Fostering a supportive moral climate for health care providers: Toward cultural safety and equity

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Abstract

In Western forms of health care delivery around the globe, research tells us that nurses experience excessive workloads as they face increasingly complex needs in the populations they serve, professional conflicts, and alienation from leadership in health care bureaucracies. These problems are practical and ethical as well as cultural. Cultural conflicts can arise when health care providers and the populations they serve come from diverse economic, ethnic, and cultural backgrounds. The purpose in this paper is to draw from Almutairi’s research with health care teams in Saudi Arabia to show the complexity of culturally and morally laden interactions between health care providers and patients and their families. Then, I will argue for interventions that promote social justice and cultural safety for nurses, other health care providers, and the individuals, families, and communities they serve. This will include addressing international implications for nursing practice, leadership, policy and research.

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Introduction

In health care settings, nurses play a central role in providing competent, responsive, and ethical care that maintains safety, equity, and quality for individuals and families as well as for their communities. In addition to nurses being advocates for their patients, effective nursing care is essential for, but not limited to, patient recovery, alleviation of patient suffering, helping patients cope with their chronic illness, and preventing further illness and injuries through health education. Although nursing care is an intellectually challenging process that requires skills and knowledge, it is provided within an increasingly complex context that is often full of ethical challenges and dilemmas. Therefore, effective and safe nursing care that meets the need of patients and their families can be provided within a positive moral climate that supports professional and ethical practices (Rodney et al., 2006, p. 24). Moral climate is defined as “the implicit and explicit values that drive health care delivery and shape the workplaces in which care is delivered” (Rodney et al., 2006). Therefore, the moral climate...
of the organization can be either enabling of or detrimental to safe and better health care outcomes.

Much of the current research in the literature highlights a number of prevailing issues that pose challenges for nurses and increase their workloads, such as the increased acuity and complexity of the needs of patients, the shortage of registered nurses, the casualization of nursing jobs, intra- and interdisciplinary professional conflicts, the alienation from leadership in health care bureaucracies, and institutional autocratic decision making (Rodney et al., 2006; Pauly et al., 2009). These contextual problems are practical and ethical as well as cultural, which could possibly influence nurses’ intentions to leave their profession and which, in turn, results in poor patient outcomes (Schluter, Winch, Holzhauser, & Henderson, 2008). However, in the literature little consideration was given to the link between cultural diversity and ethics during health care delivery. This paper aims to demonstrate theoretical links between these two areas and discuss Almutairi’s model of critical cultural competence as a promising approach to foster a supportive moral climate for healthcare providers.

Cultural diversity

Today, cultural diversity exists in most health care settings and it usually occurs when the recipients of the care are members of ethnic minority groups—immigrants and indigenous people—or the nurses themselves are from different cultural backgrounds. The latter often occurs in many countries, such as Saudi Arabia (Almutairi & Rodney, 2013). Saudi Arabia, like many other countries, is experiencing a severe shortage of registered nurses and this shortage is related to social, cultural and economic factors (Almutairi, 2012; Almutairi, McCarthy, & Gardner, 2015). In order to ensure the continuity and quality of care, Saudi Arabia conducted an active recruitment process to attract qualified, English speaking nurses to work in various hospitals in that country. As a result, qualified foreign nurses represent 63% of the total number of nurses working in Saudi hospitals, comprising a multicultural workforce (Saudi Ministry of Health, 2009). The degree of dependence of foreign nurses varies from one country to another, based on the unique circumstances of each nation. However, cultural diversity, as Almutairi (2012) pointed out, complicates the clinical interaction and poses significant challenges and difficulties in a health care environment.

Drawing on Almutairi’s research

Almutairi (2012) undertook a mixed-methods study that investigated the influence of cultural diversity of a culturally diverse nursing workforce on the quality and safety of patient care in Saudi Arabia. The nursing workforce in this study is a representative of more than 25 nationalities including, but not limited to, people from America, Canada, Australia, England, Finland, South Africa, India, Philippines, Malaysia, Lebanon, Jordan, Egypt, and Saudi Arabia. These nurses each had their own unique cultural heritage, belief system, explanations, fears and material circumstances that could have forced them to immigrate and work in a foreign country. It is possible that many of the nurses have family or financial obligations that forced them to relocate to and work in Saudi Arabia. Significantly, although this group of nurses is culturally diverse both within their nursing group and in relation to other health professional teams where they work, they provide care to Saudi patients who come from a culture that is different from their own. While the common mediating language in this context is English, that language was not the native tongue for many of the nurses, who had varying levels of proficiency which was also different from the primary language used by their patients (Arabic). In general, this study’s findings reveal that cultural diversity can compromise the physical, psychological, emotional, spiritual and cultural safety of patients and nurses alike, due to the cultural conflicts and language barriers they face.

Almutairi’s findings are very illuminating. It sheds light on the complex nature of cultural diversity during clinical encounters that were associated with many ethical concerns. For example, the qualitative interview component of his study with 24 nurses indicate that many of the nurses experienced culture shock on two levels, due to their naïve immersion into a new and unfamiliar culture, (specifically Saudi culture is unique) as well as their interactions with a collection of culturally diverse colleagues. Such cultural immersion without an adequate amount of pre-departure preparation resulted in the development of psychological problems for nurses, such as anxiety, insecurity, frustration, and the inability to adjust to a new workplace. These psychological issues related to cultural shock are also frequently reported in the literature (Brown & Holloway, 2008; Lin, 2006; McLeod, 2008; Pyvis & Chapman, 2005). Inadequate cultural preparation also left the nurses in Almutairi’s study vulnerable with a confusion and uncertainty that possibly increased their stress regarding the acceptable and unacceptable cultural and ethical practices that were expected of them in their new context. Such uncertainty often adversely affected the nurses’ clinical performance and the quality of their care. For example, the following interview excerpt (from Almutairi’s study, 2012) indicates how this nurse was unsure as to whether her nursing care was conforming to Saudi cultural expectations and whether or not the care she was giving was safe for her patients, due to cultural dissonance.

Nurse Research Participant 1: Well, it’s very hard for us nurses because … if you are new, you don’t know really the things to be done for the patient because you don’t know if it is [culturally or ethically] okay. If you are not aware of the background or the culture here … it’s very difficult for us to give care for them.

Another nurse shared her sentiments about her struggle to come to terms with the culture in her working environment and with the contradictory organizational and cultural rules and expectations she encountered, but that she could not understand. This engendered a feeling of culture shock in her:

Nurse Research Participant 2: ‘When I first came here, I had a cultural shock, because the visitors who come here they acting like they are in their homes not in the hospital. They do not respect the rules of the hospital, I try to tell them these are the rules of the hospital, I am not the one who made these rules. Sometimes they do complain because we told them the visiting time hours’.

The nurses’ psychological instability can definitely affect their clinical performance and expose them and their patients to safety risks. Significantly, these psychological problems can lead to physical outcomes, such as illness and exhaustion (Varner & Beamer, 2010).

The interviewed nurses explained how they are disempowered in this context due to cultural and linguistic barriers coupled with the low social image of nursing, which also provided a good climate for stereotyping and discrimination. For these nurses, disempowerment was demonstrated in their inability to advocate for their patients, challenge safety concerns, confront discrimination, and overcome feeling of intimidation by the indigenous dominant cultural group and by their workplace managers. While a feeling of disempowerment has a profound effect on a nurse’s performance, and ultimately on health care outcomes, nurses in this study also seemed to be morally distressed as a result. The following excerpt from an interview with one of the nurses who
participated in this study reflects this type of issue. Her feelings were also echoed by many other nurses who participated in this study.

Nurse Research Participant 3: Work ethic is a very different thing [here]. Like our unit assistants [interpreters] never show up to work on time and things like that … I mean at home just get fired for that, you do it two or three times and you get fired, but here they do it all the time and nobody seems to care, and they wander off and go for a cigarette … and go see their friend in another ward and then they are never here, and nobody seems to mind.

This nurse realized the vital role that the unit assistants—who were assigned as interpreters—played in the process of patient care, ultimately affecting the safety of both patients and nurses. However, this nurse felt frustrated by the frequent absences of the unit assistant, which seemed to be tolerated within the organization, and she also felt unsupported in challenging the assistant’s behavior. Moral distress is a serious issue and this psychological disturbance is induced by the moral complexity of a situation with potential consequences for nurses. The term, moral distress was first coined by the American philosopher Jameton (1984), when he wrote that moral distress occurs “when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (p. 6).

Another example of moral distress as it relates to patient safety within this multicultural environment was expressed by one of the other interviewed nurses. This nurse apparently was distressed and frustrated due to her inability to enact her professional and moral values in order to protect her group of patients from harm. The incident that she perceived as nepotism occurred when one of her patients required isolation in a single room because he had an infectious disease; however, she could not move him to that room because a different patient wanted it, and that patient was connected to someone who was higher up in the hospital’s chain of command.

Nurse Research Participant 4: ‘A lot of the things that happen in hospital are because somebody knows somebody. So we had a patient who was having an infectious bug basically, who needed isolation in a single room so that other patients wouldn’t catch that bug. But instead, the patient who knew somebody who is higher up in the hospital got that single room. So instead of saving the three patients who were in the same room as this patient with the bug from catching that bug, the person who has a connection got a single room because they wanted one. So there’s a lot of things that aren’t directed at patient care, they’re more directed at people getting what they want I suppose’.

The quantitative component of Almutairi’s study also revealed the vulnerability and disempowerment of the culturally diverse nurses, which supports the study’s qualitative findings. He used the Safety Climate Survey (SCS) to investigate the nurses’ perceptions of the clinical safety climate in their organization. While the cultural background of the nurses is one of the major variables in this study, almost half of the surveyed nurses failed to reveal their cultural background. The nurses who refrained from providing such information might be worried about their confidentiality and safety and, in turn, they might fear that they could lose their job, since they might think they would be easily identified if they shared their cultural background (Almutairi, 2012). One of the highly significant findings of this study is that almost half of the participants reported that they would not feel safe being a patient in this context. Such feelings were generated regardless of the realization that the institution was a joint commission, internationally accredited hospital which provided high quality of care based on international standards.

The reason for their perception of insecurity could be related to cultural conflicts, language barriers, discrimination and poor moral climate, as the qualitative findings indicated how the nurses were disempowered and morally distressed because of their inability to advocate for their patients’ safety.

In addition to the factors mentioned above, cultural diversity has a major role to play in the process of making decisions that have an ethical (values-based) nature. Ethical decisions are complex and multifaceted. For patients and their families such decisions may include, for example, whether or not to accept a particular medical treatment or how to find resources to manage a loved one’s serious illness. Health care providers’ ethical decisions may include how to best convey information about treatment options or how to advocate for better resources to support patients and their family members who are overwhelmed by the fiscal and personal demands that serious illness brings. People—whether health care providers, patients, or families—make ethical decisions based on their unique situatedness and the meanings they attach to events (Rodney, Canning, & McPherson, 2013). Yet, there are many challenges to making culturally safe ethical decisions, including, but not limited to, language barriers, a health care provider’s negative attitudes toward particular groups of patients, and a lack of understanding of the deep cultural meanings around the decision being made (Rodney et al., 2013).

Health care providers and patients alike bring their own “explanatory frameworks” to the clinical setting (Rodney et al., 2013, p. 255). For instance, health care providers bring their professional knowledge, personal history, culture, and ethical and moral perspectives as well as prejudices and assumptions about culturally different people that influence their way of interaction. Patients also bring their own distinct cultural perspectives in terms of health and illness, belief systems, fears, expectations, and so on, which likely are not recognized by their health care providers. Although these explanatory frameworks are different, they are equally valid for each party when used in their relative context (Rodney et al., 2013). For this reason, health care providers should not draw solely on their own professional knowledge, cultural perspectives, or ethical theories to make ethical decisions for their patients; ethical decisions must be negotiated in context in order to arrive at an agreement that satisfies the patients and their families.

Given the complexity discussed earlier, operationalizing cultural safety—and hence equity—requires a systematic approach to healthcare in complex contexts of meaning and diversity. Almutairi’s model of Critical Cultural Competence (CCC) is one such promising approach (Almutairi & Dahinten, in preparation; Almutairi, Dahinten & Rodney, in press). This model was empirically developed and theoretically refined drawing on a number of perspectives such as the anthropological conceptualization of culture, postcolonialism, and cultural safety (Almutairi & Rodney, 2013). CCC is a comprehensive approach that has successfully addressed the shortcomings of pre-existing theoretical frameworks of cultural competence at the conceptual level.

CCC is regarded as a life learning process that requires the agency of healthcare providers, policy guidance that addresses the socio-cultural determinants of health, and support at the organizational level (Almutairi & Dahinten, in preparation; Almutairi et al., in press). It specifically aims to manage the difficulties which exist during cross-cultural interactions and have either cultural or ethical impact on the parties involved. Almutairi’s approach to CCC is composed of four multifaceted key components. The first is cultural awareness which refers to individual recognition of socio-cultural differences, self-attitudes, the potential consequences associated with cross-cultural interactions, and socially
intersecting power relation factors such as class, racialization, gender, geographic location, and poverty. The second component is critical knowledge which addresses the conceptualization of culture, communication challenges, and knowledge regarding the dominant model of Western biomedicine as well as the recognition of the danger in relying on static views of culture. The third component is critical skills which refer to healthcare providers’ ability to enact the aspects of cultural competence and cultural knowledge and to create space during cross-cultural interactions in order to negotiate different cultural and ethical meanings so that an ethically and culturally safe environment can be maintained. The last component of this approach to CCC is critical empowerment, which revolves around the healthcare providers’ perceptions of their own empowerment within working contexts considering their own experiences with racialization, racism, or disempowerment because of gender, class, economic situation, or geographic location (Almutairi & Dahinten, in preparation; Almutairi et al., in press).

These components of CCC are woven together, and they are all essential for healthcare providers’ cultural competence and to maintain an ethically safe environment. Therefore, healthcare organizations with a multicultural workforce or clientele should adopt Almutairi’s model of CCC to inform and guide continuous professional development programs, induction and pre-departure programs, as well as organizational policy initiatives. Almutairi and his colleagues have also developed and validated a scale to measure healthcare providers’ perceptions of their critical cultural competence within mediating contexts. Moreover, such a scale can be used in a multicultural environment to measure educational and policy initiatives (Almutairi & Dahinten, in preparation).

Conclusion

In a multicultural environment, the nursing practice is culturally and morally laden due to the increasing complexity of the served populations, professional conflicts, and healthcare bureaucracies. These problems can influence interactions between healthcare providers and patients and their families and, in turn, could compromise the safety of patients and healthcare providers’ alike, thus leading to social injustice and inequity in terms of resources and outcomes. In order to move forward in creating and maintaining a culturally and ethically safe environment, organizations in multicultural contexts should adopt the critical cultural competence approach to improve institutional climates.

Conflict of interest

There is no conflict of interest.

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