CULTURAL SAFETY: A VITAL ELEMENT FOR NURSING ETHICS

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Abstract

This paper argues that the globalisation of nursing and the internationalisation of nursing education have lead to Western values being embedded into nursing curricula in nations where the cultural values and beliefs may be based in quite different philosophies. It argues for critical examination of assumptions underpinning ethics education in nursing and proposes that the principles of cultural safety need to be incorporated into ethics education to create a culturally safe ethic for both nurses and patients in a multicultural healthcare environment.

Key words: ethics, cultural safety, nursing education, internationalisation

The internationalisation of nursing education

A significant contemporary phenomenon is the globalisation of the nursing workforce and the internationalisation of higher education in nursing (Allen & Ogilvie 2004). Although the large number of students studying out of their home countries may be a relatively recent phenomenon, the internationalisation of nursing education is not. Nursing education has been an 'export industry' since the inception of the professional era in nursing following the Nightingale reforms in the Western world in the 1880s.

In New Zealand, as in most nations, the origins of contemporary nursing practice and education lie in the work of Nightingale's lady-pupils: her disciples who propagated her methods throughout the world dominated by the nineteenth century British Empire. Consequently, Western paradigms have been highly influential worldwide in the development of nursing practice and education. In Australia, for example, Dickson, Lock and Carey (2007) note that nursing education and practice "is framed by the values, beliefs and expectations of a dominant western culture, inclusive of theoretical and practice underpinnings from other first world English speaking countries" (p. 2). Western cultural perspectives and values, embedded in nursing education, practice and research have been exported to countries with different cultural perspectives and practices. They have been transported by nurses from countries in the Anglo-US axis who have worked overseas, including teachers and researchers, and many nurse leaders from non-Western nations have undertaken some of their education in English-speaking countries. As well, English is the dominant international and professional language, consequently many nursing school libraries have English language books and journals, most of which derive from either the United States (US) or the United Kingdom (UK) (Davis, 1999). These books and journals reflect the value systems of the nations in which they originate.

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Nursing ethics and education

Kerridge, Lowe and Stewart (2009) point out that most health professions require their members to comply with an ethical code or code of conduct. Nursing is no exception and Todaro-Francheschi (2012) argues that the teaching and facilitation of social/moral roles and ethical behaviour is as important as the teaching of "nurse think", i.e., practical reasoning skills, and skills acquisition.

Ethics is a branch of philosophy which concerns the values underpinning motivations and actions: it is about both thinking and doing (Kirby & Slevin, 1995). It also encompasses the consequences that result from these thoughts and behaviours. Whereas nursing ethics is described more specifically as a:

> ... domain of inquiry that focuses on the moral problems and challenges that nurses face in the course of their work. It involves an exploration and analysis of the beliefs, values, attitudes, assumptions, arguments, emotions and relationships that underlie nursing ethical decisions. (Dooley & McCarthy 2005, p. xi)

If, as contended by Dooley and McCarthy, nursing ethics involves exploration and analysis of beliefs, values and relationships then it follows that there is a social dimension which requires consideration of and respect for others (Kerridge et al., 2009). In terms of nursing practise, it means being able to practice "patient-centred nursing that is congruent with the personal values of patients, the institution and society" (Caldwell, Lu & Harding, 2010, p. 191). This is apparent in the increased emphasis on meeting the needs of a multicultural patient population, as well as a culturally diverse nursing student body (Nairn, Hardy, Harling, Parumal & Narayanasamy, 2011). It is questionable, however, how successful this increased interest in meeting the needs of culturally diverse patients and students is when we consider the values which underpin the teaching and practice of ethics in nursing.

Whose values underpin nursing ethics?

According to Johnstone (2008), in order to understand the basis of ethical professional conduct nurses need a working knowledge of the concepts and theories of ethics, and the language which describes these. She traces the history of "ethics, as it is referred to and used today" (p. 12) to the works of the Ancient Greek philosophers: Socrates, Plato and Aristotle. These men laid a foundation for the Western approach to ethics which emphasised moral decision-making, questions about how we should live and act, based in unemotional, rational justification (Kerridge et al., 2009).

Johnstone (2008) contends that ethics is culturally constructed and culture is the foundation for shared beliefs, customs and values. Yet, although the practise of nursing is universal, it is rarely questioned whether nurses globally share the same values (Davis, 1999). In the US, for example, a dominant national theme is that of the pioneer, the 'rugged individual', and subsequently the notion of 'self-reliance' has become deeply engrained in the cultural psyche (Davis). Similarly, in Aotearoa New Zealand self-reliance is a prized attribute in Pākehā society. It is exemplified in the almost legendary figures of Colin 'Pinetree' Meads, Barry Crump, Fred Dagg and Wal Footrot (Harding, 2006)[1]. A stereotypical image has been created of the New Zealand male which Phillips (1987) summarised as:

> A rugged practical bloke – fixes anything, strong and tough, keeps his emotions to himself, usually scornful of women. Yet at heart a decent person, loyal to his mates, provides well for the wife and kids ... (backcover)

The idealised values of individualism and self-reliance are embedded in our national psyche. Even though these cultural constructs now verge on being an almost mythical image of a vanished colonial past, they remain influential. Davis (1999) contends that the ethical principle of autonomy and its application in ethico-legal practices such as informed consent and advance directives operationalise such values. The problem with such cultural constructs underpinning our approach to ethics is that they are not universal values, but hegemonic constructs which, in Aotearoa New Zealand, reflect a world view of the European coloniser.

World culture can be loosely divided into two different types: the individualist and the collectivist cultures. The former tends to characterise the hegemonic cultures in Europe, North America and other English-speaking countries such as Australia and New Zealand. In such cultures the rights of the individual are predominant. The majority of the world's cultures, however, are more like those which can be categorised as 'collectivist': where, loyalty to a group may outweigh individual rights (Davis, 1999). For people acculturated in the values of societies characterised by collectivism, autonomy may be inimical because the fundamental cultural value is that of group cohesion. For example, in China, ethics is deep rooted in general philosophy and culture, and the core of Chinese culture is in three different teachings: Confucianism, Taoism and Chinese Buddhism (Qui, 2006). Arguably, the most influential of these philosophical approaches has been Confucianism, which emphasizes virtue, duty and context (Caldwell et al.,2010). The 'self' in Chinese culture is subordinate to relationships with others (Bockover, 2003). Similarly, in Japan the word for self (*jibun*) means part of a larger whole that consists of groups and relationships; therefore:

> individuals are not essentially apart from the society in which they exist. The individual or self attains and maintains form through relating to other in a variety of ways (Davis 1999, p. 121).

In Aotearoa New Zealand, the cultural values of Tangata Whenua have far more in common with those societies which can be termed 'collectivist' than they do with the cultural values of the 'individualist' colonisers. Māori identity is based in kinship relationships, but has been subject to processes of enculturation into the dominant Pākehā culture through covert and overt processes of assimilation (Williams, 2001). The processes of colonisation have subordinated the cultural values of the Māori to those of the European coloniser. The education system has been a very powerful tool in this process, based on a Western paradigm of learning with, in particular, an emphasis on written language as the basis for rational thinking (Jones & Hunter, 2004).

In healthcare, an example of rational thinking is the use of normative ethics – principles, rules, theories and guidelines – which may be used as a template to guide our actions. This approach is fundamental to the four principles formulated by the US authors Beauchamp and Childress (2001) in which autonomy, beneficence, non-maleficence and justice provide a framework for ethical decision making in health care. A particularly influential development in the latter part of the twentieth century was the emergence of the field of bioethics which Reich (1995) defined as:

1 Colin Meads is arguably New Zealand's most famous former All Black. Barry Crump, author, characterised in his own life the New Zealand male stereotype. Fred Dagg was the comic alter ego of John. Clarke who satirised the rural New Zealand male and Wal Footrot was the eponymous hero of the popular comic strip Footrot Flats, which also drew upon the rural New Zealand male stereotype for humorous effect.

> [t]he systematic study of the moral dimensions – including moral vision, decisions, conduct and policies – of the life sciences and health care, employing a variety of ethical methodologies in an interdisciplinary setting. (p. xxi)

Bioethics represents an approach to ethical decision making which Johnstone (2008) describes as primarily focused on medical concerns and which has been instrumental in propagating "distinctively American concerns and offering distinctively American solutions and resolutions to the bioethical problems identified" (p. 15). Kerridge et al., (2009) situate bioethics as part of a family of applied ethical enquiry, *practical ethics*, which addresses ethical concerns within specific contexts. They describe nursing ethics as being one part of bioethics, alongside 'medical ethics', 'psychological ethics' and 'environmental ethics'. Over the last two decades critical debate of bioethics has occurred, nevertheless the bioethical view has become influential worldwide (Johnstone, 2008).

The notion that nursing ethics is a subset of bioethics would not be a view held by all nurses and much has been written about efforts to develop a theory of nursing ethics in which care – based on the values of concern, compassion and empathy - is the ontological substance. Thus, a number of nurses have promoted an ethic of care based upon the notion that women are naturally predisposed to caring. Kuhse (1997) noted the parallels between these developments and feminist endeavours with respect to formulating a woman-centred approach to ethics. Such a position has been criticised by women of colour and lesbians. For example, hooks (1984) was critical of white upper-class women for presenting a "one-dimensional perspective on women's reality … white women who dominate feminist discourse today rarely question whether or not their perspective on women's reality is true to their lived experiences of women as a collective group" (p. 3). Similarly, the pre-eminence of Western bioethics in ethics education in nursing provides a 'one-dimensional perspective', which fails to value the moral and ethical traditions of many recipients of health care and also those who provide that care.

Ethics in the nursing curriculum: Where is cultural safety?

In Aotearoa New Zealand, The Nursing Council of New Zealand (NCNZ) is the statutory authority that governs the practice of nursing in New Zealand and as such sets the standards for nursing registration and education. Contained within the competencies (and accompanying indicators) that are required for admittance to the register of nurses is the explicit determination that the applicant "accept responsibility for ensuring that his/her nursing practice and conduct meets the standards of the professional, ethical and relevant legislated requirements" (p. 4). Schools of nursing are therefore required to ensure that students, and future graduates, are able to practice within appropriate ethical frameworks.

Consequently, every nursing curriculum contains ethics teaching, however, the amount of content, degree of visibility, and assessment of practice application varies. Some programmes have dedicated ethics courses, others may have it situated as part of another larger course, and others may incorporate it as theme which runs through a number of courses. However, ethics is positioned within a particular curriculum and whether or not the teaching draws upon principilism, bioethics or an approach based on a feminist ethics the values that are being promoted are predominantly those of the Western, largely English-speaking, world. There is a hegemonic discourse inherent in nursing education and the teaching of ethics and arguably in the practise of nursing that reflects Western philosophical traditions.

Since the late 1980s, nursing in New Zealand has accepted the need for a focus on cultural safety and an understanding of the impact of colonisation on the health of the Tangata Whenua. In the early stages of theory development (1988-1991), cultural safety had a strong bicultural focus. This arose from the view that student nurses needed to recognise the importance of the Treaty of Waitangi and the impact of colonisation on Māori. In the decade following, the concept was refined further and subjected to political and public scrutiny as it became embedded in education and practice (Ramsden, 2002). Following on from the seminal work of Irihapiti Ramsden, the concept has evolved from its initial bicultural focus to incorporate a wider multicultural focus (Richardson & Carryer, 2006). Yet, even in light of the paradigm shift heralded by cultural safety education, it has been questioned whether the danger remains that nursing education continues to perpetuate dominant ideologies (Spence, 1994). The question is as pertinent now as it was in the mid 1990s, as Woods (2010) comments:

> Yet for all of its apparent success in educating and monitoring the practices of New Zealand nurses, the acceptance of the concept of cultural safety as an approach to guiding effective care, and especially as a guide to ethical nursing practice, remains open to considerable debate (p. 716).

It is arguable that the teaching of cultural safety may be perceived as somehow a course of study which stands apart from the teaching of ethics, taught by its own groups of 'experts', therefore there has been little acknowledgement of the underlying Western bias in the expected ethical knowledge and behaviour and their reflection of values derived from Western Judeo/Christian philosophies. Nurses and nursing students are, therefore, often required to operate within ethical frameworks which are either alien to their cultural norms or those of the patients for whom they are caring. This has the potential to place them in conflicting ethical situations (Caldwell, Lu & Harding, 2010). As Woods (2010) notes:

> problems may arise when nurses attempt to match notions of desirable 'universal' moral principles, such as autonomy and justice, with the largely relativistic 'cultural norms' of different patients under the auspices of the dominant culture of medicine (p.719).

This is not to suggest that there has been a conscious process of disregard for the needs of these students. However, as Woods (2005) notes, given that there are small numbers of nurse educators who have postgraduate qualifications and with a multiplicity of possible and theoretical approaches to teaching nursing ethics, it may be that it is the lecturer's background and preference that drives the choice of ethical frameworks. As a corollary, it is likely that there will be an even smaller number of nurse educators who are able to not only teach ethics but also authentically incorporate a Māori perspective into this teaching.

Is it time to critically deconstruct nursing ethics?

In the early 1990s writers from a diversity of academic disciplines began to question the hegemonic discourse inherent in Western ethics. Over the last decade in countries of the Pacific rim there has been questioning of the largely unchallenged primacy of Western bioethics in medicine (For example: Qui 2006; Doring 2003; Miyasaka et al., 1999; Fan 1998; Ip et al., 1998). Nie (2000), however, cautioned against assuming a homogeneous Chinese or American bioethics and points out that there is no single approach and that both cultural and medical traditions manifest individualistic and communitarian values.

Within nursing, this debate has been particularly applied to bioethics. Myser (2003) cautions those working in the field of bioethics to engage in stringent self-reflection with respect to the construction of dominant mainstream theories and methods. She emphasizes the apparent lack of critical examination of the "dominance and normativity of whiteness in the cultural construction of bioethics in the United States" (p. 2). Myser suggests that in not recognising this privileged whiteness, and then to theorise from a non-reflective ethnocentric standpoint, is to risk perpetuation of cultural colonisation. A process in which nursing has engaged through the hegemony of nursing education and practice from an Anglophone perspective and the assumption that, even though nursing may be global, nurses share the same values throughout the world. For example, in Korea, Han and Anh (2000) investigated how Korean student nurses made ethical decisions in relation to the Korean nurses' code of ethics; however, there is no evidence that this code reflects Korean cultural values. Similarly, Park et al. (2003) replicated a US study, questioning whether the study's results, which explored the use of five ethical decision-making models, would be relevant in Korea. What was not questioned, however, was whether a research tool based in Anglo-American values would be appropriate in this context.

Nurses are engaged in appraising, exploring and scrutinising what is taught and practised in the distinctive field of nursing ethics; however, not all nurse researchers/writers acknowledge the core of ethnocentricity rooted in the still dominant Western philosophical traditions that inform most nursing ethics curricula and practice. In Europe, for example, nurse clinicians such as Allmark (2005) and Esterhuizen (2006) have questioned the value of ethics and the use of professional codes in nursing practice. Despite the globalisation of nursing and heavy nursing recruitment from non-Western countries neither of these two nurses critiques the dominant Western cultural imperative inherent in this perspective. Conversely, other nurse academics and researchers have explored the discrepancies and tensions between nursing ethics based on Western moral philosophy and cultural norms with those from a variety of different Asian philosophical and cultural traditions, including Davis (1996), The Working Group for the Study of Ethical Issues in International Nursing Research (2003), Wros, Doutrich and Izumi (2004), Xu, Davidzhar and Giger (2005), and Cameron, Schaffer and Park (2001).

In Aotearoa New Zealand, Māori researchers and academics have begun developing a framework for Māori research ethics (Forster, 2003; Smith et al., 2009), which will reflect the values of a people for whom the collective is paramount in contrast to the dominant values expressed in the social, cultural and institutional environments which mainly reflect Western moral traditions and a focus on norms, rights and principles. It is critical that nursing educators reflect such developments in our approach to the teaching of ethics otherwise we risk espousing an ethic that may be unsafe for students, nurses and patients.

Woods (2010) offers a way forward with his concept of the socioethical nurse. He posits that cultural safety contains key ethical elements which reflect "communal values, traditional practices, and co-operative virtues within a multicultural society" (p. 719). He outlines the key features of such an ethic as: promoting social justice and empowerment; maintaining individual/ collective cultural autonomy and identity; and, trust and respect. The challenge now lies with those of us who teach ethics in the nursing curriculum to challenge our own assumptions and explore ways in which the principles of cultural safety can enhance our teaching.

Conclusion

The use of Western philosophical ethics, sifted through a European cultural lens, has become the

standard template for the teaching of nursing ethics worldwide. In doing so it enshrines the notion that all other cultures should have and use the same values which predominant in those cultures which can be characterised as 'individualistic'.

Critical examination of what and how we teach nursing ethics is required to ensure that the subject matter is not perceived merely as a sub-category of bioethics reflecting hegemonic European values. New Zealand nurses have been global leaders with respect to cultural safety and it is now time to extend that understanding of cultural safety into the teaching of ethics. By doing so it may provide a way forward to facilitate nurses developing understanding and competence to address ethical dilemmas in clinical practice across a multiplicity of cultural perspectives, while at the same time the ethical values derived from their own culture are respected and valued.

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