
Biomedical pluralism and transnational care-seeking: implications for culturally competent care

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Outline

- Background
 - Cultural competence and uncertainty
 - Migration from Poland to Scotland
 - Childbirth in Poland and Scotland
 - Transnational negotiation of pregnancy care between Poland and Scotland.
 - Transnationalism, biomedical pluralism and being culturally competent in practice: challenges to 'business as usual'.
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Cultural competence

.. acknowledges and incorporates—at all levels—the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs

(Betancourt et al, 2003: 294)



CC in practice: Uncertainty and ‘disempowerment’

- Uncertainty arising not from naivety but from what [health workers] *do* know (Daniels and Schwartz, 2007)
 - Concern about ‘getting it wrong’/causing offence and emphasis on cultural knowledge which can be at odds with patients’ worlds (Kai et al, 2007)
 - Routinisation, codification and sequestration replace moral deliberation, flexibility and acknowledgement of uncertainty (Guneratnam, 2008)
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The studies

- In-depth interviews with 41 staff in maternity care on barriers and facilitators to cultural competence in everyday practice.
 - Secondary analysis of Polish respondents' accounts (in Polish) of pregnancy care:
 - 5 participants 18-40 weeks of pregnancy interviewed in-depth as part of a study on H1N1 vaccination
 - 18 Polish participants in research on antenatal screening and diagnostic testing
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Uncertainty and clinical expertise

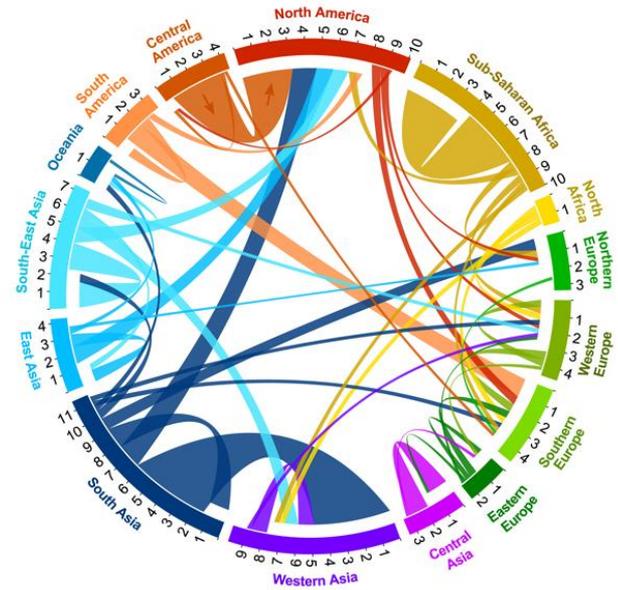


- Biomedicine becomes accessible through sensitivity to individuals' lifeworlds, cultural practices and socio-economic positions/experiences.
- Forms of knowledge and expertise distributed across the lay/clinical divide in particular ways.

'explanatory models ought to open clinicians to human communication and set their expert knowledge alongside (not over and above) the patient's own explanation and viewpoint'. (Kleinman and Benson, 2006: 294)

Medical universalism and transnational care

- Reflexivity encouraged through focus on medical practice as cultural (Kleinman and Benson, 2006)
- Emerges as a single, universal culture rather than diverse, locally-embedded forms of knowledge and practice (Van Hollen, 2003 Street, 2014).



- Increasing evidence of migrants' transnational use of biomedical care (Gideon, 2011; de Freitas, 2005)

Setting: Lothian, Scotland

- Population of around a million.
- Around 9,000 annual births.
- 26% in Edinburgh and 19% in Lothian to women born outside UK or Ireland in 2013.



Care in Scotland and Poland

Scotland

- Emphasis on 'normality' and minimal intervention (but 27.8% cs rate)
- Midwives are the experts in 'normal' pregnancy and lead the journey through pregnancy
- Little private care
- Critical voices focus on choice and 'woman-centredness'

Poland

- More medicalised (33% cs rate)
 - Gynaecologists/obstetricians lead pregnancy care: insurance-based system with significant use of private care
 - Critical voices focus on dignity in childbirth
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Polish respondents' perspectives

- Difference between 'home' and 'here' articulated through contrasts in the technologies for identifying pregnancy-related risk and the relations of care in which they were embedded.
 - Antenatal care distrusted more than intrapartum care.
 - Most accounts were ambivalent and dynamic.
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Unfamiliar Division of expertise

From the beginning I was sceptical about the whole thing when I found out that my pregnancy would be led by a midwife and not a doctor .. Now I know that the midwives are competent, but at the start I was sceptical ...I thought they didn't entirely know what they were doing. I didn't know what she knew or what she didn't know. Would she have to refer me to a doctor or not? It was a bit messy at the time.. in reality I just didn't know what to expect and what she expected of me.

Polish respondent 5

- Social as well as medical risks detected in Scotland: *'just chat'; 'it was social not medical'*
- Less 'known' by Scottish than Polish professionals

Pregnancy and modernity

I was pregnant for the first time and [having her abdomen measured with a tape measure] was a shock for me. Later I talked about it with a doctor in Poland and he opened his eyes wide and said 'is this going back to medieval times or something?'

Polish respondent 3

- Many women perceived the Scottish system to be depriving them of the technological resources to identify risk and ensure safe outcomes for themselves and their babies
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Contrasting assessment of risk

We had a lady who'd had some miscarriages previously in Poland. She was having abdominal pains at thirteen weeks. ..and phoned me up and said could she have this medicine that her Polish doctor would prescribe for her and I already actually knew about it from a previous girl and had said "No because it wasn't one that's been sanctioned in this country". So she wasnae very happy ... she took a flight to Poland and got the medicine out there.

(Community midwife 3)

- Early pregnancy considered 'disposable' in Scotland.
- Contrasting indications for c-sections.
- Resistance to instrumental deliveries.
- But intra-partum care generally appreciated

Widespread use of Polish care

- Visits, phone calls and Skype, transport of medicines.
- Sometimes silently alongside and sometimes actively brought into negotiation with Scottish health workers.

I think that many women, Poles .. travel to their own doctor who looked after them during the period before their pregnancy, to boast that they are pregnant and to have tests done .. but here there aren't these tests .. and it was something that I needed, something I expected, that's my pregnancy.

Polish Respondent 6

Being culturally competent

- Not so much sensitivity to lay cultures as ‘winning over’ women from one biomedical system to another.
 - ‘Cultural difference’ or ‘outdated medicine’?
 - *‘it’s a cultural difference if you like’*
 - *‘We don’t do that here and we’ve got all the evidence to back it up’*
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I had a Polish woman who was fully dilated and refused to have a forceps, and the head was really well down. She absolutely would not have a forceps or a ventouse [suction] and she had a full dilatation general anaesthetic section that she didn't need because she just flatly refused. She had never told anybody antenatally that she wouldn't have a forceps. And then in fact the section proved to be quite difficult as you would expect because we had to reach down quite far for the head

Actually she was fine. She was very well. She didn't run into any difficulties. So it was quite difficult because you were [hesitates, choosing the right word] "annoyed with her" is the wrong word, but you felt she had taken an inappropriate decision. We were forced into doing an operation that she didn't need. She was happy because she didn't want forceps and she didn't have forceps. And her baby was fine. The only thing, she was a little bit annoyed that we were all badgering her, because the senior registrar, myself, and another consultant, all spoke to her in theatre and of course it's inappropriate to do it at that point in the proceedings, but we were all just kind of looking at this baby's head and thinking, "This is bonkers!". [laughs]

Obstetrician 2

Challenges to 'business as usual'

- Medical expertise as a core 'certainty' clinicians brought to cross-cultural encounters was undercut
 - Polish professional expertise harnessed for this: contested evidence by professionals by whom women were more 'known'.
 - Unease at undermining colleagues elsewhere:
 - goes against the professional grain
 - bad for patient confidence and care
 - Cultural competence only one amongst a range of everyday imperatives
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Shadowy counterparts in Poland

... but that's what it is or I've known people go home and have scans or consults and then come back and go "... but my doctor says this..." and it's like ".. well I can see their viewpoint, but that's not what our feeling is about that" and when we look at the evidence, that's not what we think is the best for you and and that can be quite difficult.

Community Midwife 4

maybe it is because they're in sort of two different systems but you feel that its just sub-optimal you know, because you kind of maybe I ... I'm doing what somebody said or giving a different slant on what somebody has been told before or so that's ... Obstetrician 4

She's been given advice by someone who is equally as expert as me .. Obstetrician 1

Context-dependent

*it's difficult to get the balance right
...I'm always kind of conscious
that given the research advice
that I would tell them about it, but
you you've got to respect cultural
diversity as well, and if these
families are going to go back to
Poland and that that's the way
that they choose to bring their
children up it's kind of getting it
right, so that you're not
offending..and not sort of trying to
impose*

Health Visitor 1

*You're treading a fine line
because you obviously want to
work with the client. You're not
wanting to dictate at all*

Health Visitor 4

New sites of stigma?

- 'Over-consumption' of scarce resources and regulation at 'street level'
- Population-specific stigma?
- Disrupting expertise and trust

I brought [test results] with me, but my midwife asked me in ironic way if I was under care here, or there. So I took it as very unpleasant comment. She had a problem, she was thinking that I was checking her. .. I didn't expect that they would use [the results]. We have different units, slightly different norms and so on. But the fact that she treated me in this ironic way asking where I was seeking help, and did I trust them .. That was just very unpleasant.

Polish respondent 5

Conclusions

- Positives overlooked
 - Counting experiences of biomedicine into migrant patients' therapeutic landscapes
 - Drawing on sociological/anthropological perspectives which recognise:
 - biomedical practices and knowledge as locally varied
 - lay perspectives as increasingly medicalised – findings extend beyond this population
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Conclusions ...

- No easy solutions but counting biomedical pluralism into eliciting explanatory models might help
 - Undergraduate and postgraduate teaching which foreground uncertainty and ‘messiness’: bioethics teaching as a model
 - Explore implications for other settings, specialisms and migrant groups
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