participants were consented to the study. Participants were told they did not have to answer any questions and that all data would be de-identified. Audiotapes were transcribed and downloaded to a password protected computer. Care was taken to de-identify participants from their positions at the institution and to mask the identity of the institution.

Chapter 4: Findings

Organization of Findings

The findings are organized by aim. The section on Aim 1 will address the policies, values and practices of the institution. The following section addresses the findings from Aim 2, which are the limitations that were identified in the study and the last section addresses Aim 3 which are the recommendations.

Findings for Aim 1

Aim 1 was to identify existing institutional policies, values, practices in this health care system that inform the provision of Patient and Family Centered and Culturally Safe reproductive health care for the Somali community.

policies. Policies are defined for this study as written statements of principles of action adopted by the organization. The policy documents that were identified and analyzed for this study can be found in Appendix B. The following statement encompasses major areas that the institution's policies address:

At ...Medical Center, we recognize the important role that patients and families play in health care. As we care for patients, we honor the strengths, priorities and preferences of each patient and family and involve them in medical decisions, every step of the way. (PFCC website)

The analysis of policies resulted in identification of the following policy themes: patient and family centered care, respect for individual beliefs and non-discrimination, and treatment decision making.

patient and family centered care. Patient and Family Centered Care was a prominent theme of multiple policy documents.

... Medical Center Improves Health by Providing Exceptional *Patient and Family Centered Care* In an Environment of Education and Innovation. (Mission, Values and Vision
<http://www....medicine.org/about/mission>)

"...Medicine embraces patient- and family-centered care as the best way to deliver health care. We provide patients and their families with a welcoming physical environment, respect for their values, empowerment and collaboration, coordination and integration of care, comfort and support, and access and navigation skills" (...Medicine website).

Patients Are First is the focused orientation of our ...Medicine culture toward service, to support key aspects of what a patient would consider is excellence in service: respectful, compassionate, timely, recognizing and welcoming, personalized, inclusive of families, efficient, coordinated, informative, and innovative in support of their care.(Patients are First, 2008,
<https://depts....edu/pts1st/>)

PFCC was a prominent theme in many policies and the above quotes demonstrate how PFCC was valued, instituted and supported by policy throughout the institution.

respect for individual beliefs and non-discrimination. Several policies addressed non-discrimination based on the individual characteristics and respecting cultural and religious beliefs of both patients and health care providers.

Patients have the right to reasonable access to care and treatment and/or accommodations that are available or medically advisable regardless of one's race, color, creed, religion, sex, sexual orientation, national origin, disability, age, status as a disabled veteran, having an advance directive, or ability to pay for care. Patients have the right to care that is considerate and respectful of their cultural and personal values and beliefs, as well as their psychosocial values and preferences. (*Guide to Advance Directives, Other Health-Care Choices*)

The purpose of this policy is to outline procedures designed to address an employee's request not to participate in an aspect of patient care or treatment due to cultural values or religious beliefs. While ...Medical Center will respect and accommodate such values or beliefs to the extent possible, the quality or efficient administration of patient care services shall not be compromised as a result. ("Patient Care Responsibilities and Employees' Cultural Values and Religious Beliefs")

Patients have the right to express their values and beliefs and to exercise spiritual and cultural beliefs that do not interfere with the well-being of others or their planned course of treatment....Patients have the right to care that is considerate and respectful of their cultural and personal values and beliefs, as well as their psychosocial values and preferences....Patients have the right to express their values and beliefs and to exercise spiritual and cultural beliefs that do not interfere with the delivery of patient care and the wellbeing of others (Patient Rights and Responsibilities Policy)

Policy supports the right of the individual to be treated without discrimination. There is a policy that states that employees may request to be exempt from participating in patient care that violates their religious and cultural values. These policies assert the respect that is the right of individuals and endorse the patients' right to express their cultural and spiritual values.

treatment decision making. Policies addressed the rights and responsibilities of patients and care providers when decisions about treatments needed to be made. These policies also addressed rights to refuse medically advised treatments.

- Patients, the family, and/or their legally authorized decision-maker(s) have the right, in collaboration with their doctor to be informed and make decisions involving their health care, including the right to accept medical care or to refuse treatment to the extent of the law and to be informed of the medical consequences of such refusal...*Patients have the right to participate in ethical questions that arise in the course of their care, including issues of conflict resolution, withholding resuscitative services, foregoing or withdrawing of life-sustaining treatment, ..., (Patient Rights and Responsibilities Policy)
- Patients have the responsibility to participate in discussion about, and to ask questions about, their plan of care.

- Patients have the responsibility to inform the care team if they do not clearly understand a contemplated course of action and what is expected of them
- Patients have the responsibility of notifying their health-care providers when a cultural situation exists concerning the health-care process (Patient Rights and Responsibilities Policy).

A policy entitled, "Making Difficult Treatment Decisions" in the Administrative Policies and Procedures advises health care providers how to navigate difficult decisions.

Decision-making concerning treatment is the essence of medical care. The urgency of the patient's medical condition and the setting may significantly impact the depth of these interactions between medical personnel and their patients. A long-standing relationship and established rapport between patients and professionals are optimal circumstances for the decision making process. At times (particularly in emergency settings), health care professionals and patients are virtual strangers, meeting each other for the first time when decisions need to be made, often with insufficient time for in-depth reflection. Some patients are surrounded by family members and friends who can play an active role in treatment decisions, while others are alone. Furthermore, healthcare professionals and patients are influenced by their values, experiences, religious beliefs, psychological, ethnic, and socio-economic backgrounds. For these reasons, it is helpful to have guidelines for decision making that specifically addresses medical, ethical, cultural, and social issues.

The following policy provides providers with guidelines when patients decline interventions in the obstetrical setting.

The ... Medical Center supports the right of competent, adult patients to make decisions about their treatment, based on the fundamental right of the patient to control what happens to his/her body. Competent adult patients have the right to accept or refuse treatments their physician recommends, including life-sustaining treatments and cardiopulmonary resuscitation. (Making Treatment Decisions)

Obstetrics presents a unique consent situation because no matter how close to term, an unborn fetus does not have legal standing. Technically, an obstetric emergency should be a maternal emergency in order to invoke the implied consent provisions of the law. The typical question/scenario is whether to proceed with an "emergency" Caesarean section if the mother is unable to make her own decisions. These guidelines may be helpful:

1) Surrogate available: The surrogate may consent to the C-section even if the indication is fetal (distress). This would be based on substituted judgment, i.e., what the mother would have wanted. If the surrogate refuses, seek a risk management consult.

2) No surrogate available: If there are maternal indications for the C-section (abruption, placenta previa, etc.), proceed. If the indication is fetal, proceed as long as there is no indication that the mother would have refused. (Informed consent manual)

I REFUSE THE RECOMMENDED PROCEDURE(S), TREATMENT(S), AND/OR TEST(S). As noted above, the risks involved in my refusal have been fully explained to me by my health care professional. I fully understand these risks and dangers, including death (Refusal of Treatment)

These policies clearly state that patients have the right to decline interventions. The informed consent manual contains the following passage regarding the consent of a cesarean delivery.

A. What about obstetric patients who refuse interventions (such as Caesarean section)?

As noted above, the mother (if competent) is the decision-maker in these situations, and the fetus does not have legal standing. This means that the mother may refuse intervention even if that refusal seriously endangers her life and/or well-being or that of the unborn fetus. If you have concerns about the mother's competence, you may be able to turn to a surrogate to decide about care for the mother (there is no surrogate for a fetus); however, if the mother is affirmatively refusing care and has questionable capacity, you should seek a risk management consult as well as an evaluation of the mother's capacity.

If the mother has decision-making capacity and is refusing intervention, you should thoroughly document in the medical record, including the risk-benefit discussion and the consequences of refusal you described to the patient. Be very specific in describing the consequences of refusal to the patient, including the "worst case scenario" for both mother and baby. There is a specific form available for refusal documentation; try to have the patient sign the form if possible.

This policy clearly states the expectations regarding cesarean delivery and informed consent.

participants' perspectives on policies. When asked about institutional policies that would inform care in the case scenario, study participants often could not name specific policies but most often identified policy topics related to patient and family centered care.

I believe that there are institutional guidelines, policies? I ... Yes, I believe that ... there are policies that state we provide patient-centered care. Um, I couldn't quote them to you.

We have worked patient and family centered care into some really big policies. So, as opposed to having separate policies... it's embedded. It's embedded into our staff evaluations. It's embedded in the mission of the hospital.

I think that that the construct of Patients are First has really rallied this organization, because everybody identifies with patient-centered and those who didn't now do. Because they understand it. They understand that our organization puts the patients first. And that means ... that gives everybody sort of the yardstick by which to say, if I have to make a decision about what to do next or what to do in this situation, I can ask myself, "Does this benefit the patient? In that sense, it definitely has directed ... given a direction to people

We talk about patients are first a lot, and Patient Family Centered Care. They are very complimentary of each other. Patient and Family Centered Care says we're partnering with our patients. Patients are First says we're gonna teach our staff to use strategies that are best practice for patients.

Patients have the right to care that is considerate and respectful of their cultural and personal values and beliefs, as well as their psychosocial values and preferences.

Well, first of all, we have a policy that all employees who are in contact with patients and families receive ongoing training and education about culturally appropriate care.

All of our guidelines in terms of admission from any aspect in, in emergency department, any clinic, any front door of our medical center, um, is all not, you know, we have no restrictions based on color, creed, background, um, and so that's something that's kind of embedded in, in all of our guidelines..

Participants also acknowledged that policies were broad and not specific enough to guide care of the Somali population.

Policies are I would say more limited to really help in specific situations. They are more of a global nature.

One participant explained that while policy regarding the cultural assessment of patients at the national level is evolving (Joint Commission, 2013); this had not yet been done at the institutional level.

The Joint Commission, for example, has rolled out for the last few years a bunch of directives or guidelines, points in which they address whether all of the care team members working with a patient have ascertained whether we've asked the patient what her cultural practices are, what her religious practices are, and what her needs are (The Joint Commission 2013)... That is a requirement that is not from inside the hospital. That is a national emphasis that was not in place more than a few years ago. It's a really big difference because now it's actually clearly stated... The CLAS (Cultural and Linguistic Standards of Care) standards are not just a feel-good measure that we want to tell people that we think that their lifestyles are fine. It affects their ability to engage with us as care givers, and therefore it really engages our ability to provide good care for them at all... I know that on the nursing side, it's on the nursing intake forms. I don't know where it is in the physician paperwork form, but I know that the expectation is that the physician as well as the nurse would make him or herself aware of what the patient's cultural background is and then ask what preferences are around different choices as a patient moves through care.

The Joint Commission has picked up the CLAS standards, and the CLAS standards are a wonderful set of guidelines which have just been updated this past year. We originally had a CLAS of set standards which were kind of agreed on by many different organizations, advocacy organizations at the national level, which were concerned that a lot of patients were kind of being steamrolled through the regular American care processes... I had sent her the CLAS standards and the CLAS standard updates, I have sent her specific recommendations that are on the national listservs saying that hospitals are using these standards to change the way they put out information to their doctors and nurses and thereby change care, and I have not ever seen this particular culturally-sensitive CLAS standards transferred over into policy that's reached the staff at my level.

Policies that address the culturally safe care of individuals were found to be lacking in this institution.

Institutional policies clearly supported Patient and Family Centered Care, the respect of individual beliefs, an environment that does not endorse discrimination and provided guidelines in treatment decision-making. Participants often could not name specific policies but did endorse policies about Patient and Family Centered Care. Several participants noted that the available policies were too broad to provide guidelines about how to navigate this specific clinical scenario.

values. Values for this study was defined as are one's (or an institution's) judgment of what is important. Values are those things we regard as deserving, or useful.

values identified in documents. The medical center's documents identify values through the mnemonic of ARISE (Accountability, Respect, Innovation, Service and Excellence). This document is part

of the medical center's orientation for new employees and annual competency training (personal communication). This mnemonic is explained as:

- Accountability: Take responsibility for our actions and their outcome
- Respect: Valuing one another
- Innovation: Using creative ways to reach our goals
- Service: Meeting the needs of our patients and their families, physicians, colleagues, and the community
- Excellence: Doing our best!

There is clear value and promotion of Patient and Family Centered Care in this institution. The values underlying Patient and Family Centered Care were found on the logo and on the institution's website. These values are communication, information sharing, choices, respect, partnership and strengths based.

values identified in interviews. Participants discussed some, but not all of the values identified in institutional documents. Patient and family centered care was described as both a philosophy and an overarching value of the institution. However, the specific value of respect was cited and discussed by every participant. The major values, consistently expressed, had the themes of respect,

respect for individual beliefs and values. Respect included respect for the patient and family's beliefs and values and respect for their rights to make decisions

...you maintain an attitude of respect with the patient.

Patients have the right to care that is considerate and respectful of their cultural and personal values as well as their psychosocial values. They have the right to express those spiritual and cultural values in their care ...

In this regard, respect was associated with values such as understanding and empathy.

... to be respectful. I think we have to do some exploration with them to really understand.

It's not just respect like an autonomous respect but kind of this, what it is; it's a desire to really understand that person.

I think our Patient Family Centered Care values are fairly well-entrenched, which is that, you know, that we are respectful and we want to ask people what they need.

So I think the value is, I mean from my language is to be in the right relationship with the person so it's this mutual empathy and empowerment.

If we can enter into that conversation in an *empathetic* way, and it doesn't have to take a huge amount of time to do that, right? But it also can, I think if we're able to create that kind of an alliance with the patient, so it's *respectful*, it's *empathetic*. I think empathy as a value; it's just a preeminent value for me.

Difficulties in understanding women from Somalia were expressed in the following statement.

Yeah, {we are} just working really hard to understand what is it that we don't understand about this whole ... this group of women and what their particular needs are.

respect for patient choices. Respect was also expressed as respecting patients' rights to information and to make choices about their care. Providing options and choice were cited in the interviews as respectful behavior.

We believe in respecting patient's autonomy to make decisions.

We as an organization respect people's authority and ability to make decisions about their care.

...sort of the model of informed decision-making is the risks, benefits and alternatives are presented, and then the patient gets to choose... among knowing that ... first of all, that ... understanding, and then knowing what the options are, and then being in the position to make decisions, informed decisions, about that. So it's really, patient-centeredness has more to do than just knowing what patients' wishes are. It's really our obligations as providers to make sure that they have the information that they need, that they understand the information, that they... that the information is presented to them in a way that they do not feel directed, coerced...

This respect for a patient's beliefs as they inform decision-making was expressed by several participants.

...and that's your choice and your decision and you base it on your values, not the medicines and not my professional values.

...if you can be encouraged to consider ... to wear the other person's shoes, to walk a mile in her moccasins ... so that you can see that in fact more than one set of values can co-exist...and are valid. Yes. Then it's possible that I can feel very strongly that if I were in the patient in the bed, this is the choice that I would make. But I'm not the patient in the bed. You're telling me what's important to you and I can accept that and let's together see how we can accomplish that.

She and I have come to an understanding, or she and her partner and I have come to an understanding, and, you know, we're there. And then after that, it's really, you know, managing everyone else who interacts with her to make sure that they respect and treat her respectfully as well.

The institution clearly valued Patient and Family Centered Care and respect for the patient in terms of respecting individual values and beliefs, understanding, empathy and decision-making.

practices. Practices are the actual application or use of an idea, belief, or method as opposed to theories about such application or use ([https://www.google.com/#q=define practice+](https://www.google.com/#q=define+practice)). Few practices were identified by participants. This may be due to the limited involvement of participants with patient care.

practices to support Patient and Family Centered Care. Practices that were used included hourly rounding, which is performed mainly by nursing staff, and is conducted in order to anticipate the needs of the patient and increase patient satisfaction scores. The Patient and Family Centered Care website at the institution explained that Patient and Family Centered Care was practiced by asking

patients and families for their input through patient satisfaction surveys and participation on patient advisory council. There are 7 patient advisory councils consisting of patients, families and staff members. These members of the Patient and Family Centered Care councils advise the institution of ways to improve practice. There has not been a Patient and Family Centered Care council on the Labor and Delivery unit for several years.

if you take something like hourly rounding. Which is a component of the Patients are First program, and you explain to your patient, "We want to anticipate your needs. We want to be able to come in and meet your needs before you have to ask." Those actions become very patient centered because it's not putting the patient in, in the position of being dependent and say and having to ask for things.

Other practices listed included asking the patient what they hoped for, what their greatest fear was, and what their goals were.

I usually ended my conversation as, "What is your greatest fear?" Because asking that, first of all, many patients don't even reflect on what their greatest fear is ... until you ask the question. And it was very revealing. But you really wanted to focus on is "What is your greatest fear?" And often it was dying. And I could say to them, "I am going to promise you that you will not die."

consultations. Consultations with ethics, spiritual care, social work and interpreters were widely cited as common practices. Interpreters were used in indicated situations.

I think it's a good thing to consult with others who might be ... especially if it's a resident, that's probably a new situation for the resident. And there are always people available, um, who can help. We can't make these decisions. I mean these are, these are sort of I want to say consultative processes, you have to kind of ... I think it's very hard for one person by themselves.

engagement. The practice of engagement was discussed frequently in the interviews. Engaging with patients, their families, and the Somali community was perceived as a practice that promoted Patient and Family Centered Care. Forming partnerships, alliances and collaboration were identified as valuable practices associated with engagement.

I think it has everything to do with the care giver's ability to and willingness to *engage* with the patient, which, from my point of view, having been in health care for 35 years, is the absolute keystone of doing effective patient care, and to *engage* with the patient, you have to go to where the patient is mentally, emotionally, and understand their physical situation, their social situation at that moment, which means we have to ask the patient. That is, to me, the key definer between whether we're going to have successful care or not. Otherwise, we're just technicians.

I think that nurses are probably better at this than doctors but I think good training about how to have that conversation, how to you know, sit down, be at eye level, *engage* the person, even preliminarily about how, where they are, how they're doing.

We really want to have the patient and the family at the center of our work that we are here to help and support that patient and the family, so it's a matter of us trying to understand what, what

the viewpoints are, what their philosophy is, what potentially is the patient afraid of, how can we support, um, better understanding of the situation. Those kinds of things.

There is one thing that I would add to this definition of Patient and Family Centered Care which I think is reflected in your culturally safe care and that is that it's a partnership. A partnership implies an equality that may not be otherwise addressed in this definition that is here. When I'm describing a partnership I like to say that it's not doing things to people. It's not deciding what somebody else would want and doing it for them. It's actually in collaboration, in conversation with that person together make it coming to some decisions. So I think that our thought process is that we have to *partner* with the patient.

Another participant explained that engagement was suboptimal at times.

I find that this organization is extremely non-reflective about its very privileged position that our doctors and nurses in the academic community are very lacking in empathy or any ability to understand the background of most of the patients that they see coming from the non-white middle class area. I am very, very concerned that when we look at outcomes if we even do look at outcomes we average outcomes...It's completely off the charts, people don't come to their appointments we are not engaging them in care, we are not working with them in any way.

Various participants explained how the facilitation of informed choices was practiced.

Teaching information at the level that they seem to be the most responsive....one of the things that we're doing with our patients is teach back, helping patients to, to reflect back to us their understanding so that we can make sure that we're on the same plane.... sometimes slowing down and making sure that the communication is as understandable as possible, not using medical terminology, trying to understand what other, what other concepts, are involved from them.

Put them in a position to, to make informed decisions on a somewhat urgent basis is, as labor develops and problems develop.

Yeah..., so I, I would hope that with enough players in and enough talent and enough time to really hear that she understands everything, the consequences of those decisions and that they're in line with what she holds to be good quality of life and good values and her essence and then the medical team stands by and provides excellent care of everything else but what they thought would be the treatment.

...when we talk about patient-centered care, it is that the patient is involved, included, in the decision-making, and that by nature means that the patient understands the clinical information that's being presented to them and also is being given choices. So they're not directed to one decision...

..that they're actually presented with ... Um, sort of the model of informed decision-making is the risks, benefits and alternatives are presented, and then the patient gets to choose..... um, among knowing that ... first of all, that ... understanding, and then knowing what the options are, and then being, um, in the position to make decisions, informed decisions, about that. So it's really, um, patient-centeredness has more to do than just knowing what patients' wishes are. It's really, um, our obligations as providers to make sure that they have the information that they need, that they understand the information, that they, um ... that the information is presented to them in a way that they do not feel directed, coerced.

These are the options that are going to be offered to you and so there's a little bit of a negotiation there that ...

The attempt to respect both the patient's decision and the protocols of the institution were possibly conflicted by the health care providers' response to the refusal of a proposed treatment and explained in this quote.

So there is a part of the respect issue is that when we tell the patient, we all *understand* that this is your choice not to receive blood. We're gonna have some right here (referring to units of blood). We're gonna order them up in case. You know. So that, you know, and it's sort of like in case you change your mind, in case ... so, just that communication, in my experience can create for the patient the sense that, that her values are not being respected. And I recognize that there can be a, an institutional conflict there.

Practices that were identified were the practices of Patient and Family Centered Care consultations, engagement and facilitation of informed patient's decisions.

Summary of Findings for Aim 1

The findings regarding policies were that the policies endorsed the values of Patient and Family Centered Care and respect. Respect was conceptualized at the level individual's beliefs vs system level of cultural beliefs. Nondiscrimination and respect for an individual's treatment making decisions were endorsed by institutional policy. Many participants could not name specific policies but did cite the policies that endorsed Patient and Family Centered Care. Participants also acknowledged that institutional policies were too broad to address this specific clinical scenario. One participant acknowledged the lack of policy to guide providers in the cultural care of patients. Values that were found to be endorsed in the document analysis included the acronym ARISE, the Patient and Family Centered Care values of communication, information sharing, choices, respect partnership and strengths based. In the interviews PFCC was identified as an overarching philosophy and value of the organization. Respect was repeatedly cited in the interviews and was associated with understanding and empathy. Respect for a patients beliefs and choices was said to be practiced by honoring a patient's decisions. Practices that were identified were practices that supported Patient and Family Centered Care and practices that promoted engagement, consultations and practices that facilitated informed decision-making.

Findings for Aim 2

Aim 2 was to identify limitations of existing policies to guide the provision of Patient and Family Centered and Culturally Safe reproductive health care for the Somali community.

The major limitations that were identified were the lack of policy, the lack of training in socio-cultural aspects of providing care, the possibility of emotional or moral distress in health care providers,

assumptions, lack of engagement, the dominance of the biomedical culture, and inattention to moral distress of providers.

lack of policy. Accountability in Patient and Family Centered Care and Culturally Safe care, how to provide care that is non-discriminatory and respectful of cultural and spiritual values and beliefs were absent. The following statements are quotes from participants.

I don't think we have anything like that. I think we should have something like that, because in our Seattle area, we have a fairly large population of Somali women.

You know, are ... is there education about culturally sensitive care in, in our onboarding for new medical staff that includes about 80 or so slides in, in a couple of hour, hour and half presentation. There, there's one, one slide that directs people to the Ethnomed site...

So there, there's a bit of commentary there that goes with that on, on providing culturally sensitive care and resources for, um, education around the cultural specifics.

emergent nature of the clinical scenario. Participants spoke of the emergent nature of the clinical scenario and the difficulties of maintaining a calm environment during a potential emergency.

You've seen it yourself ... Oh, your baby's going to die. People just lose it. The structure is we're going to not raise our voice at her. We're going to remain calm, even when we're freaked out.

It's kind of in some ways a corollary to the code blue, right? How we used to do it is just like flip out and everybody's there and people don't know what they're doing. Versus how it's being done now, which is like everybody knows what they're going to do, they go to their place, everyone's calm. Maybe you can structure, you could have like a code culture or something. It's like okay when we have a code culture, then we ... I don't know what you would call it.

lack of training. Gaps in training for health care providers regarding socio-cultural aspects of care were cited by most participants as a limitation.

Sometimes we are somewhat bound by lack of knowledge of their culture and how to culture, be culturally safe. I couldn't have said the words 'institutional racism' to you or 'white privilege' if I had not attended a three-day seminar/workshop...that specifically addressed those issues. I don't think that there has really been, particularly, in health-care, I think that the, focus on the medical advances and techno- technological advances have become so intense that the socio-cultural aspects of health-care have, you know, just ... they've been carved out and we're not getting trained..

So this is the thing, is if we can do some kind of education about to how to think about people. Like, meaning ...contextualize.

What did our helplessness around this patient situation, how did that influence how we did or did not provide care, how the person kept getting referred around, how ... to what extent did we not even consider the socioeconomic context, you know? How, how could you understand t the impact of abuse in this woman's life.

Lack of training in socio-cultural care was repeatedly cited in interviews as a limitation.

assumptions. One participant stated that staff made assumptions about mothers from Somalia.

This could be seen in this statement,

We shouldn't...assume that every Somali..... woman is, is uneducated and is going to be terrified of a C-section. We shouldn't assume that. I mean, we can go into the conversation understanding that that's a common fear...and explore that. But we shouldn't assume it. I don't know that it's, it's, hmmm ... difficult with the community. I think that there is a stereotype that this community is going to resist Cesarean delivery and as with any stereotype, it arises from a generalized experience. So, I think that in our generalized experience, the Somali population has a value against surgical delivery. And we ... we've internalized that as, um, or generalized it to all Somali women... which I think, ah, you know, it is a bias, number one, but number two, I think that when there is initial resistance to the, the recommendation for a Cesarean section, that reinforces that belief. But I also believe that due to that bias or that stereotype, there's actually a greater effort made toward informed consent.

Another participant linked assumptions and judgments to moral distress.

I think that's another thing is if we can manage our moral distress, if we can recognize it and manage it, then we can pass it on to the patient. If we can't, then our judgment's coming out, our judgement is coming out.

One participant conceded that institutionalized racism is endemic in our society and that may be a variable in this clinical encounter,

Years ago, we began a series of education through the People's Institute on racism and that was really my introduction to the idea of culturally-safe care. It's really the ability to recognize institutionalized racism and the impact on the populations that it impact- ... that it does impact, that it affects. Because to really understand the difference between culturally sensitive and culturally safe, is more than just generalizing certain cultural... I mean and, as I referred to earlier with the Somali population, there's been enough assimilation over the decades with our, our patients that we shouldn't even generalize that way anymore... I think that the recognition that there is white privilege and that people of color are at a disadvantage... in our society, um, that anybody would be naïve to deny that.

Although this participant introduced the notion of institutionalized racism and linked it to Cultural Safety, there was no other reference to it other than the policy that stated there should be no discrimination against patients.

lack of early engagement. Although engagement was identified as a practice that is related to the value of respect and the practice of Patient and Family Centered Care there was some evidence that the act of engaging was not consistently practiced. The first quote was in reference to the many mothers from Somalia who present in labor without a birth plan and no apparent evidence of having discussed with providers her wishes around her preferences regarding a cesarean delivery

How does a person get this far without having those discussions long before through their providers?

I think at the threshold of the hospital is often too late to develop that... where you are taking the hospital to the community and that's where you take Patient and Family Centered Care and tailor it to a particular population and it's no longer just a broad. It's about partnership. It's about information sharing. It is you're taking it to that community.

Somehow there's got to be a place for engaging.

I think that nurses are probably better at this than doctors but I think good training about how to have that conversation, how to you know, sit down, be at eye level, um engage the person, even preliminarily about how, where they are, how they're doing.

That's a really good example how this would completely change the ability of the patient to even engage with her care team. If we started in a sensitive manner, if the nurse and genetic counselor and the referring physician all took the patient's cultural needs into consideration, we would have that conversation differently from word 1 and not put the patient on the spot, not make her feel defensive, not make her feel panicked, and not make her feel angry before we even start to talk about the facts.

Engagement with the individual and the community was seen as lacking.

dominance of the biomedical culture. The dominance of using a biomedical cultural perspective to provide care to patients was seen as a limitation.

I think there's a culture, a wider culture which is simply the medical field.

That doctor has their own culture that deserves to be heard as well but not in this situation.

We just provide information in a very American way, I think.

It's just that Somali women, as you say, come from a very particular cultural perspective which in many ways does not align well with the American standard halfway.

These quotes seem to indicate an acknowledgement of the American or biomedical culture in this setting.

inattention to provider's moral distress. Moral and emotional distress were identified by participants as being a potential factor that may be influencing the ability of health care providers to provide patient and family centered care.

I think that's another thing is if we can manage our moral distress, if we can recognize it and manage it, then we can pass it on to the patient. If we can't, then our judgment's coming out, our judgement is coming out.

The other corollary here I think that I'm hearing is the moral distress on the part of the nurses and the physicians.

I think that there are like many right answers, many right definitions of moral distress and one is witnessing a fellow human being choosing something you would not choose. ...I think that ...the professional who wants to give the C-section, yes they may feel thwarted from doing what they feel was the right thing but they are also experiencing that distress of bearing witness to something so sad and in their mind, they think is preventable. ...They think oh if we just have the C-section, we're done and ...I would talk to them about the conversations hopefully that have been had where the patient shared with us their perspective of what was going on, what they really call quality of life so what are their hopes and what are their worries, I would always talk

about are we really using this patient's strengths versus their weaknesses? And if so, buck up, (laughs). We have done our due diligence. We have, we have, -it's, that's why I'm saying it's beyond it can be patient and family centered care and know that you love your kids and want to go with God's plan but this is still the right answer over here versus oh that's how your choosing your treatment path and therefore I can use my skills to make that path that you have chosen the best possible one.

Providers are expected to practice the values of respect and Patient and Family Centered Care. They are further constrained in their understanding of this scenario because of the professional edict to remain objective in their demeanor. A participant explained the practice of referring providers to experts to manage their subjective emotional responses.

So, and I can imagine that, that after, you know, that outcome where somebody was doing their best at the time, and trying to honor a decision that wasn't what the provider would have recommended then there's a bad outcome, that they're gonna feel, you know, pretty horribly about that and, and getting them in the hands of (names a staff person) and, or somebody who has a role for that purpose that helps support somebody after, I think would be helpful.

One participant explained it like this ...

They are as though somehow emotion would cloud rationality. And the danger of that as I see it is it's a presumption of objectivity when it's, it isn't, right? And it's a denial of the inner subjectivity of the situation. And I think when we deny that, we're kind of dangerous because you know rationality rules kind of are the illusion of objectivity. Without, without realizing how much subjectivity is in the categorization of things and you know, all of that sort of thing.

Another participant said this about the emotional responses of health care providers in this scenario.

So I think there's that level and, and I think that... so in the professional who wants to give the C-section, yes they may feel thwarted from doing what they feel was the right thing but they are also experiencing that distress of bearing witness to something so sad and in their mind, they think is preventable.

When asked for recommendations on guiding health care providers through this, she responded,

I would talk to them about the conversations hopefully that have been had where the patient shared with us their perspective of what was going on, what they really, call quality of life so what are their hopes and what are their worries, I would always talk about are, are we really using this patient's strengths versus their weaknesses? And if so, buck up. We have done our due diligence. We have, we have, it's, that's why I'm saying it's beyond, it can be patient and family centered care and know that you love your kids and want to go with God's plan but this is still the right answer over here versus oh that's how your choosing your treatment path and therefore I can use my skills to make that path that you have chosen the best possible one....we do have the moral distress of it and I still have to witness the death of this child. And I have to witness the grief of this mother and I have to trust that this mother understood that and has resources to, to do it.

She followed up with this statement.

I have found this institution to be very open to attempting to provide support to staff and come at it from a variety of ways, from the life-and-death rounds where they discuss the emotional part of caring for people, from proactive staff support that we try to do with Spiritual Care, the tea for the souls and the refresh and reflects to reactive support when something goes wrong. ... Long time ago and, and I hope this isn't, I hope this is the ... I hope this comes across correctly and not cowboy-ish but I, I remember a hospice nurse saying to me "if you are not willing to show up at this job and get your heart broken every day, you are not right for this job". So if you are willing to do that, you need to know, you need to be willing to figure out how to patch up your heart every day as well.

There may be some level of emotional or moral distress occurring in this scenario.

Summary of Findings for Aim 2

Participants identified several types of limitations to providing care to Somali women that was consistent with the mission of patient and family centered care. They identified that policies were broad and didn't address how to provide Culturally Safe care. Many participants cited providers' lack of knowledge or the lack of training in the praxis of culturally appropriate or safe care. Several participants noted that there were assumptions made about women from Somalia; and conceded that institutional racism and the dominance of the biomedical culture may be factors interfering with care. Several participants noted that there was a lack of engagement with the individual early during prenatal care. Lastly, emotional or moral distress of providers was noted by participants as a factor not sufficiently addressed.

Findings Aim 3

Aim 3 was to identify administrative recommendations for strategies to address limitations in institutional policies and practices to guide the provision of patient and family centered and culturally safe reproductive health care for the Somali community.

Participants identified two categories of recommendations: pragmatic emergency response planning and changing the paradigm.

pragmatic emergency response planning. Participants spoke of the emergent nature of the clinical scenario and the difficulties of maintaining a calm environment during a potential emergency. Several participants had suggestions about how to intervene. One such suggestion included having an alert when something was going wrong; this alert could trigger a question to the patient inquiring who of her support system should be included in dissemination of clinical information and in decision-making. The notion that there may be several options that should be considered viable by the health care team

was necessary for this alert to be feasibly instituted. In the case of dissemination of bad news, such as in genetic testing, prognostics (etc.), the patient could be asked if she wants all the clinical information or if that should go through a support person, or if she wants to hear the news at all. By offering these options regarding dissemination of clinical information the patient would be more able to make decision based on her individual desires and with the help of her support system should she wish. It was also suggested, if possible, she be able to have time to discuss the clinical information with her support system before being asked to make a decision and to be assured that whichever option for care she chose the goal would be to provide safe care and respectful support.

It was strongly suggested by several participants that a written birth plan be made in the prenatal time period that could potentially address patient wishes during a childbirth emergency involving fetal or maternal distress. The components of the birth plan could include decision-makers, support people, values and wishes. The stress and urgency of assessing the patients understanding and desires during potential emergencies could be mitigated by thoughtful discussions earlier during the prenatal time period. The success of this practice may rest on the ability of the health care provider to engage and establish rapport with patient.

One participant suggested there be a code-like response to these types of scenarios. In the evolving culture of code responses there is now a call to limit unnecessary people from the emergency. There are many people who are needed for an emergent delivery; they could be preparing outside the room and obtaining necessary equipment while the ambiance in the room could be calm and compassionate instead of the emergent and frantic environment that sometimes evolves in emergency situations. A participant who had a clinical background had several recommendations.

Those are the tools. It's not going to be ten people. I need to, in about one minute, as soon as she says, "Yes," yeah, you bet, you guys can be right here, right there... but I can't have all of you hovering over here.

You've seen it yourself ... Oh, your baby's going to die. People just lose it. The structure is we're going to not raise our voice at her. We're going to remain calm, even when we're freaked out.

It's kind of in some ways a corollary to the code blue, right? How we used to do it is just like flip out and everybody's there and people don't know what they're doing.

Having a scripted, nuanced, practiced response to highly dynamic clinical emergencies may be one way to manage the emergent nature of the clinical scenario and maintain patient centered care. This participant linked the subjective and emotional responses to the emergent clinical scenario.

I think yes and it's our job to manage our anxiety, so that it's not ... If the voices are getting raised and dah dah dah, that is within our purview to bring that down a notch. We've seen that work in code blue. ..Anxiety doesn't equal outcome, right? Our freak out is not integral to the success of this interaction. How can we manage that as health care providers? Maybe if (names staff person) working that day, (names same staff person) needs to be the one to come around and say, okay, let's all just kind of move away right now for a minute. Let's give her (referring to patient) a little bit of a break. .. and maintain contact.

A scripted and practiced response (akin to a code practice drill) was suggested to facilitate a calm environment. One participant suggested that staff learn the “on stage/off stage” strategy. This participant explained,

It's not going to be ten people...how it's being done now, which is like everybody knows what they're going to do, they go to their place, everyone's calm. This radius around the bed is the on-stage part and that's where the acting, you may need to be skilled actor stuff's happening off-stage, but the patient doesn't need to see that.

Another participant explained that after the incident is resolved it is important to manage the subjective responses of other staff on the unit.

I've had my experience with this patient. She and I have come to an understanding, or she and her partner and I have come to an understanding, and, you know, we're there. And then after that, it's really, you know, managing everyone else who interacts with her to make sure that they respect and treat her respectfully as well...

These recommendations also illustrate the subjective responses of staff in terms such as “anxiety” and “freak out” and the emergent and dynamic characteristic of this clinical scenario.

changing the paradigm. Participants also made recommendations that suggested a need for a change in the prevailing paradigm. These recommendations included creating alliances instead of adversarial relationships, and community leadership roles in guidance and training, and supporting staff.

Creating alliances instead of adversarial relationship included understanding the individual and their culture and engaging the community.

We should understand their culture, their background as much as possible and incorporate that into our approach.

Well, I would, I think the most important thing in that situation is not to setup a “we -they” with the patient and family, and not to setup barriers of you have to do it my way, or I'm not going to, you know, I'm going to get upset with you.

Take the stance that you're trying of understand instead of the stance of "I'm going to tell you what has to happen here," try as much as you can to understand with the patient or family they're coming from.

One thought would be to try and engage one or more community leaders in a discussion of how can we honor your wishes about care and you know, and/or provide education about the birthing process to make sure a little bit more honoring interest of the Somali group, but also that we're helping people get the best care possible.

These quotes have behavioral practices that may assist the health care provider in navigating this clinical scenario.

Engagement was associated with the value of respect and lack of engagement was identified as a limitation. When asked "do you have any other recommendations for navigating this situation in a Patient and Family Centered Care manner"? A participant responded,

I, well, we, and this may have already occurred but, but one thought would be to try and engage one or more community leaders.

Another participant stated that providing care that was culturally sensitive (referring to the Joint Commission of Accredited Hospital's Cultural and Linguistic Standards of Care) may increase the ability of a patient to engage in care.

That's a really good example how this would completely change the ability of the patient to even engage with her care team. If we started in a sensitive manner, if the nurse and genetic counselor and the referring physician all took the patient's cultural needs into consideration, we would have that conversation differently from Word 1 and not put the patient on the spot, not make her feel defensive, not make her feel panicked, and not make her feel angry before we even start to talk about the facts.

Another participant explained why engagement would improve outcomes.

What I would hope would come out of a prolonged relationship with the community itself through the health organization would be helping the Somali families trust our hospital more, come in more for prenatal care, begin and training our own prenatal people to be asking those kinds of questions, to be having that kind of conversation. As you say hopefully that kind of training would eventually extend beyond specific Somalis and to any woman no matter what background she is.

Engagement was identified as a useful practice and engagement is how one establishes alliances, collaborative relationships and partnerships.

leadership, guidance and training. Several participants noted the need for endorsement from leadership, of having guidance in how to practice in a patient and family centered way, training in how to ask sensitive questions and training in the value clarification.

I think we can work at it and I think that leadership plays an essential role. If we see somebody modeling behavior, somebody who maybe doesn't even do it that well himself or herself but applauds us for doing a good job, it makes all the difference.

The nurses weren't happy, the doctors weren't happy, the relatives weren't happy, the person himself showed no joy or whatever. Everyone felt like it could have been done differently but didn't have a clue how to do it or there were specific barriers to doing it right and you can identify those and I think that's the teaching that we can and need to do in care as well as ... and I love care because the premise of it is that we ask the patient. If we could take that premise and put that premise into the birthing solution.

Let's find the scripts to ask the patient what her values are in a way that makes sense, we need scripts for that. The doctors and nurses are human they don't know how to bring this out of their own life experiences. Well how could they know that? We need to help with scripts and go you are in a really tough place remember there is that status scripts here is this woman she is freaked out she's....We have a pathway for this, we practiced it now go back and do that.

Well, first of all I think that it's important for a provider to be very clear about what his or her own values are and if those values are coming into conflict. I'm hoping that even at the educational level in basic medical school, certainly at the advanced level of residency, I hope that there are some training courses in how to deserve one's own values, how to develop a value of partnership with the patients and to recognize what part of your own value system simply cannot bend.

You know, some accommodation of some, provider education about, you know to reinforce the autonomy of patients, in medical decision making...even when they are making decisions that we would disagree with, reminder some of that, but also thinking about some post-episode support.

Leadership was seen as critical to the success of paradigm changing initiatives.

provider support. Recommendations to assist providers after they had navigated a particularly difficult clinical encounter were identified. This included "Tea for the Soul" which is provided by Spiritual Care for staff that have experienced a difficult event. "Tea for the Soul" consists of the provision of tea and refreshments, and a semi-facilitated conversation including suggestions regarding the stressful event and self-care. The practice "Tea for the Soul" uses reflective practice to foster understanding. Another recommendation to support staff is the practice on some units of having a battery operated candle at the station of a nurse who is caring for a dying patient so that staff can be aware of the difficulties she/he may be facing during the shift and provide appropriate support. Debriefings and the use of narrative medicine during ground rounds were other practices used in some departments this institution that could be adapted for the intrapartum unit.

Summary of Findings Aim 3

Table 6 contains a summary of the major recommendations. The recommendations came under 2 categories: pragmatic and paradigmatic recommendations. The pragmatic recommendations provided several suggestions on how to deal with the emergent nature of the clinical encounter. Leadership and staff support were viewed as critical to the success of dealing with this scenario. Paradigmatic changes

included the suggestion of attempting to understand and contextualize the individual's response and culture, creating alliances instead of adversarial relationships, and engaging with both individuals and the community.

Table 6: Limitations and Recommendations

Limitation	Recommendation
Emergent nature of the clinical scenario	<ul style="list-style-type: none"> ▪ Assess mother's wishes in prenatal time period and document in birth plan ▪ Script roles during code ▪ Develop protocol to guide providers ▪ Create code culture
Lack of early engagement	<ul style="list-style-type: none"> ▪ Engage with patient early in prenatal care ▪ Engage with community leaders
Lack of knowledge and training in socio-cultural aspects of providing care	<ul style="list-style-type: none"> ▪ Training ▪ Adopt CLAS Standards of Care ▪ Implement cultural safety curriculum
Possibility of emotional or moral distress in health care providers	<ul style="list-style-type: none"> ▪ Preemptive training ▪ Post episode staff support ▪ Assess for presence moral distress

Chapter 5: Discussion

Gaps in Policy

Despite having provided health services for the Somali community for 25 years there was no specific policy of the Medical Center that addressed this clinical scenario. Policies tended to be too broad to provide sufficient guidance in this scenario. At a broader level, there was little in the way of protocols or guidelines for the provision of culturally competent or safe care despite the increasingly diverse populations served by this institution. There is a clear need for a specific policy that would provide guidance for health care providers in navigating this bicultural encounter and their own subjective responses. Having such a policy would assist providers in their efforts to be prepared and activated as recommended in the Idealized Perinatal Design.

Other clinical scenarios that have been challenging to navigate in this health care institution have necessitated developing policy level guidelines. Two policies were identified that addressed the specific cultural needs of two non-dominant cultures: Jehovah Witnesses and the Lesbian/Gay/Bi/Transgendered (LGBT) community. The specific policy regarding Jehovah Witnesses (Souter & Gernsheimer, 2009) was designed to assist health care providers who are providing care for members of the Jehovah Witness faith who decline indicated blood transfusions. There was a new policy (2014) to address non-discrimination of individuals who identify as members of the LGBT community. The medical center is recognized as leaders in LGBT Healthcare Equality by Human Rights Campaign 2014 Healthcare Equality Index because they have "patient and employee non-discrimination policies that specifically mention sexual orientation and gender identity, a guarantee of equal visitation for same-sex partners and parents, and LGBT health education for key staff members" (Medical Center Policies). There was also a policy that aimed to preserve the cultural and religious values of employees as it relates to end of life care provided at this institution (Medical Center Policies and Procedures, 1998). These policies were presumably made by the identified need and request for guidance.

existing policy. The policy on informed consent in this institution affirms a patient's right to decline care; even a cesarean delivery in the setting of fetal distress and can be found in the institutions informed consent manual. This policy is supported by the national guidelines of the American College of Obstetrics and Gynecology (ACOG) Policy # 321 (2005). This policy contains the following statement,

Pregnant women's autonomous decisions should be respected. Concerns about the impact of maternal decisions on fetal well-being should be discussed in the context of medical evidence and understood within the context of each woman's broad social network, cultural beliefs, and values. In the absence of extraordinary circumstances, circumstances that, in fact, the Committee on Ethics cannot currently imagine, judicial authority should not be used to implement treatment regimens aimed at protecting the fetus, for such actions violate the pregnant woman's autonomy.

(American College of Obstetrics and Gynecology Policy # 321, 2005 p.1126).

The ACOG policy points to the need to understand maternal decisions in the context of cultural beliefs and values. In the ACOG policy maternal autonomy is absolute. This study indicated there was a gap in the use of cultural theory, policy and practice in the navigation of this scenario. This guideline is clear; nevertheless, this clinical encounter is complex and often conflicted.

The informed consent manual addresses the specific concern of a mother declining a cesarean delivery and informs that surgery cannot be done without consent. These policies affirm the notion of and Patient and Family Centered Care obligations of health care providers. In terms of provider obligation the Guttmacher Report is instructive. The Guttmacher Report on Public Policy regarding "Rights vs. Responsibilities: Professional Standards and Provider Refusals", explains that while health care providers have the right to refuse to provide care that is antithetical to their own personal values this can only be done if there is a way for the patient to receive care that respects their personal autonomy and is cited here (Sonfield, 2005, p. 6).

It should come as no surprise that many of the most detailed standards and policy statements about refusal focus on abortion, contraception and other forms of reproductive health care, along with end-of-life care. These services have often generated controversy among policymakers and the general public. The professional associations have made their position clear, however: A health care provider's moral or religious beliefs cannot justify attempts to override a patient's autonomy. The right to withdraw from services cannot be used as a pretext for blocking or denying patients' own rights to care.

These policies make clear the idea that maternal autonomy must be respected and that a provider must provide care unless there is someone else present who can assume responsibility.

needed policy. There are two main policies needed. The first is a specific policy that addresses the specific nuances of this clinical scenario that could incorporate many of the recommendations made by participants. This policy could clearly re-iterate and inform health care providers of the legitimized respect for maternal autonomy in the consent or declination of a cesarean delivery based on the policies of informed consent and the ACOG Position Statement # 321 is indicated. This policy should also include pragmatic suggestions such as limiting the number of people involved, maintaining a calm environment,

considering consults with spiritual care and with community spiritual leaders. The treatment of possible health care provider's emotional or moral distress can be covered in this policy with directions for debriefing sessions and referrals for individual counseling which can provide guidance that is specific to this encounter should be made available and be listed in this policy. Guidance in documentation to allay fears over litigation can be listed in the policy. This policy should be constructed with advice and endorsement by the department of risk management. Guidance in the provision of grief and loss care in the Somali community as well as the culturally specific burial traditions can be provided in this policy. Providing Culturally Safe care is more likely if the Somali community is involved in the construction of this policy and excellent place to start is the local Somali Health Board.

The second policy needed is one that addresses the identified gap in socio-cultural training. Patient and Family Centered Care has been institutionalized by policy and the same could be done for Culturally Safe care. This policy could contain guidelines in the education of service providers and the provision of Culturally Safe care. This policy could require some accountability and assessment of Culturally Safe care. Narrative medicine and reflective journaling may be processes that could be used to address assessment and accountability.

Institutional Values

This institution has values (as found in documents & expressed by its leadership) about being patient centered, respecting individual's cultural beliefs & values, and respecting patient's right to make choices based on those beliefs. Presumably, it would be safe to say that any individual from any culture would appreciate care that is respectful and patient centered. Despite this compatibility there are difficulties in the navigation of this clinical scenario. Organizational culture is defined by Needle (2004) as the beliefs, collective values and principles of an organization which are influenced by factors such as history, market, technology and national culture. One of the major/most salient influences on this organization is the biomedical culture.

Biomedical Culture and Values

In cultural competency we tend to focus on the non-dominant culture. Focusing on the biomedical culture provides a different perspective. Cultural Safety turns the lens onto the service provider. Undoubtedly the values of individual practitioners vary. Although health care providers in the United

States may come from various cultural backgrounds, in their professional roles they are socialized into a biomedical culture (Chen, 2007). During their training health care providers are acculturated into a system that values empirical knowledge and objectivity (DeVecchio, Good, James, Good & Becker, 2002; Chen 2007). The hidden curriculum is a term that refers to the way “unwritten, unofficial, and often unintended lessons, values, and perspectives that students learn in school” (Hidden Curriculum, 2014) are transmitted to students. Often unintentional, the hidden curriculum informs students how to behave, regard or treat persons who are different. These values can either support or delegitimize the mission of an institution. Bringing the messages conveyed in the hidden curriculum out in the open can bring clarity to cultural and value conflicts. It may be that providers are further constrained in their understanding and processing of this scenario because of the professional edict to remain objective in their demeanor despite their subjective emotional responses and possible moral distress in this clinical scenario.

In this study, several participants acknowledged that there is a culture of the institution. At times this culture was characterized as an American culture or biomedical culture. The biomedical culture is characterized by the value of the empirical and objective epistemology of science (Chen, 2007). In the biomedical culture, science holds the greatest authority in terms of decision-making - which is filtered through individual and collective experiences and worldviews. The people of the United States, as a whole, value individualism, self-reliance and self-efficacy. In this pluralistic health care encounter one can see how in general, like many Americans, health care providers tend to value the life of one fetus over the potential of many as-yet-unconceived children’s lives. The social norm in the United States is to have 1-3 children and women often gain esteem not only in their roles as mothers but also by working outside the home (Benson Gold, Sonfield, Richards, & Frost, 2009). In contrast to the Somali culture, many American women are now choosing to have fewer or no children at all in order to pursue other life interests such as careers. This phenomenon of having a few children over a life time is normalized in the United States. The biomedical culture leaves an imprint of influence on institutional culture and values. These values are carried over into the way we practice in health care. Examples of how biomedical values may carry over into the provision of health care include legitimizing scientific based knowledge over other ways of knowing; prioritizing expediency over relationships; and the specific, limited and dissected care of a person as opposed to a more holistic paradigm. The culture of an institution affects

praxis, the translation of theory into practice. The influence of the values of the biomedical culture may be a factor here and requires further investigation.

Table 7: Comparison of Values of Biomedical & Somali Cultures

Value	Biomedical Culture	Somali Culture
Legitimized Knowledge	Rationale	Spiritual
Highest Authority	Law	Allah
Outlook	Individualism	Communitarian
Agency	Self-Efficacy	Acceptance of Allah's Will Inshallah
Parity # of Children	Few children	Many children
Decision-making	Individual Autonomy	Relational Autonomy
Nature of relationship	Professional Ontology	Relational Ontology

Table 7 outlines some of the differences in the cultural values of biomedicine and the Somali community. The purported values of the institution support patient and family centered care for Somali women; however, there is little guidance or policy for providers on how to act while they are attempting to navigate this clinical scenario where there are complex and differing values and cultural norms. The possibility of providers experiencing moral distress was suggested by participants and attention needs to be given to this issue. The notion of emotional distress experienced by physicians is discussed by Degni et al (2012) in their paper regarding Western biomedical providers' perceptions (Degni et al, 2012) about providing reproductive care to women from Somalia. Providers felt frustrated and helpless when women from Somalia declined their health care services because of a lack of gender concordance (Degni et al, 2012). There is a need to assess the subjective responses of physicians in relation to the provision of reproductive services to women from Somalia.

divergent & normalized values. Review of the literature for this study cited evidence of differing cultural values and norms of Somali women and Western health care providers and the troubled subjective responses by health care providers. The study by Ng and Newbold (2010) on provider and immigrant women's expectations for the provision of health care provided several findings relevant to this study. The first is that there were different expectations regarding cultural competency and knowledge of the immigrants' cultural background, and secondly was the diverging beliefs about the type of prenatal care needed especially in relation to the medicalization of childbirth (Ng and Newbold 2010). Degni et al.

(2011) found that there were concerns that Somali women maintain ethnocentric ideas about prenatal care and some providers expressed discomfort with the relational aspects of care such as hugging, and different communication norms. Providers were sometimes offended or humiliated when Somali women declined obstetrical interventions (Degni et al. 2011). Essen et al (2011) found providers were aware of the negative attitudes Somali women had about cesarean delivery and were stressed when cesarean deliveries were declined by individuals in this community. The mistrust and resistance Somali women exhibited towards the reproductive health care system was viewed as frustrating and sad by their reproductive health care providers (Lazar et al., 2013). These findings are consistent with the suggestion by this study's participants that reproductive health care providers may be experiencing emotional/ moral distress or value conflict.

Berwick's essay addressed the criticism that Patient and Family Centered Care may leave providers feeling emotionally distressed. The critique is that providers may feel that they need be in "self-denial" and "martyrdom" and "exhausted" (Berwick, 2009).

I believe, rather, that the moats we dig between patients and clinicians can drain spirit from both. When in a caring relationship we deny to the other what we could with free hearts give, we both suffer from the denial; one loses the help, the other loses the joy of helping. Among the most destructive forms of denial is the message: "You should not want that." Even more destructive, in my opinion, is the training and institutional habit of phrasing our choices as lies, in the form, "We cannot do that," when we darn well could.

This notion of aligning with the patient even through differences in values was echoed by one of the participants who said.

So I think there's that level and, and I think that that so in the professional who wants to give the C-section, yes they may feel thwarted from doing what they feel was the right thing but they are also experiencing that distress of bearing witness to something so sad and in their mind, they think is preventable..... I would talk to them about the conversations hopefully that have been had where the patient shared with us their perspective of what was going on, what they really, um, call quality of life so what are their hopes and what are their worries, I would ...always talk about, are, are we really using this patient's strengths versus their weaknesses? And if so, um buck up (laughs). We have done our due diligence. We have, we have, it's, that's why I'm saying it's beyond um, it can be patient and family centered care and know that you love your kids and want to go with God's plan but this is still the right answer over here versus oh that's how your choosing your treatment path and therefore I can use my skills to make that path that you have chosen the best possible one.... I have found this institution to be very open to attempting to provide support to staff and um, uh, come at it from a variety of ways, from the life-and-death rounds where they discuss the emotional part of caring for people, from proactive staff support that we try to do with Spiritual Care, the tea for the souls and the refresh and reflects, to reactive support when something goes wrong. The ... Long time ago and, and I hope this isn't, I hope this is the ... I hope this comes across correctly and not cowboy-ish but I, I remember a hospice nurse saying to me "if you are not willing to show up at this job and get your heart broken every day,

you are not right for this job". So if you are willing to do that, you need to know, you need to be willing to figure out how to patch up your heart every day as well.

Later in the interview this participant said,

It's also my incredible joy of you are doing exactly what you want to in life and fully living your life. While Patient and Family Centered Care was valued, marketed and endorsed by this institution there was gap in policy on cultural care. Because of the increasing diversity, occurring over time in the geographical area where the institution is located, owing to the processes of globalization, providing care for individuals with differing values will be even more common in the decades to come. In a study examining resident physician's comfort with the cultural care of patients researchers found there was little clinical time, role modeling, training or formal evaluation given to the cultural care of patients (Weissman, Betancourt, Campbell, et al., 2005). The concept of Cultural Safety, however, may facilitate understanding about the differences in cultural values present in this scenario. Examining the culture of medicine may facilitate increased medical residents understanding of cultural differences because few cultural competency curriculums acknowledge the student's own background (Boutin-Foster, Foster & Konopasek, 2008). Many of the values of both the health care providers and the Somali individuals are culturally constructed; it may be advantageous to use a critical approach to construct policy that endorses culturally safe care. This policy will be useful if there are clear guidelines regarding praxis and the support and guidance for the subjective responses of health care providers.

Intersectionality

Normalizing one view over another tends to occur when there are differences in power between two groups. In contrast to many refugees from the Somalia, health care providers tend to exercise a fair amount of power in the health care setting. Intersectionality is a theory developed by Crenshaw (1991) and the study of intersectionality has to with how systems of oppression are mutually constituted and work together to produce inequality, in other words, multiple categories of difference work together to produce inequities. Poor immigrant health is often attributed to cultural beliefs and practices, some believe that more attention should be paid to the structural factors on immigrant health disparities (Viruell-Fuentes, Miranda, & Abdulrahim, 2012). Viruell-Fuentes et al. (2012, p.2103) recommend an intersectional approach to disparity research citing the need for a shift from "individual-level cultural explanations to research that provides a broader, more in-depth analysis of racism as a structural factor

that intersects with other dimensions of inequality, such as gender and class, to impact immigrant health outcomes". Ethnicity and cultural beliefs are not the only factors that affect patient culture; class, education, gender, sexual orientation, religion, and personal life context are important to consider in the patient's life world (Lo & Bahar, 2013). Compassion, open-ended communication and respect are seen as critically important in the provider-patient relationship (Lo & Bahar, 2013). The data from the study suggests this institution values Patient and Family Centered Care and respect which is compatible with the values of the Somali community. Despite this compatibility there are difficulties in the navigation of this clinical scenario.

In the United States, ethnic diversity in all health care professions is lacking (Grumbach & Mendoza, 2008). The majority of physicians in the United States are White. While 13% of the population in the United States is Black only 4% of physicians are Black and this trend persists despite attempts to increase diversity in the last 3 decades (Association of American Medical Colleges, 2014). In Washington State, 2013, the ethnic composition of physicians is as follows: Asian 11.6% Black; or African American 1.2%; Hispanic or Latino 2.2%; 56.8% White; and American Indian or Alaskan Native 0.6% (Association of American Medical Colleges, 2014). Among all younger non-White physicians 52% are women and 48% are men (Association of American Medical Colleges, 2014) however among White physicians there are more male 65% than female physicians (Association of American Medical Colleges, 2014). Using data from the Association of American Medical Colleges (2005), Navhi (2013) explains that over 60% of medical students in the United States come from households with incomes in the top while only 20% come from households that earned in the bottom three quintiles. Twenty percent of medical graduates complete school without any debt (Association of American Medical Colleges (2005). Navhi recommends training for medical students in the care of people who come from less privileged circumstances and recruiting students from less privileged backgrounds into medicine.

Physicians in the United States tend to come from privileged backgrounds whereas women from Somalia often have experienced war, loss and interpersonal violence (Jaranson, et al. 2004). In a study of Swedish midwives who provided antenatal care to women from Somalia it was found that despite coming from these adverse experiences such as war and poverty, Somali women tended to be resilient and content (Byrskog, Olsson, Essén & Klingberg Allvin, 2015). Language skills and trusting relationships,

patience and networking were important factors in the provision of care to women from Somalia who had experienced violence (Byrskog, et al. 2015). The relational aspects of care are important to women from Somalia although the experiences of the Somali women and health care providers tend to be vastly different. The finding that a limitation to providing patient and family centered and culturally safe care was lack of engagement; this lack of engagement may be exacerbated by the profound differences in privilege and experiences between providers and women from Somalia. Examining possible categories of intersectionality is illuminating although it risks essentializing individuals.

Table 7 Possible Intersectionalities of Health Care Providers and Somali Women

Intersectionalities	Health Care Provider	Somali Mother
Race	Often white	Black
Gender	Often male	Female
SES	Middle to upper SES	If refugee often low SES with multiple losses
Religion	Unidentified –often Christian	Muslim – visible identifiers such as hijab, Post 9-11 xenophobia,
Cumulative Life Experience	Often privileged by virtue of being highly academically educated	Often traumatized and experiences of loss, high prevalence of PTSD in refugee populations, historical trauma and colonization
Formal education	Highly educated	Variable
Social capital	Usually high	May be low due to refugee status and multiple losses of friends & family in war and experiences in refugee camps
Identity Within setting	Dominant	Inexperienced, unfamiliar, non-dominant

This table provides information on possible intersectionalities but risks portraying women from Somalia as tragic and vulnerable individuals. Somali women often are incredibly resilient, it is likely they would not have survived if they weren't resilient and often exercise their agency when declining aspects of clinical care they find culturally unsafe. The notion of intersectionalities at work in this clinical scenario gives credence to the notion that simplistic notions of culture at the individual level are inadequate to fully explain inequities. The acknowledgement of the possible areas of intersectionality in the case study provided as context for this research legitimizes the use of theory that considers inequities at a broader systems level of inequitable power dynamics.

Examining the possible differences in intersectionalities illuminates some of the nuanced and covert factors influencing this clinical scenario. Iris Young believed that we do not need to take the standpoint of the “Other” in order to practice moral respect; rather we need to acknowledge the differences through asymmetrical reciprocity. Young explained that “Moral respect between two people entails reciprocity between them in the sense that each acknowledges and takes account of the other. But their relation is asymmetrical in terms of the history each has and the social position they occupy” (Young, 1997, p. 44). Young described how trying to identify with another without acknowledging differences of power, status and history confound the picture we have of the “Other”. Knowing different histories informs of us of the different experiences and expectations (Young, 1997). One of the critiques of Western Medicine is that it tends to treat the problem not the person without taking that person’s personal history and experience into account. Charon (1991) stated “Sick people need physicians who can understand their diseases, treat their medical problems, and accompany them through their illnesses”, which necessarily calls for engagement. Narrative medicine “can assist in the diagnostic encounter by “encouraging empathy and promote understanding between clinician and patient, allowing for the construction of meaning and may supply useful analytical clues and categories. In the therapeutic process, narratives: encourage a holistic approach to management, are intrinsically therapeutic or palliative, may suggest or precipitate additional therapeutic options and in the education of patients and health professionals, narratives: are often memorable, are grounded in experience, encourage reflection, and in research, narratives: help to set a patient centered agenda, may challenge received wisdom, and may generate new hypotheses (Greenhalgh& Hurwitz, 1999, p. 49). Narrative medicine is a tool that is consistent with Patient and Family Centered Care and Culturally Safety and their practices of self-reflection, patient autonomy, use of empathy and increased understanding.

Engagement

While the value of respect was expressed as prominent value in this institution the associated practice of engagement was found to be lacking. Many participants suggested there was a need for engagement at the individual and community level. Engagement in the early prenatal time is critical to the respect of a mother’s wishes. For example, It is interesting to think that providers may not have discussed the prevalence of cesarean deliveries with Somali mothers in the prenatal time period when this is a

common point of cultural conflict. Engagement is a necessary component in the development of a more relational approach to the provision of reproductive health services to women from Somalia. Many of the articles in the literature review regarding the perspective of Somali women about reproductive health care pointed to the wish for a more relational ontology between providers and patients. What are the difficulties in achieving this engagement? This is an area that will require further research. The lack of engagement identified in this study may be related to provider discomfort with the communication norms and other relational aspects.

What are the precursors and factors involved in physician engagement? Dobie (2007) explains that during medical residency, “residents are exposed to a hidden curriculum that places the acquisition of biomedical knowledge above and at times at odds with development of the awareness and relationship skills important to the patient-physician relationship” (Dobie, 2007, p. 422). Dobie describes her students’ fear of losing their empathy through the rigors of training and the hidden curriculum and recommends educational interventions using reflection, mindfulness and narrative medicine during residency which she explains will necessitate a paradigm shift. Further pushing against accepted conceptualization of physician –patient relationship, Dobie suggests that in Patient Centered Care there is a mutuality of what is given and taken and suggests this can be done while maintaining the patients locus of control over decision-making. This idea is consistent with Young’s (1997) notion of asymmetrical reciprocity. This mutuality changes the prevalent power dynamics inherent when intersectional differences are profound as in this clinical scenario. The student receives the gift of self-awareness through reflection on their own subjective responses to the relationship (Dobie, 2007). Self-reflection and mindfulness may also assist the provider to be present and hopefully better understand the patients (i.e. engaged); a needed concept in the clinical encounter on which this research was based (Dobie, 2007). The students’ self-awareness and reflection of their own subjective values may assist them in navigating their possible subjective responses of emotional or moral distress.

It may be that this clinical scenario is influenced by the differing value systems so while there are some broad guidelines, albeit inadequate, the possibility of moral distress and value conflict are not adequately addressed by existing policy or practice. Normalizing the cultural values of one community over another’s is commonplace and makes it easier to deny another’s values although it can lead to

difficulties and distress when one is required to honor the values of another community such as in the practice of patient and family centered care and cultural safety. Providers are expected to practice the values of respect and Patient and Family Centered Care in this institution. Acknowledging and attending to the cultural values of health care providers is a prerequisite to understanding this research problem. For example if providers are having moral distress what are the implications for the provision of care and what are the indicated interventions that would mitigate this distress– both in real time, and subsequently to promote effective reflective practice? Value clarification exercises, explicit and specific policy and training in cultural safety are possibilities.

The following statement expresses what one participant thought should happen when a health care provider experienced conflicted values.

Yes, it would be hard and of course you're drawing on me in my own personal beliefs. It would be hard and I personally would need to try to understand her. I couldn't just immediately say, "Oh is that what you want? Okay, well then that's what we'll do," because it literally is a life and death decision. I would need to understand.

This statement points to the need for engagement in order for providers to understand the values of the individual patient or community. The notion that there are divergent values at play is rarely acknowledged in the busy and task oriented clinical encounter. The differences in values seem to be culturally mediated in this scenario which is ironic given the gap in policy regarding the Culturally Safe care of patients in this institution. Understanding and acknowledging that there are multiple and competing values at work in this scenario could be achieved through the use of reflective practice and narrative medicine. This self-reflection would be consistent with the premises of Cultural Safety which directs the provider to acknowledge through self –reflection how their own social location and privilege influences their understanding of the patient and contextualized life experiences as well as the delivery of care.

Indication for Cultural Safety

Examining the possible intersectionalities influencing this clinical scenario may assist providers in self-reflection. In this way the social location of the individual or provider can be assessed for the influence it may have on structural factors such as racism, colonialism and historical trauma. Cultural Safety is also better able to address structural concerns that may be influencing the scenario such as colonialism, historical trauma, racism and intersectionality all of which may have a role in this scenario given the history of Somalia. An example of this would be for a provider to understand that a patient may

have difficulties in trusting the health care provider who is a member of an ethnic group who had perpetuated genocide, historical trauma or colonialism on the patient's ethnic group. The idea here is that the provider can be cognizant of the possibility and not personalize this fear that is grounded in the contextualized experience of the patient. Using self-reflection the provider may better understand a patient's mistrust whereas previously the provider may have been puzzled or offended. This skill comes only with practice, self-reflection, training and role modeling. Cultural Safety is indicated here because there is a need for providers to be self-reflective about the role of divergent personal and cultural values and experiences in this scenario.

The finding in this study suggests a need for training in the provision of Culturally Safe care and is consistent with previous literature. The theoretical basis of Cultural Safety must be understood and subscribed to by leadership if it is to make a significant impact on the provision of health care.

This study contributes the finding that policy is required to assist in the navigation of this complex scenario. Leadership was cited numerous times as being integral to the process of change in practice. Policy-making occurs at the level of or with the endorsement by leadership. The data pointed to a need for policy on how to navigate this specific scenario. There is a need to train providers in the delivery of Culturally Safe care that covers the important, profound and nuanced differences between cultural competency and Cultural Safety. Additionally, there is an indication to assess for the presence of moral distress and value conflict in health care providers. Interventions aimed at preventing or mitigating the effects of emotional/moral distress and value conflicts may be indicated. Training in how to navigate scenarios that are complicated by differing values such as exercises in value clarification may be indicated. These are all obligations that require leadership endorsement in order to be properly assessed and given the necessary attention.

A specific policy outlining how to proceed during this specific clinical encounter in an orchestrated fashion akin to a code like scenario will be useful. Input and support from risk management, the legal department, ethics, spiritual care, and relevant multidisciplinary clinical champions should be considered in the construction of policies, guidelines, and training that will be pertinent to the clinical encounter. Engaging the Somali community and relevant stakeholders and leaders will be critical to the success of any policy or training. A policy that addresses the gap in Culturally Safe care is indicated. There is a need

to assess for the presence of emotional/moral distress, and due to the value conflicts in health care providers who provide reproductive care to this community and to mitigate against its development or escalation. Interventions aimed at preventing or mitigating the effects of emotional/moral distress and value conflicts may be indicated.

Implications for further research

How do we support providers through this clinical encounter? A next step in this program of research would be to assess the presence of emotional or moral distress and the current coping mechanisms of providers, and the effectiveness of those mechanisms (internal and/or external) in providers in regards to this specific scenario. There are instruments available to assess for moral distress that could be adapted for this purpose (Corley, Elswick, Gorman, & Clor, 2001; Hamric, Borchers, & Epstein, 2012).

Assessing for barriers to engagement is a needed area of research. Alexander, Lin, Sayla, and Wynia, (2008) constructed a 9 item model of engagement to measure physician engagement in addressing health disparities. They entitled their conceptual model, AREA, which stood for awareness of issue, reflection on issue and one's potential in addressing it, empowerment or the realization that one has the capacity to work on it and action taken to address the issue. The use of this survey may be one way to assess engagement in physicians.

A specific policy outlining how to proceed during this specific clinical encounter in an orchestrated fashion akin to a code like scenario will be useful. Input and support from risk management, the legal department, ethics, spiritual care, and relevant multidisciplinary clinical champions should be considered in the construction of policies, guidelines, and training that will be pertinent to the clinical encounter. Engaging the Somali community and relevant stakeholders and leaders will be critical to the success of any policy or training. A policy that addresses the gap in Culturally Safe care is indicated. There is a need to assess for the presence of emotional/moral distress, and due to the value conflicts in health care providers who provide reproductive care to this community and to mitigate against its development or escalation. Interventions aimed at preventing or mitigating the effects of emotional/moral distress and value conflicts may be indicated.

Limitations

There were several limitations to this study. The sample size was limited by the number of medical center staff administration who were familiar with all of the policies, values and practices relevant to this study. There may have been social bias as several participants know the principal investigator in her role as a staff nurse; others knew her in her role as researcher or community advocate. Lastly, my social location informs my thinking and may limit my access and understanding to other perspectives.

Conclusion

Due to globalization health care providers in the U.S. and other Western countries are increasingly called upon to provide services for people from diverse backgrounds, perspectives and values. The need to work across divergent cultural expectations will only increase in the future. While the literature hints at concerns with subjectivity and how decisions are made, as well as power dynamics and agency and how they affect decision-making, there is insufficient data to construct a well conceptualized explanation of what is happening in cases of moral distress health care provider working in multicultural settings. Addressing contextual concerns in the ethical dilemma may be one way of addressing cultural values into the discourse on ethical decision-making.

Health care providers need and deserve policies and resources in which to manage their own subjective response to these types of complex clinical encounters. Interventions aimed at ameliorating potential emotional or moral distress is indicated and requires further study. The engagement of health care provider and patient occurs because “narrative medicine focuses on our capacity to join one another as we suffer illness, bear the burdens of our clinical powerlessness, or simply, together, bravely contemplate our mortal limits on earth” (Charon 2007, P1267). Perhaps attending to the needs of health care providers will mitigate some of the difficulties in this scenario. Parker (2007) explains how engagement can be fostered.

The education of the new professional will reverse the academic notion that we must suppress our emotions in order to become technicians.... We will not teach future professionals emotional distancing as a strategy for personal survival. We will teach them instead how to stay close to emotions that can generate energy for institutional change, which might help everyone survive.

References

- ACOG Committee Opinion # 321 (2005). Maternal decision making, ethics, and the law. American College of Obstetricians and Gynecologists. *Obstetrics and Gynecology*. 106. 1127-1137. <http://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co321.pdf?dmc=1&ts=20150125T2329468170>
- Ameresekere, M., Borg, R., Frederick, J., Vragovic, O., Saia, K. & Raj, A. (2011). Somali immigrant women's perceptions of cesarean delivery and patient-provider communication surrounding female circumcision and childbirth in the USA. *International Journal of Gynaecology and Obstetrics*, 115(3), 227-30.
- Anderson, J., Perry, J., Blue, C., Browne, C. Henderson, A., Khan, K.B., Reimer Kirkham, R., Lynam, J., Semeniuk, P. & Smye, V. (2003) Rewriting" Cultural Safety Within the Postcolonial and Postnational Feminist Project Toward New Epistemologies of Healing. *Advances in Nursing Science*, 26(3), 196–214.
- Alexander, G. C., Lin, S., Sayla, M. A. and Wynia, M. K. (2008), Development of a Measure of Physician Engagement in Addressing Racial and Ethnic Health Care Disparities. *Health Services Research*, 43: 773–784. doi: 10.1111/j.1475-6773.2007.00780.x
- Andrews, M., Backstrand, J., Boyle, J., Campinha-Bacote, J., Davidhizar, R., Doutrich, D., & ... Zoucha, R. (2010). Chapter 3: Theoretical Basis for Transcultural Care. *Journal of Transcultural Nursing*, 21(4), 53S-136s. doi: 10.1177/1043659610374321
- Association of American Medical Colleges. (2014). Diversity in the Physician Workforce: Facts & Figures 2014, the 18th report in the Facts & Figures Data Series. Retrieved March 9, 2015 <http://aamcdiversityfactsandfigures.org/about-this-report/>.
- Association of American Medical Colleges (2005). Medical Educational Costs and Student Debt: A Working Group Report to the AAMC Governance. Washington, DC Association of American Medical Colleges. . Retrieved March 9, 2015 <http://www.neomed.edu/students/es/finaid/secure/step5/edcostsanddebt.pdf>
- Association of Faculties of Medicine of Canada. (Nd).Chapter 3 Cultural Competence and Communication AFMC Primer on Population Health. Retrieved January 29 2015. <http://phprimer.afmc.ca/Part1-theoryThinkingAboutHealth/Chapter3CulturalCompetenceAndCommunication/Culturalawarenesssensitivityandsafety>
- Ball, J. (nd) Cultural Safety in Practice with Children, Families and Communities. Childhood development intercultural partnerships. Ret. September 10, 2012 <http://www.ecdip.org/docs/pdf/Cultural%20Safety%20Poster.pdf>
- Beine, K., Fullerton, J., Palinkas, L., & Anders, B. (1995). Conceptions of Prenatal Care among Somali Women in San Diego. *Journal of Nurse Midwifery*, 40(4), 376-381.
- Benson -Gold, R., Sonfield, A., Richards, C.L. & Frost, J.J. (2009). Next steps for America's family planning program: leveraging the potential of Medicaid and Title X in an evolving health care system. *Guttmacher Institute*. Ret. 8-27-12. <http://www.guttmacher.org/pubs/NextSteps.pdf>
- Berwick, D. (2009). What 'Patient-Centered' should mean: confessions of an extremist. *Health Affairs*, 28(4), w 555-w565.

- Betancourt, J.R. Weissman, J.S. Kim, M.K. Park, E.R. & Maina, A. W. (2007). Resident physicians' preparedness to provide cross-cultural care: implications for clinical care and medical education policy. Retrieved January 29 2015
http://www.commonwealthfund.org/usr_doc/1026_Betancourt_resident_MDs_preparedness_provide_cross-cultural_care.pdf
- Bissonnette, J. (2008). Adherence: a concept analysis. *Journal of Advanced Nursing*, 63(6), 634-643. doi:10.1111/j.1365-2648.2008.04745.x
- Blanchet Garneau, A. & Pepin J. (2015). Cultural competence: a constructivist definition. *Journal of Transcultural Nursing*, (1), 9-15. doi: 10.1177/1043659614541294. Epub 2014 Jul 17.
- Borkan, A. (2010). Rejecting vulnerability; Somali women's resistance to cesarean delivery in Columbus, Ohio. *Honors thesis in Cultural Anthropology. Ret. September 1 2012*
<http://deepblue.lib.umich.edu/bitstream/2027.42/77628/1/aborkan.pdf>
- Boutin-Foster, C. Foster, J.C. & Konopasek, L. (2008). Cultural competence viewpoint: physician, know thyself: the professional culture of medicine as a framework for teaching cultural competence. *Academic Medicine*, 83(1), 106-111.
- Brown, E., Carroll, J., Fogarty, C. & Holt, C. (2010). "They get a C-section...they gonna die": Somali women's fears of obstetrical interventions in the United States. *Journal of Transcultural Nursing*, (3), 220-7.
- Byrskog, U., Olsson, P., Essén, B. & Klingberg Allvin, M. (2015). Being a bridge: Swedish antenatal care midwives' encounters with Somali-born women and questions of violence; a qualitative study. *BMC Pregnancy and Childbirth*, 15:1 doi: 10.1186/s12884-015-0429-z
- Byng, M.D. (2008). Complex Inequalities: The case of Muslim Americans after 9/11. *American Behavioral Scientist* 51, 659.
- Campinha-Bacote, J. (2011). Delivering patient-centered care in the midst of a cultural conflict: the role of cultural competence. *The Online Journal of Issues in Nursing*, 16 (2), Manuscript 5. Retrieved May 22nd 2014. <http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-16-2011/No2-May-2011/Delivering-Patient-Centered-Care-in-the-Midst-of-a-Cultural-Conflict.html>
- Carlson, E. D. & Chamberlain, R. M. (2004). The black-white perception gap and health disparities research. *Public Health Nursing*, 21, 372-379. doi: 10.1111/j.0737-1209.2004.21411.x
- Carpenter-Song, E.A., Nordquest Schwallie, M. & Longhofer, J. (2007). Cultural competence reexamined: critique and directions for the future. *Psychiatric Services*, 58(10), 1362-1365.
- Carroll, J., Epstein, R., Fiscella, K., Gipson, T., Volpe, E., & Jean-Pierre, P. (2007). Caring for Somali women: Implications for clinician-patient communication. *Patient Education and Counseling*, 66(3), 337-345. doi:10.1016/j.pec.2007.01.008.
- Casey, D. & Houghton, C. (2010). Clarifying case study research: examples from practice. *Nurse Researcher*, 17 (3), 41-51.
- Castel, A.F. & Kurata, S. (2004). Journey into the Somali culture. *NASP Communiqué*, 33(3), <http://www.nasponline.org/publications/cq/cq333somali.aspx>

- Center for Medicare and Medicaid Services. (2012, b). CMS names 88 new Medicare and shared saving accountable care organizations. CMS Web site.
<http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4405&intNumPerPage=10&checkDate=&checkKey=2&srchType=2&numDays=0&srchOpt=0&srchData=accountable+care+organization&keywordType=All&chkNewsType=6&intPage=&showAll=1&pYear=1&year=2012&desc&cbOrder=date>. Accessed January 24, 2013.
- Chalmers, B. & Omer-Hashi, K. (2002). What Somali women say about giving birth in Canada. *Journal of Reproductive & Infant Psychology*, 20(4), 267-282.
- Charon R (2001). "Narrative medicine: A model for empathy, reflection, profession, and trust". *JAMA: The Journal of the American Medical Association*, 286(15), 1897–1902.
 doi:10.1001/jama.286.15.1897. ISSN 0098-7484.
- Charon, R. (2007). What to do with stories; the sciences of narrative medicine. *Canadian Family Physician*, 53(8), 1265-1267.
- Chen, P. (2007). *Final exam: a surgeon's reflections on mortality*. New York: Random House.
- Cherouny, P.H., Federico, F.A., Haraden, C., Leavitt Gullo, S. & Resar, R. (2005). Idealized design of perinatal care. IHI Innovation Series white paper. Cambridge, Massachusetts: *Institute for Healthcare Improvement*; Retrieved April 1 2013.
<http://www.ihl.org/knowledge/Pages/IHIWhitePapers/IdealizedDesignofPerinatalCareWhitePaper.aspx>
- Committee on Quality Health Care. (2001). *Crossing the quality chasm: a new health system for the 21st century*. Institute of Medicine, Washington, DC: National Academies Press.
- Cooney, C. (1994). A comparative analysis of transcultural nursing and cultural safety. *Nursing Praxis In New Zealand*, 9(1), 6-12.
- Cooren, F. (2004). Textual agency: how texts do things in organizational settings. *Organization*, 11(3), 373-393.
- Corley, M. C., Elswick, R. K., Gorman, M. and Clor, T. (2001), Development and evaluation of a moral distress scale. *Journal of Advanced Nursing*, (33) 250–256. doi: 10.1111/j.1365-2648.2001.01658.x
- Crenshaw, K.W. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color, *Stanford Law Review*, 43(6), 1241–1299.
- Cross T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care, volume I*. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.
- Davies, M., & Bath, P. (2001). The maternity information concerns of Somali women in the United Kingdom. *Journal of Advanced Nursing*, 36(2), 237-245. doi:10.1046/j.1365-2648.2001.01964.x
- Degni, F., Suominen, S., Essén, B., El Ansari, W. & Vehviläinen-Julkunen, K. (2012). Communication and cultural issues in providing reproductive health care to immigrant women: Health care providers' experiences in meeting Somali women living in Finland. *Journal of Immigrant Minority Health*, 14(2), 330-43.
- DeIVecchio, M.J., James, C. Good, B.J., & Becker, A. (2002). *The culture of medicine and racial, ethnic and class disparities in healthcare*. Working Paper 199. Russell Sage Foundation. IOM Unequal Report CDROM 2002.

- DeSouza, R. (2008) Wellness for all: the possibilities of cultural safety and cultural competence in New Zealand. *Journal of Research in Nursing*, 13 (2), 125-135.
- Dobie, S. (2007). Viewpoint: reflections on a well-traveled path: self-awareness, mindful practice, and relationship-centered care as foundations for medical education. *Academic Medicine*, 82(4), 422-7.
- Doutrich, D., Arcus, K., Dekker, L., Spuck, J. & Pollock-Robinson, C. (2012). Cultural safety in New Zealand and the U.S.: Looking for a way forward together, *Journal of the Transcultural Nursing Society*, 23(2), 143-150.
- Drevdahl, D.J., Canales, M.K., Dorcy, K.S. (2008). Of goldfish tanks and moonlight tricks: can cultural competency ameliorate health disparities? *Advances in Nursing Science*, 31(1), 13-27.
- Dybdahl, R., & Hundeide, K. (1998). Childhood in the Somali Context: Mothers' and children's ideas about childhood and parenthood. *Psychology and Developing Societies*, 10(2), 131-141.
- Eldh, A.C., Ekman, I. & Ehnfors, M. (2008). Considering patient non-participation in health care. *Health Expect.* (3), 263-71. doi: 10.1111/j.1369-7625.2008.00488.x.
- Empathy. (2015, January 23). In *Wikipedia, the Free Encyclopedia*. Retrieved 15:54, January 30, 2015, from <http://en.wikipedia.org/w/index.php?title=Empathy&oldid=643866616>
- Engage. (n.d.). *Dictionary.com Unabridged*. Retrieved January 30, 2015, from Dictionary.com website: <http://dictionary.reference.com/browse/engage>
- Essén, B., Johnsdotter, S., Hovellius, B., Gudmundsson, S., Sjöberg, N.O., Friedman, J. & Ostergren, P.O. (2000). Qualitative study of pregnancy and childbirth experiences in Somalian women resident in Sweden. *British Journal of Obstetrics and Gynaecology*, 107(12), 1507-1512.
- Essén, B., Binder, P. & Johnsdotter, S. (2011). An anthropological analysis of the perspectives of Somali women in the West and their obstetric care providers on caesarean birth. *Journal of Psychosomatic Obstetrics & Gynecology*, 32(1), 10-18.
- Farzon, N. (2013). The privilege gap in medicine. *Academic Medicine*, 88 (7), 907. doi: 10.1097/ACM.0b013e3182952bc3
- Feinberg, L. 2012. Moving toward person- and family-centered care. *Public Policy Aging Report*, 24 (3), 97-101. doi: 10.1093/ppar/pru027
- Greenhalgh, T. & Hurwitz, B. (1999). "Narrative based medicine: Why study narrative?" *BMJ*, 318, 48-50.
- Grumbach, K. & Mendoza, R. (2008). Disparities In human resources: addressing the lack of diversity in the health professions. *Health Affairs*, 27(2), 413-422.
- Hamric, A.B., Borchers, C.T. & Epstein, E.G. (2012). Development and testing of an instrument to measure moral distress in healthcare professionals. *AJOB Prim Res*, 3 (2), 1-9.
- Hasnain, M., Connell, K.J., Menon, U. & Tranmer, P.A. (2011). Patient-centered care for Muslim women: provider and patient perspectives. *J Womens Health (Larchmt)*, 20(1), 73-83.
- Herrel, N., Olevitch, L., DuBois, D.K., Terry, P., Thorp, D., Kind, E. & Said, A. (2004). Somali refugee women speak out about their needs for care during pregnancy and delivery. *Journal of Midwifery & Women's Health*, 49 (4), 345-349. doi:10.1016/j.jmwh.2004.02.008

- Hidden curriculum (2014, August 26). In S. Abbott (Ed.), *The glossary of education reform*. Retrieved from <http://edglossary.org/hidden-curriculum>
- Hill, N., Hunt, E. & Hyrkäs, K. (2012). Somali immigrant women's health care experiences and beliefs regarding pregnancy and birth in the United States. *Journal of Transcultural Nursing*, 23(1), 72-81.
- Hochschild, J.L. (2009). Conducting intensive interviews and elite interviews. Workshop on interdisciplinary standards for systematic qualitative research. Retrieved May 10, 2014. <http://scholar.harvard.edu/jlhochschild/publications/conducting-intensive-interviews-and-elite-interviews>.
- "Inshallah". Oxford Dictionaries. Oxford Dictionaries. Oxford University Press. <http://oxforddictionaries.com/definition/inshallah>. (Accessed 17 February 2012).
- Institute of Medicine, (2001) *Crossing the quality chasm: A new health system for the twenty-first century*. Washington: National Academies Press.
- Jaranson, J.M., Butcher, J., Halcon, L., Johnson, D.R., Robertson, C., Savik, K., Spring, M., & Westermeyer, J. (2004). Somali and Oromo refugees: Correlates of torture and trauma history. *American Journal of Public Health*, 94(4), 591-598.
- Johnson, E.B., Reed, S.D., Hitti, J., & Batra, M. (2005). Increased risk of adverse pregnancy outcome among Somali immigrants in Washington State. *American Journal of Obstetrics and Gynecology*, 193 (2), 475-482. doi:10.1016/j.ajog.2004.12.003
- Lawn, S. (2011). Compliance, concordance and patient centered care. *Patient preference and adherence*, 5, 89-90. doi 10.2147/PPA.S17822
- Lazar, J.N., Johnson-Agbakwu, C.E., Davis, O.I. & Shipp, M.P.L. (2013). Providers' perceptions of challenges in obstetrical care for Somali women. *Obstetrics and Gynecology International*. Article ID 149640, doi:10.1155/2013/149640
- Lewin, S.A., Skea, Z.C., Entwistle, V., Zwarenstein, M. & Dick, J. (2001). Interventions for providers to promote a patient-centred approach in clinical consultations. *Cochrane Database Syst Rev*. (4), CD003267
- Lewis, T. (2009). Somali Cultural Profile. Ethnomed. Retrieved 1-7-13. <http://ethnomed.org/culture/somali/somali-cultural-profile#section-10>
- Lo, M. (2010). Cultural brokerage: Creating linkages between voices of lifeworld and medicine in cross-cultural clinical settings. *Health*, 14 (5), 484-504.
- Kai, J., Beavan J., Faull, C., Dodson L., Gill P. & Beighton, A. (2007). Professional uncertainty and disempowerment responding to ethnic diversity in health care: a qualitative study. *PLoS Med*; 4(11), e323.
- Malin, M. & Gissler, M. (2009). Maternal care and birth outcomes among ethnic minority women in Finland, *BMC Public Health*, 20(9), 84.
- McCloskey, D.J., McDonald, M.A. Cook, J., Heurtin-Roberts, S., Updegrove, S., Sampson, D. Gutter, S. & Eder, M. (2011). Community engagement: definitions and organizing concepts from the literature. http://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_Chapter_1_SHEF.pdf

- McEldowney, R. & Connor, M.J. (2011). Cultural safety as an ethic of care: a praxiological process. *Journal of Transcultural Nursing*. 22(4), 342-9. doi: 10.1177/1043659611414139. Epub 2011 Aug 15.
- McWhinney, I. (1989). The need for a transformed clinical method. In: Stewart, M.; Roter, D., editors. *Communicating with Medical Patients*. London: Sage.
- Miller, F. & Alvarado. K. (2005). Incorporating documents into qualitative nursing research. *Journal of Nursing Scholarship*, 37 (4), 348-353.
- Missal, B., Clark, C., Kovaleva. M. (2015). Somali immigrant new mothers' childbirth experiences in Minnesota. *J Transcult Nurs*. pii: 1043659614565248. [Epub ahead of print]
- Nahvi, Farzon A. (2103). MD letters to the editor; the privilege gap in medicine. *Academic Medicine*, 88(7), 907doi: 10.1097/ACM.0b013e3182952bc3
- Narruhn, R., & Schellenberg, I. R. (2013). Caring ethics and a Somali reproductive dilemma. *Nursing Ethics*, 20(4), 366-381. doi: 10.1177/0969733012453363
- Needle, D. (2004). *Business in Context: An Introduction to Business and Its Environment*. ISBN 978-1861529923.
- Nursing Council of New Zealand.(2005). Guidelines for cultural safety, the treaty of Waitangi and Maori health in nursing education and practice. Wellington, New Zealand. Nursing Council of New Zealand.
- Nursing Council of New Zealand (2011), Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice. ISBN 978-0-908662-38-8
- Ng, C. & Newbold, K. B. (2011). Health care providers' perspectives on the provision of prenatal care to immigrants. *Cult Health Sex*. 13(5), 561-74. doi: 10.1080/13691058.2011.555927.
- Office of Minority Health. (2013). The national culturally and linguistically appropriate services, US Department of Health and Human Services. Retrieved January 3rd 2015. http://www.hdassoc.org/wp-content/uploads/2013/03/CLAS_handout-pdf_april-24.pdf
- Omar, M.M., Högberg, U., & Bergström, B. (1994). Fertility, infertility and child survival of Somali women. *Scandinavian Journal of Social Medicine*. 22(3), 194-200.
- Palmer, P.J. (2007). "A new professional: the aims of education revisited," *Change*, 39(6), 5-12.
- Patient Centered Outcomes Research Institute (2012).National priorities for research and research agenda. <http://www.pcori.org/assets/PCORI-National-Priorities-and-Research-Agenda-2012-05-21-FINAL1.pdf>
- Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).
- Pavlish, C., Noor, S., Brandt, J. (2010). Somali immigrant women and the American health care system: discordant beliefs, divergent expectations, and silent worries. *Soc Sci Med*. (2), 353-61.
- Pew Research Center (2012). The global religious landscape: Muslims. Retrieved February 26, 2015 <http://www.pewforum.org/2012/12/18/global-religious-landscape-muslim/>
- Plummer-D'Amato, P. (2008). Focus group, methodology part 1: considerations for design. *International Journal of Therapy and Rehabilitation*, 15(2), 69-73.

- Polachek, N.R. (1998). Cultural safety: A new concept in nursing people of different ethnicities. *Journal of Advanced Nursing*, 27, pp. 452–457.
- Polit, D. & Beck, C.T. (2008). *Nursing research; generating and assessing evidence for nursing practice*. 8th edition. Philadelphia. Wolters Kluwer Lippincott, Williams & Wilkins.
- Ramsden, I.M. (2002) *Cultural Safety and nursing education in Aotearoa and Te Waipounamu*. Unpublished Doctoral Dissertation. Victoria University of Wellington. New Zealand.
- Respect (2015). Oxford University Press. Retrieved February 3 2015.
http://www.oxforddictionaries.com/us/definition/american_english/respect
- Richardson, S. (2004). Aotearoa/New Zealand nursing: from eugenics to cultural safety. *Nursing Inquiry*, 11(1), 35-42.
- Richardson, S. & Williams, T. (2007). Why is cultural safety essential in health care? *Medicine and Law*, 26(4), 699-707.
- Richardson, F., & Carryer, J. (2005). Teaching cultural safety in a New Zealand nursing education program. *Journal of Nursing Education*, 44(5), 201-208.
- Rittenmeyer, L. & Huffman, D. (2009). How professional nurses working in hospital environments experience moral distress: a systematic review. *JBI Library of Systematic Reviews*. 7(28), 1233–1290. JBL 000214.
- Robinson, J.H., Callister, L.C., Berry, J.A. & Dearing, K.A. (2008), Patient-centered care and adherence: Definitions and applications to improve outcomes. *Journal of the American Academy of Nurse Practitioners*, 20, 600–607.
- Rosenberg, J. P. and Yates, P. M. (2007), Schematic representation of case study research designs. *Journal of Advanced Nursing*, 60, 447–452. doi: 10.1111/j.1365-2648.2007.04385.x
- Saldana, J. (2009). *The coding manual for qualitative researchers*. 2nd Edition. Los Angeles. Sage Publications.
- Saha, S., Beach, M. C., & Cooper, L. (2008). Patient centeredness, cultural competence and healthcare quality. *Journal of the National Medical Association*, 100(11), 1275-1285.
- Salem, W., Flynn, P., Weaver, A., & Brost, B. (2011). Fertility after cesarean delivery among Somali-born women resident in the USA. *Journal of Immigrant & Minority Health*, 13(3), 494-499. doi: 10.1007/s10903-010-9362-4
- Silow-Carroll, S. Alteras, T. & Stepnick, L. (2006). Patient-centered care for underserved populations: definition and best practices. *Economic and Social Research Institute*. Retrieved April 1 2014
http://www.esresearch.org/documents_06/Overview.pdf
- Small, R., Gagnon, A., Gissler, M., Zeitlin, J., Bennis, M., Glazier, R., & ... Vangen, S. (2008). Somali women and their pregnancy outcomes postmigration: data from six receiving countries. *BJOG: An International Journal of Obstetrics & Gynaecology*, 115(13), 1630-1640.
- Sonfield, A. (2005) Rights vs. Responsibilities: Professional Standards and Provider Refusals. *The Guttmacher Report on Public Policy*, 8(3), p. 7-9.

- Souter, K.J. & Gernsheimer, T. (2009). Bloodless Surgery Guidelines. Administrative Policies and Procedures. Retrieved March 1, 2015.
[https://sslvpn.medical.washington.edu/BU/transfusion/Documents/_DanaInfo=\[REDACTED\].org,SSL+blood_bloodless_guidelines.pdf](https://sslvpn.medical.washington.edu/BU/transfusion/Documents/_DanaInfo=[REDACTED].org,SSL+blood_bloodless_guidelines.pdf)
- Suh, E.E. (2004). The Model of Cultural Competence through an evolutionary concept analysis. *Journal of Transcultural Nursing*, 15, 93-102.
- Tervalon M, Murray-García J. (1998). Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *Journal of the Health Care of the Poor and Underserved*, 9(2), 117-25.
- The Joint Commission. (2014). Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals. Oakbrook Terrace, IL: The Joint Commission. Retrieved January 27, 2015.
<http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf>
- Turnbull L. (2004). Health-care providers organize forum to assist Somali mothers; rate of caesareans, childbirth issues will be addressed at meeting. *Seattle Times*, 17 April 2004, p. B1.
- [REDACTED] Medical Center (2015) Mission, Values and Vision. Retrieved January 29, 2015
[http://www.\[REDACTED\].org/\[REDACTED\]medical-center/about/mission](http://www.[REDACTED].org/[REDACTED]medical-center/about/mission)).
- [REDACTED] Center (2014). [REDACTED] named 2014 Leader in LGBT Healthcare Equality. Retrieved January 12, 2015.
[https://sslvpn.medical.washington.edu/TopStories/Pages/_DanaInfo=\[REDACTED\].org,SSL+\[REDACTED\]named-2014-Leader-in-LGBT-Healthcare-Equality.aspx](https://sslvpn.medical.washington.edu/TopStories/Pages/_DanaInfo=[REDACTED].org,SSL+[REDACTED]named-2014-Leader-in-LGBT-Healthcare-Equality.aspx)
- [REDACTED] Medical Center (1998). Employee requests to not participate in aspects of care Administrative Policies and Procedures. Retrieved March 1, 2015.
[https://sslvpn.medical.washington.edu/sites/PoliciesProcedures/apop/Pages/_DanaInfo=\[REDACTED\]medicine.org,SSL+105-4.aspx?P=1](https://sslvpn.medical.washington.edu/sites/PoliciesProcedures/apop/Pages/_DanaInfo=[REDACTED]medicine.org,SSL+105-4.aspx?P=1)
- Upvall, M., Mohammed, K., & Dodge, P. (2009). Perspectives of Somali Bantu refugee women living with circumcision in the United States: a focus group approach. *International Journal of Nursing Studies*, 46(3), 360-368. doi:10.1016/j.ijnurstu.2008.04.009
- Value. (Nd.) *The American Heritage® Dictionary of the English Language, Fourth Edition*. (2003). Retrieved September 2 2012 from <http://www.thefreedictionary.com/value>
- Viruell-Fuentes, E.A., Miranda, P.Y. & Abdulrahim, S. (2012). More than culture: Structural racism, intersectionality theory, and immigrant health. *Social Sciences & Medicine*, 75(12), 2099-2106.
- Weissman, J.S., Betancourt, J., Campbell, EG, et al. (2005). Resident physicians' preparedness to provide cross-cultural care. *JAMA*, 294(9), 1058-1067. doi:10.1001/jama.294.9.1058.
- Wiklund, H., Aden, A., Högberg, U., Wikman, M., & Dahlgren, L. (2000). Somalis giving birth in Sweden: a challenge to culture and gender specific values and behaviours. *Midwifery*, 16(2), 105-115.
- Wojnar, D. (2011). Perinatal care needs of first generation Somali immigrants in the USA. Abstract: Western Institute of Nursing, Communicating Nursing Research Conference: Portland, OR.
- Wojnar, D. & Narruhn, R. (2015). Transcultural Aspects of Perinatal Health Care of Somali Women, (Chesnay, M. & Anderson, B.A.Eds.) *Caring for the Vulnerable Perspectives in Nursing Theory, Practice, and Research*. 4th edition. Jones & Bartlett Learning, LLC.Sudbury, MA.

Young, I. (1997). *Intersecting voices: dilemmas of gender, political philosophy, and policy*. Princeton University Press. Princeton New Jersey.

Appendix A. Interview Guide for Administrators.

Participant ID Number

Date

Record interview start time _____

Aims

1. To identify existing institutional policies, values and practices in this health care system that informs the provision of Patient and Family Centered and Culturally Safe reproductive health care for the Somali community.
2. To identify limitations of existing policies to guide the provision Patient & Family Centered and Culturally Safe Reproductive care for the Somali community.
3. To identify administrative and provider recommendations for strategies to address limitations in institutional policies and practices to guide the provision of Patient and Family Centered and Culturally Safe reproductive care for the Somali community.

Script

Introduction

My name is Robin Narruhn and I am a doctoral candidate in the School of Nursing. Thank you for agreeing to be interviewed for this study.

The purpose of this study is to identify the values, policies and practices, and the limitations and recommendations for strategies to address limitations in institutional policies and practices that inform the provision of Patient and Family Centered and Culturally Safe Reproductive care to the Somali community.

During this interview I will be asking you about the values, policies and practices at the Medical Center that guide the provision of Patient and Family Centered and Culturally Safe Reproductive care to the Somali community. I will use a hypothetical case study that will provide a contextual base for these questions. At the very end I would like to ask you a few demographic questions.

To get started I will like to present a hypothetical scenario to provide some context for my questions.

Case Study

The fictitious case is a 26-year-old pregnant woman, Amina, of Somali descent. This is her third pregnancy, she has one son. Amina is pleased with this pregnancy. Although Amina speaks some English, a certified interpreter is used for her prenatal visits and childbirth hospitalization. The external fetal monitoring (EFM) indicates a fetal heart distress. The resident consults with the attending physician and makes a recommendation for a delivery by Cesarean delivery, and Amina is visibly upset. She declines the Cesarean -section, saying that she needs more time to labor. She begins to pray out loud in Somali as the FHR continues its decelerations.

Questions for Aim 1

Aim 1. To identify existing institutional values, policies and practices in this health care system that informs the provision of Patient and Family Centered and Culturally Safe reproductive health care for the Somali community.

What are the institutional values that the Medical Center uses to guide the provision of health care?

Prompts

- How does the value of ____ (name value) influence the provision of Patient & Family Centered reproductive care in this case study?
- How does the value of ____ (name value) influence the provision of Culturally Safe reproductive care in this case study?

1. What are the institutional policies that guide the provision of Patient and Family Centered reproductive health care?
2. What are the institutional policies that guide the provision of Culturally Safe reproductive health care?
3. What are the institutional practices that guide the provision of Patient and Family Centered reproductive health care?
4. What are the institutional practices that guide the provision of Culturally Safe reproductive health care?

Questions for Aim 2

Aim 2. To identify limitations of existing policies to guide the provision Patient & Family Centered and Culturally Safe Reproductive care for the Somali community (Interviews & Document Review).

1. Are there clinical scenarios when Health Care Providers needed more guidance to navigate complex clinical scenarios involving reproductive care for women from Somalia in a Patient and Family Centered manner?
2. Are there clinical scenarios when Health Care Providers requested more guidance to navigate complex clinical scenarios involving reproductive care for women from Somalia in a Culturally Safe Manner?

Prompts

- Can you tell me more about that scenario?
- What happened next?
- What was the outcome?
- Were the involved parties (patient, family, health care providers and administration) satisfied with the outcome? Why? Please tell me more...

Questions for Aim 3

Aim 3. To identify administrative recommendations for strategies to address limitations in institutional policies and practices to guide the provision of Patient and Family Centered and Culturally Safe reproductive care for the Somali community.

1. What recommendations do you have for navigating this encounter in a Patient and Family Centered manner?

2. What recommendations do you have for navigating this encounter in a Culturally Safe manner?

Are there any related documents or policies that you believe I should read?

Is there anything else you would like to tell me?

Before we end this interview, is there anything else you would like to tell me about?

End of interview. This is the end of the interview. Thank you for your time. I am now turning off the tape.
Record end of interview time _____

- [HTTPS://DEPTS.\[REDACTED\]PTS1ST/LDI/](HTTPS://DEPTS.[REDACTED]PTS1ST/LDI/)
- [HTTPS://DEPTS.\[REDACTED\]/PTS1ST/TOOLS/](HTTPS://DEPTS.[REDACTED]/PTS1ST/TOOLS/)
- [HTTPS://DEPTS.\[REDACTED\]/PTS1ST/RESULTS/](HTTPS://DEPTS.[REDACTED]/PTS1ST/RESULTS/)
- [HTTPS://DEPTS.\[REDACTED\]PTS1ST/TEAMS/](HTTPS://DEPTS.[REDACTED]PTS1ST/TEAMS/)

9. POLICIES [REDACTED]

- [HTTPS://\[REDACTED\]ORG/SITES/POLICIESPROCEDURES/PAGES/DEFAULT.ASPX](HTTPS://[REDACTED]ORG/SITES/POLICIESPROCEDURES/PAGES/DEFAULT.ASPX)
- Patient Rights and Responsibilities Policy
 “[REDACTED] 2012 Annual Education (Organization Specific Topics Module)”

10. REFUSAL OF TREATMENT

- [HTTPS://\[REDACTED\]EDU/SITES/POLICIESPROCEDURES/APOP/PAGES/,DANAINFO\[REDACTED\].ORG,SSL+5-37.ASPX](HTTPS://[REDACTED]EDU/SITES/POLICIESPROCEDURES/APOP/PAGES/,DANAINFO[REDACTED].ORG,SSL+5-37.ASPX)
- [HTTPS://\[REDACTED\]ORG/SITES/POLICIESPROCEDURES/APOP/PAGES/5-39.ASPX](HTTPS://[REDACTED]ORG/SITES/POLICIESPROCEDURES/APOP/PAGES/5-39.ASPX)
- [HTTPS://SSLVPN.\[REDACTED\]MANUALS/AMC_CONSENT/,DANAINFO=KNOW1.\[REDACTED\]SSL+\[REDACTED\].IC.HTM](HTTPS://SSLVPN.[REDACTED]MANUALS/AMC_CONSENT/,DANAINFO=KNOW1.[REDACTED]SSL+[REDACTED].IC.HTM)

REFUSAL OF TREATMENT JOINT COMMISSION, 2014

11. RESIDENT ORIENTATION

Appendix C Aims with their Corresponding Deductive Codes

Aim 1-To identify existing institutional policies, values and practices in this health care system that inform the provision of patient and family centered and culturally safe reproductive health care for the Somali community.

Codes: Policy, Values and Practices

Aim 2-To identify limitations of existing policies to guide the provision of patient and family centered and culturally safe reproductive health care for the Somali community

Code: Limitations

Aim 3-To identify administrative recommendations for strategies to address limitations in institutional policies and practices to guide the provision of patient and family centered and culturally safe reproductive health care for the Somali community.

Code: Recommendations

Appendix D Aims with Corresponding Findings

Aim 1- To identify existing institutional policies, values and practices in this health care system that inform the provision of patient and family centered and culturally safe reproductive health care for the Somali community.

1.Policies

- Patient and Family Centered Care
- Respect for individual beliefs and non-discrimination.
- Treatment Decision-making
- Participants' perspectives on policies

2.Values

Institutional Values

- ARISE
 - Accountability: Take responsibility for our actions and their outcome
 - Respect: Valuing one another
 - Innovation: Using creative ways to reach our goals
 - Service: Meeting the needs of our patients and their families, physicians, colleagues, and the community
 - Excellence: Doing our best!
- Patient and Family Centered Care
 - communication, information sharing, choices, respect, partnership and strengths based.

Values Identified in Interviews

Respect

- Respect for individual beliefs and values
- Respect for choices

Patient and Family Centered Care

3.Practices

Engagement/partnership/alliance, facilitating decisions
Patient and Family Centered Care

Aim 2-To identify limitations of existing policies to guide the provision of patient and family centered and culturally safe reproductive health care for the Somali community

Lack of Early Engagement
Lack of Policy
Emergent Nature of Clinical Scenario
Assumptions
Dominance of the Biomedical Culture

Aim 3- To identify administrative recommendations for strategies to address limitations in institutional policies and practices to guide the provision of patient and family centered and culturally safe reproductive health care for the Somali community.

Code:

Pragmatic Recommendations
Paradigmatic Changing Recommendations

Appendix E Consent Form

Consent Form

[REDACTED]

 CONSENT FORM (for Administrators)

“Institutional Policies and Practices in the Provision of Patient and Family Centered and Culturally Safe Reproductive Care for Women from Somalia.”

Principal Investigator: Robin Narruhn, RN, MN
 Doctoral Candidate
 School of Nursing
 Phone: 206-290-9942

Researchers’ statement

We are asking you to be in a research study. The purpose of this consent form is to give you the information you will need to help you decide whether to be in the study or not. Please read the form carefully. You may ask questions about the purpose of the research, what we would ask you to do, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. When we have answered all your questions, you can decide if you want to be in the study or not. We will give you a copy of this form for your records.

PURPOSE OF THE STUDY

The purpose of this study is to learn about the values, practices and policies regarding the provision of patient centered and culturally safe reproductive care for women from Somalia. This study aims to identify best practices and areas for improvement in the provision of reproductive care for women from Somalia and how to best support physicians who provide care to this community.

STUDY PROCEDURES

If you participate in the study you will be interviewed. In the interview you will be asked about the institutional values, policies and practices that guide the provision of reproductive health care to women from Somalia. The interview will last twenty to sixty minutes. This time includes time for us to talk about the project, time for you to sign the forms, and time for me to answer your questions. You do not have to answer any question that you do not want to answer. You may withdraw your consent at any time and discontinue participation without any consequence.

The interview will ask questions such as

1. What are the policies about reproductive decision making and patient centered care?
2. What are the recommendations or guidelines which guide health care providers in the provision of Patient and Family Centered reproductive care for women from Somalia?

The interview will be audio-taped. These recordings will be destroyed after the data has been analyzed. No one other than the study team will have access to these audiotapes.

RISKS, STRESS, OR DISCOMFORT

Some of the questions may make you remember distressing experiences or may make you uncomfortable.

BENEFITS OF THE STUDY

There may be no direct benefit to you from participating in the study. However, the information you provide may help improve the care provided to childbearing women in the future and provide guidance for providers in delivering care.

CONFIDENTIALITY OF RESEARCH INFORMATION

The information you provide will be used for research purposes only. Your information will be labeled with a study code number. An independent document linking your name and other identifiers to the study code

number will be kept in a locked file, separate from your information. This link and any audio recordings will be destroyed by (September 1 2014).

Government or university staff sometimes review studies such as this one to make sure they are being done safely and legally. If a review of this study takes place, your records may be examined. The reviewers will protect your privacy. The study records will not be used to put you at legal risk of harm. No study information or your identity will be shared with your employer.

OTHER INFORMATION

You may refuse to participate and you are free to withdraw from this study at any time without penalty. You will be given a \$10 gift card in appreciation for your time participating in the interview.

Printed name of study staff obtaining consent Signature Date

Subject's statement

This study has been explained to me. I volunteer to take part in this research. I have had a chance to ask questions. If I have questions later about the research, I can ask one of the researchers listed above. If I have questions about my rights as a research subject, I can call the Human Subjects Division at (206) 543-0098. I will receive a copy of this consent form.

Printed name of subject Signature of subject

Copies to: Researcher
 Subject

Vita

DATE: March 20, 2015

NAME: Robin Narruhn PhD Candidate MN BSN

EDUCATION

2015	PhD in Nursing Science Winter 2015 University of Washington, Seattle
2009	Master of Nursing in Advanced Practice Community Health Systems Nursing University of Washington, Seattle
2006	Baccalaureate of Science in Nursing University of Washington, Bothell
1983	Associate Degree in Nursing, Spring 1983 Shoreline Community College, Seattle

Professional Experience

Summer 2014 1997—Present	Instructor, Social Justice and Health Care BHS 497C, UWB Staff Nurse, Labor & Delivery, Antepartum and Postpartum ...Medical Center,
Summer 2013	Instructor, Social Justice and Health Care BHS 497E, UWB
Summer 2011	Teaching Assistant, Professional Identity and Leadership NSG 530, UWS
Spring 2011	Teaching Assistant, Transition to Professional Practice NURS 419, UWS
Winter 2011	Teaching Assistant, Learning Lab/simulations NCLIN 416, UWS
Winter 2011	Teaching Assistant, Nursing of Families NURS 415, UWS
Autumn 2011	Teaching Assistant, Professional Identity and Leadership NSG 530 UWS
Summer 2010	Teaching Assistant, Professional Identity and Leadership NSG 530 UWS
1994—1997	Staff Nurse, Labor & Delivery, University of Arizona Medical Center, Tucson, AZ
1987—1993	Staff Nurse, Labor & Delivery and Postpartum Northwest Hospital, Seattle, WA

Awards, Scholarships, Honors

Fellowship 2010-2014	Graduate Assistance in Areas of National Need Fellowship (GAANN) Fellowship designed to train students in area of national need (nursing faculty). The purpose of this fellowship was to provide training to doctoral graduate students in order to graduate with competency in teaching. Training consisted of one year of formally mentored teaching assistant positions and courses on pedagogical methods.
Study Abroad June 2011	New Zealand, Interviewed several nursing faculty and scholars and observed classes regarding the theory of Cultural Safety, sponsored by GAANN fellowship.

TEACHING INTERESTS

- Undergraduate-obstetrical and maternal-child nursing, ethics, community health, social justice, culture studies, leadership
- Graduate-Cultural studies, leadership, ethics, qualitative methods

TEACHING EXPERIENCE

Instructor with Dr. Espina “Social Justice, Power and Health Care BHS 497 C” UWB Summer 2014
 Guest Lecturer October, 2014 Masters of Nursing Class Seattle University “Cultural Safety”
 Instructor with Dr. Espina “Social Justice and Health Care BHS 497 E” UWB Summer 2013
 Guest Lecturer October 2013 Masters of Nursing Class Seattle University “Cultural Safety”
 Teaching Assistant for Dr. Flagler “Professional Identity and Leadership NSG 530” UWS, Summer 2011
 Teaching Assistant for Dr. Willgerodt in “Transition to Professional Practice NURS 419” UWS, Spring 2011
 Teaching Assistant for Juvann Wolff “Learning Lab/simulations NCLIN 416” UWS, Winter 2011
 Teaching Assistant for Dr. Flagler “NSG 530 class sessions on ethics and leadership” UWS, Autumn 2011
 Teaching Assistant for Dr. Flagler in “Professional Identity & Leadership NSG 530” UWS, Summer 2010

RESEARCH EXPERIENCE

Doctoral research was a case study of an academic medical center and the description of the provision of Patient and Family Centered and Culturally Safe reproductive care for women from Somalia. Data sources were interviews and document review. Analysis was content analysis using Atlas.ti. The major findings were that there was a gap in policy that addressed cultural needs and specific policy to navigate a specific scenario.

Master’s thesis research was content analysis of conceptualization of social justice in BSN level community health nursing textbooks.

Community based research has been done with the Somali Health Board as a consultant. In this research Somali nurses conducted focus groups in the community to assess the cultural appropriateness of a Somalia prenatal Centering program. This research eventually led to the application and receipt of a grant from the March of Dimes and collaboration with King County Public Health to institute a Somali Centering program at Colombia Health Center.

CLINICAL EXPERIENCE

Staff Nurse, High-Risk Labor & Delivery, Antepartum and Postpartum
 ... Medical Center, Seattle WA 1997—Present
 University of Arizona Medical Center, Tucson AZ 1994—1997
 Northwest Hospital, Seattle WA 1987—1993

- Staff RN in Level 3 teaching hospital providing antepartum and postpartum care and labor support
- Work with laboring women in high risk situations, including medical, social and obstetrical complications
- Assist in collection of clinical data ensuring research procedures followed and maintained
- Preceptor of nursing students, new staff and new graduates on labor and delivery
- Assessed antepartum women for obstetrical wellbeing and provided appropriate nursing care
- Provided support and coaching for women during unmedicated deliveries and provided nursing assistance during delivery
- Facilitated bonding through demonstration of baby behavior assessment and teaching
- Work with diverse populations

CONSULTATION EXPERIENCE

2012-2015 Somali Health Board Perinatal Subgroup Advisor

PUBLICATIONS

Wojnar, D.M. & Narruhn, R. (2015). Transcultural aspects of perinatal health care of Somali women. In de Chesnay, M. & B. Anderson (Eds.). *Caring for the Vulnerable: Perspectives in Nursing Theory, Practice, and Research*. (4th Ed.), Jones & Bartlett Learning, LLC. Burlington, MA.

Narruhn, R. & Schellenberg, I. (2013). Caring ethics and a Somali reproductive dilemma. *Nursing Ethics*, 20(4), 366-81.

Narruhn, R. Abdullahi, A., Musse, S. Huntington, J. & Jackson, C. (2009). Ethnomed Somali Childbirth Project (2009). Perinatal Profile for Patients from Somalia. <http://ethnomed.org/clinical/mother-and-infant-care/perinatal-profile-for-patients-from-Somalia>

PRESENTATIONS

Partnerships with Somali Health Board to Promote Prenatal Centering Project for Women from Somalia. (2014). Centers for Medicare and Medicaid Services & Somali Health Board. <https://www.youtube.com/watch?v=ZCwxy2wKhNw&feature=youtube>

Center for Medicare and Medicaid Services Partnerships for Patients. (2014 ... Medical Center Patient and Family Engagement Success Story – Webinar. 03-24-2014 Master Class 8 Flyer

Narruhn, R. (2006). Quality Healthcare for Diverse Populations, October 2006 Globalization and the Somali Diaspora, Seattle WA. Podium Presentation.

SERVICE, PROFESSIONAL AND COMMUNITY

Pacific Island Health Board Member (Interim Co-Chair) 2014-2015
 Washington Center for Nursing Diversity Initiative (Mentor) 2013-2015
 Somali Health Board Perinatal Group (Advisor) 2012-2015
 Association of Community Health Nursing Educators 2012
 Washington State Nurses Association 1997-2015
 Patient and Family Centered Care Neonatal Council UWMC 2012- 2014

PROFESSIONAL ACTIVITIES

Editorial Board/ Reviewer for *Annals of Nursing and Practice* Autumn 2014

SERVICE ADMINISTRATIVE AND ACADEMIC

PhD Admission Committee, Student Participant UW Seattle