political updates

The Ethics of Out-of-Country Midwifery Training

by LISA DELORME, RM, MSM

In 2014, the North American Registry of Midwives (NARM) stopped accepting out-of-country (OOC) clinical experience for PEP applicants due to challenges with oversight of international clinical training locations (http://narm.org/news/revised-policies-ooc/). Students of MEAC-accredited (Midwifery Education Accreditation Council) schools could continue training at school-approved OOC sites. In November, 2014, MEAC issued a statement on OOC training (http://meacschools.org/education-faq/out-of-country-clinical-training/). We hope this piece can help students and midwives alike engage thoughtfully with the issue of OOC training facing the midwifery community today.

– Editors of Midwifery Matters

Students of many different disciplines are increasingly requesting global health content in their programs' curricula.[1,2] As globalization and cultural competency emerge as priorities in health care this content is becoming an important part of education for many health care practitioners.[3,4,5] Based on information from MEAC-accredited school course catalogues and the recent attention given to international clinical rotation criteria by NARM, it is clear that international rotations occupy a significant role in the educational experience of many direct-entry midwifery (DEM) students. Yet while the provision of international experiences for direct-entry midwives has grown, the discussion around the ethics of international work and the development of policy to support ethical practice has only just begun. Furthermore, much of this discussion is theoretical as there is a significant lack of empirical research on this subject.[6] The research that is available notes that ethical issues occur when students from high-resource countries travel to low-resource countries with different cultural and social norms. With out-of-country rotations occurring in DEM education, it is essential that the ethics of providing care in an international and often foreign context be understood and considered.[6,7]

Significant concern has begun to emerge that the structure of educational experiences which involve sending predominantly white middle-class students to work in populations of people of color facing economic hardship can represent a continuum of racist, imperial or colonial relationships and may serve to reinforce perceptions of Western/European power and privilege.[4,8] These continued systems of power and oppression are intricate and shape both the internal world of the individual and the collective external environment. In his analysis on ethical and pedagogical issues in sending students to learn in other countries, Epprecht states that barriers exist to exchanges that are free from unbalanced or detrimental power relations.[9] These barriers are found within the "hidden curriculum," a set of often subconscious cultural beliefs that include the historical legacy of racism, heterosexism, and anthropocentrism among other prejudices, and serve to enforce the colonizing tendency of international work.

While social disparities are often evident during international clinical rotations, participants often do not recognize or are uncomfortable acknowledging the role their privilege plays in perpetuating inequity. There is evidence that among most members of privileged groups, inequities are often framed as disadvantages associated with belonging to the less privileged group. It has been noted that the way in which individuals perceive inequity, either as manifestations of privilege or as consequences of disadvantage, can have important psychological consequences and may be used to allow members of the dominant group to avoid the distressing personal implications of inequality.[10] Tiessen (2012:15) found that while increasing cross-cultural understanding was one of the most popular reasons students decided to participate in international volunteering, the experience did not serve to "promote an improved understanding of one's positionality and relative privilege ascribed through class, race, gendered power relations and access to opportunities and resources."[11] Furthermore, in international work involving women there is a tendency for Western participants to form a collective identity with women in their host community, failing to appreciate power differences based on color, class and nationality. As Nestel (2006:17) states, "Feminist projects that posit a shared female identity across categories of difference and that fail to take into account how women are positioned as both dominant and subordinate in relation to one another are themselves fated to reproduce relations of domination."[12]

Women in developing countries are commoditized as learning models for North American midwifery students.

One set of ethical issues that lie at the heart of the discourse of unexamined privilege in international rotations are those relating to student motivations. In her study on the motivation of Canadian students participating in short-term international volunteering electives, Tiessen identified several key concerns including 1) self-oriented motivations; 2) an absence of interest in effecting structural change; 3) a lack of personal responsibility in examining global inequities; and 4) a lack of motivation based on solidarity and giving to others.[11] When altruistic motivations are declared, participants frequently identify as "helpers," a role which has connotations of a vertical relationship and once again speaks to unexamined positions of power.

Self-oriented motivations are very common in international clinical rotations in health care professions, as students often embark on these experiences to develop or improve clinical skills.[13] This has left many to question the ethics of allowing members of a dominant group to travel to another location in order to practice skills, often beyond what they would be allowed to practice on other members of their own communities, on marginalized people who may not have another option for care.[7,12,14]

Motivation primarily based on skills acquisition may also promote a unilateral or unequal flow of gains towards the already privileged student/institution/community and may ultimately have negative consequences for the host community.[15] This relation based on unequal power dynamics caused one student to remark (Abedini et al. 2012:825): "When you're really looking out for your own interests and there's a huge power and economic differential …

there's a potential for exploitation, and … if you're not really able to know the local interests, there's a potential for doing harm."[16] Students and sending institutions need to evaluate whether the ability of the student to provide a novice level of health care to the host community balances the rewards the student may gain from the experience including: fulfilling graduation requirements, gaining/improving clinical skills, resume building, having an adventure, and expanding/improving one's self-image. Exploitation occurs when the project serves the student's or sending institution's needs instead of first focusing on the self-identified needs, desires, and movements of the host community.[17]

Although students may feel they are serving the needs of the host community this may not be the case, as clients may not feel safe to speak freely and honestly in the presence of a power differential based on class, race, professional standing and/or nationality or due to a lack of health education.[4,18] The issue of a unilateral or unbalanced flow of gains can be especially problematic in short-term rotations, as a lack of a sustained relationship may result in the student requiring more energy than is ultimately gained by the receiving community.[2] Despite the numbers of studies documenting the effect of international volunteering on students, there has been surprisingly little attention paid to formal evaluation of the impact of international clinical rotations on host communities.[19]

While there is sufficient evidence in the literature from other professions to document that ethical issues exist with sending students from high-resource countries to low-resource countries for educational purposes, is this the case with international clinical rotations in direct-entry midwifery education? Although there is a scant amount of literature on the subject of international clinical rotations among DEM students, the answer from the limited resources available appears to not only be yes, but also that these ethical issues often parallel those found in other disciplines.

In her research on the re-emergence and eventual professionalization of midwifery in Ontario, Canadian author Sheryl Nestel found that many midwives, seeking the number of births required for registration, travelled to developing world sites or to border clinics serving marginalized Mexican immigrants.[12] There the midwives were not only able to enhance their skills, but also then were able to lay claim to the knowledge of the birth practices of women in developing countries. They were also able to manage complicated maternity cases, something they would have never been able to do in Ontario, which in turn granted them more professional repute. It was the privilege granted to them through their white skin, middle-class status, and Canadian passport that allowed these women to travel across borders and gain access to women's bodies in other countries. From these experiences, some midwives reported being challenged by the lack of choice and the violence experienced by birthing women. However, Canadian midwives were able to rationalize the violence experienced by these women through discourses of benevolence and sisterhood across borders and power differentials. This same sense of a global sisterhood did not seem to apply at home, however, as immigrant midwives were largely excluded from the registration of midwives in Canada. Nestel remarked that the Canadian midwives showed no awareness of the benefits accrued to them due to their unearned privileges. They left these countries with skills that allowed them to gain an elite place as primary health care providers in the Canadian health care system. For the women whose bodies provided this increase in status and material wealth, little reward was given. Their place and the place of their children, within an unequal social structure, remained unchanged.

The same ethical issues noted by Nestel in the professionalization process of Ontario midwives, and present in other health care disciplines, seem to be present in DEM midwifery education. In an examination of Karen Hays' summary of Seattle Midwifery School* graduates' responses to a questionnaire on foreign training sites, many of the same constructs and themes can be identified. All of the 59 respondents reported going to an international site in a developing country with the average stay being 3 to 8 weeks. Reasons students chose to go to an overseas hospital site included (in order of most cited to least cited): 1) achieving the number of births required for graduation; 2) cross-cultural experience; 3) clinical skills improvement; 4) fun, adventure, travel, location/climate; and 5) interest in seeing obstetrical complications. None of the reasons mentioned were for the benefit of the host community, despite the fact that these women were travelling from a high-resource environment to a low-resource environment. This list is a clear demonstration of the unilateral and unequal exchange that is a major ethical issue inherent in many international clinical rotations. It is also apparent that women in developing countries were once again commoditized as learning models for North American midwifery students. Students were allowed to perform skills that they often were not able to do at home, including suturing, IVs, and management of various complications (neonatal resuscitation, episiotomy) or variations of normal (breeches, twins) in which they most likely had very little skill or training.[20] This desire for clinical skill reflects a lack of opportunities for experience with medical complications and emergency situations, which is a gap that has been identified in midwifery education in high-resource countries.[21] Through their membership in a mainly white, middle-class, North American group, DEM students were able to travel to a low-resource country and to return with resources that would allow them professional advancement in their own countries. But, as Nestel observed in Canada, this rarely resulted in advancement or significant gain in the low-resource countries where important knowledge and skills were obtained.

It is clear that, as in many educational programs, DEM educators need to evaluate the ethical issues inherent in international education. Conscious program and policy development may divert the perpetuation of historic and current forces of oppression that without forethought and awareness may be inherent in current models of international rotations.[22] More research is needed on the ethics and impact of international midwifery work. In the interim, we can try to avoid future harm through engaging in honest conversation around the ethics of international and cross-cultural work, and through developing policies and guidelines to meet this goal. ◉

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*Seattle Midwifery School became the Department of Midwifery at Bastyr University in 2010.

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