

Cultural Awareness of Nurses in Practice

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From times immemorial, student nurses have been reciting the Nightingale Pledge to honour their commitment to the nursing profession. Most probably, during their recitation, the students may have decided to emulate Florence Nightingale during their practice. What is little known is that the 'Nightingale Pledge' was actually composed in 1893 by Mrs. Lystra E. Gretter and a Committee for the Farrand Training School for Nurses in Detroit, Michigan, USA. She named the pledge as a token of esteem for the founder of modern nursing.

The lines, ".....I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug" was a constant echo which spelt the safety of the nurse towards the patient. In recent years, it was felt that the Pledge outlived its usefulness, and needed to be brought in with the times. The pledge as outlined by the Trained Nurses Association of India has sought to redress this issue by reiterating, "I will serve mankind with love and compassion, recognizing their dignity and rights irrespective of colour, caste, creed, religion and nationality". The aim of this article is to discuss nursing service in terms of patient safety, chiefly, from the point of view of the patient's culture.

Safety of the patient has always been paramount in the mind of a professional nurse, whether at a clinical or educational setting. Abraham Maslow identified 'safety and security' as a basic need sited

just above the fundamental physiological needs. The need for safety has both physical and psychological implications. The person needs to feel safe, both in the physical environment and in relationships. For a long time now, nurses have considered safety from the physical point of view. Maintaining physical safety of a patient has always been an integral part of nursing care. The time has come to consider other aspects of patient safety, i.e. cultural safety.

India is a multicultural society where people of diverse cultures and religions coexist and most often present themselves in the clinical setting. When one speaks about culture, one often tends to reflect on the ethnicity of person or the state or geographical location one belongs to. What must be kept in mind is that ethnicity is only one aspect of the culture of a person. There are other aspects which are equally important:

- ♦ Gender
- ♦ Religion
- ♦ Caste
- ♦ Sexual orientation
- ♦ Age
- ♦ Education
- ♦ Socio-economic status

Culture also includes people's experiences as an influence of migration, social status and employment. All these experiences have an outcome on a patient's health status and hence require consideration by the nurse.

Meaning of Culture

A review of medical and nursing literature provides an array of definitions and meanings of the word 'culture'.

Madeleine Leininger, an eminent nurse anthropologist, who has

done much for transcultural nursing provides her definition of culture. She states that, "culture is the pervasive and continuous force that influences and shapes the lives of human beings in significant ways".

According to Betancourt (2004), "we all belong to more than one culture, which, may for example, be social, professional, or religious; the concept goes beyond race, ethnic background, and country of origin."

Every person is a unique individual, and all the above sub-cultures contribute to that individuality. When caring for a client, nurses must consider all the factors regarding the client. Indeed, in the old school of thought, student nurses were taught 'to care for a patient regardless of their culture'. In other words, all patients were to be accorded the same quality of care, without consideration of their individual culture. Nurses who abided with this concept were considered as 'safe nurses'.

The new trend of thought discounts this idea and defines a 'safe nurse' as one who 'cares for a patient regardless of their culture'. Each sub-culture is meaningful to the patient. When nurses are caring for a patient, they not only look after the clinical condition of a patient, but, in order to impart a holistic approach to their care, they also look at the other dimensions of nursing care, namely, the family and psychosocial aspects of the patient.

It is not possible to provide a stereotyped level of care to all patients and disregard their individual culture, but it is possible to generalize the care given.

Galanti (1991) provides a differentiation between stereotyping and generalization:

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"A stereotype is an ending point; no attempt is made to learn whether the individual in question fits the statement.

A generalization is a beginning point, it indicates common trends, but further information is needed to ascertain whether the statement is appropriate to a particular individual."

One should not assume that patients can be categorized into little boxes on the basis of their caste or culture. Neither should one think that the various aspects of one cultural group are applicable to every other patient belonging to that same group.

It is a well-known fact that a patient's health beliefs and practices are governed by their culture. The question that we need to ask is how can we ignore the culture of a patient and yet state that the care provided is of a high standard? As professional nurses, we need to introspect into our relationship with patients and ask :

- * Does the fact that a patient belongs to a lower socio economic status, makes the patient a lesser individual?
- * Does the fact that a patient is a homosexual or lesbian, makes the patient a lesser individual?
- * Does the fact that the patient does not belong to the same caste/creed/state as the nurse, make them (the patients) lesser individuals?
- * Does the fact that a patient is elderly, make the patient a potential case for senile dementia?
- * Does the fact that a patient is in the paediatric age group, does not necessitate the need for nurse-patient communication?
- * Does the fact that the patient has a "socially unacceptable" illness such as mental illness, AIDS, alcoholism, substance

abuse, or sexually transmitted disease, make them lesser individuals?

If nurses profess to work in a caring and non-discriminatory manner, they must accept the patient for what he or she is, and not for what nurses feel the patients should be. We often use our own cultures and backgrounds to determine what is 'normal' and 'acceptable' even though we are aware that everyone is different. As such, other cultures are observed as inferior, unacceptable and strange. This is known as *ethnocentrism*.

Nursing students should learn right from the fundamental stage of their nursing education that it is equally important to care for a patient's culture as it is to check vital signs or perform nursing procedures.

Ethnocentric nurses are inhibited from delivering therapeutic and safe care to their patients. By evaluating their own existing biases and prejudices, nurses are more likely to work towards the interests of the patients rather than forcing the patients to do what nurses think is right.

In the final analysis, when confronted with the temptation to discriminate, nurses must contemplate whether, if placed in the patient's situation, they would like to provide technically inferior care because of the difference in caste, colour and / or religion?

Cultural competence

Deloughery (1998) set a new phrase termed as '**cultural competence**' which has been defined as, "The standard goal of caring for clients whose cultural background is different from the nurse". Cultural competence means really listening

to the patient with the objective of learning about the patient's perceptions of health and illness and the equation between the patient's culture and the patient's perceptions.

Cultural competence is not a magic treatment that will alone improve the health outcome of the patient. It is an essential skill for nurses who wish to deliver quality care to their patients. Working in a culturally diverse environment tests the ability and skill of a nurse to effectively care for patients in not only a clinically proficient manner, but also, from the point of view of cultural competence.

Cultural competence is about providing care to a patient, while concurrently meeting the needs of the family as well. A nurse who is culturally competent is not required to possess specialist knowledge about various cultures. Rather, it calls for sensitivity and awareness on the part of the nurse and demonstration of the same in her practice.

Luckmann (1999) outlined eight significant hurdles which challenge the nurse's efforts in maintaining cultural competency. They are: lack of knowledge, fear and disgust, racism, bias and ethnocentrism, stereotyping, ritualistic behaviour (nursing rituals in patient care), language barriers, and differences in perceptions and expectations. Nurses must have some knowledge about these obstructions in order to overcome them.

Leishman (2004) conducted a qualitative study to explore the views of nurses on the importance of cultural awareness in health care practice. Findings revealed a lack of knowledge and understanding among the participants in relation to the different cultural groups who comprised the population. Deficits in nursing education were also exposed. In her conclusion, Leishman stated that enhanced knowledge