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From May to August 2012, I had the opportunity to observe and participate in health care at two very different parts of the world—a malaria clinic in Ghana and a Tibetan refugee colony in Northern India. With my upbringing in Bangkok, Thailand and educational experiences in the United States, I am interested in the different ways nurses and their roles fit into societal changes in every cultural context. One of the starkest differences is the view of compassion and professionalism in the role. Compassion is defined in the Merriam-Webster dictionary as “sympathetic consciousness of others’ distress with a desire to alleviate it” (Merriam-Webster, 2014). Even though many nurses chose their vocation primarily from this driving force of compassion, clinical competency requires that they keep a professional distance from patients (NCSBN, 2009). It may be assumed that the disconnect is from the Anglo-American culture traits that value individualism, independence and self-reliance (Leininger, 2006). Therefore, the purpose of this paper is to explore the role of compassionate care in transcultural nursing and some different nonwestern-approaches to care.

Since there is limited literature available on this exact topic, an interdisciplinary approach was utilized to review nursing science and cultural anthropology writings. I will also share an ethnographic travelogue to exemplify some of the cultural differences in nursing roles.

Definition of Terms

Transcultural Nursing

Nursing theorist Madeleine Leininger (2006) defined transcultural nursing as “a discipline of study and practice focused on comparative culture care differences and similarities among and between cultures in order to assist human beings to attain and maintain meaningful and therapeutic health care practices that are culturally based” (p. 16). A better understanding of
transcultural nursing care will sensitize nurses to the ever growing diverse patient demographics in the health care system. Furthermore, it will help to formulate the best nursing care practice for all populations. An important component of transcultural nursing includes how compassion and empathy are communicated from one person to another. Especially in a profession like nursing where care and nurture are at its core, compassion is an important term to be defined.

**Compassion**

The word compassion comes from the Latin word “com” which means “together” and “pati” which means “to suffer” so the word literally means “to suffer together.” (“Compassion,” 2013). This research will focus on compassion as the manifestation of the desire for “fellow-feeling” and understanding by health care professionals in the transcultural nursing setting.

Recently there have been questions about Nursing’s roots in compassion and the future direction of its growth. As noted by Straughair (2012), while the practice of nursing continues to develop with Evidence Based Practice (EBP), “some of the ethos of the compassionate nurse was lost in favor of technical skills” (p. 160). This is supported with research that identifies decreased patient satisfaction resulting from lack of compassionate nursing care. The issue becomes more intricate when globalization is considered and health care professionals realize that they no longer work in a vacuum but instead with people from all cultures and nations—all with different expectations from their health care providers. According to Leininger (2006), it is now impossible to remain isolated from the influences of other nations, cultures and people. The author believes that “human care is what makes people human, gives dignity to humans and inspires people to get well and help others” (p.3). Since culture is the “broadest, most comprehensive and holistic feature of human beings,” (p. 3) culture and care together will be a powerful factor in the health, wellbeing, and survival of all people (p. 4).
Culture

There are numerous definitions of culture but most anthropologists agree that cultures consist of shared perception, beliefs, evaluation, communication and action among those with a common language, history and geographical location (Triandis, 2001).

Furthermore, with these shared perceptions/beliefs different cultures have different definitions and expectations for health. Shrewder (2008) has found many definitions of health among the different ethnic groups in the United States. Some of those definitions are:

1. Health as energy, energy reserve or energy potential
2. Health as absence of unpleasant symptoms
3. Health as the ability to carry on functions, duties and activities of daily life
4. Health as autonomy
5. Health as freedom from disease
6. Health as a fragile equilibrium (p. 69)

Because each ethnic group has various definitions of health, it is no surprise that the expectation of health care from each person will be different too. Some of Leininger’s (2006) discoveries of common themes in cultural care needs include the desire for cultural survival, responsibility and love through kinship, and respecting role differences for others after the death of loved ones.

Literature Review

The study of cultures is an ever-evolving and fluid concept; therefore to assume that any culture has specific stagnant characteristics would not be accurate or helpful. To appreciate the broad cultural differences in the Western and Nonwestern context of healthcare, the researcher will refer to the “individualism-collectivism cultural syndrome” which was defined by Triandis (2001) as the most apparent differences among cultures, both cross-culturally and historically.
Triandis observed that those from individualist cultures—such as Northern Europe and North America, are represented with the element of personal self—while those from collectivist cultures such as Asia, Africa and South America, are represented by the elements of the collective self. For example, an individualist would say “I am kind” while a collectivist might say “my family thinks I am kind” (p. 908).

Collectivist citizens rely on their community and the goals of the group are pre-eminent (Triandis, 2001). Relationships are highly valued and children are raised in an environment that fosters “conformity, obedience, security and reliability” (p. 912). In individualistic cultures, people are “autonomous and independent form their in-groups” (p. 912). Priority is given to each individual’s goals rather than the communal goals of their in-group and children are raised to appreciate independence, exploration, creativity and self-reliance. What follows are examples from medical-anthropological studies in collectivist populations that portray the cultural differences mentioned and the context in health care.

**Case Studies**

**Ethiopian**

A study done in central Ethiopia by Birhanu, Assefa, Woldie & Moranka (2011) used a survey to determine perceived empathy for patients visiting health care centers. The study itself defined empathy as an encompassing term for positive communication that:

“1) gives attention to biological, psychological and social aspects of health, 2) explores what the illness means to the patient, and 3) increases patient involvement in their own health care” (p. 161). The Ethiopian patients found provider most empathic when they “appear fully attentive, avoids distractions, smile … and sit on the same level as patient” (p. 162) by doing this, the provider conveys care and helps the patient to be at ease. According to Triandis (2001),
collectivists pay a lot of attention to contextual clues while communicating; for example, tone of voice, body language and eye contact are of high importance. However, those in individualist cultures pay more attention to the specific language and the content of what is said.

The findings in this study seem to correspond with the Western view of professional health care and did not provide much insight into the particular cultural view of the Ethiopians. It is notable that even though the research was conducted by Ethiopians in Central Ethiopia, almost all of the sources used were from American nursing journals. However, the study did discover that the extent to which the patients know the health-care providers can significantly predict perceived empathy. If the patients personally knew their health-care providers, their perceived empathy score became higher—indicating the interpersonal trait of the collectivist culture.

**Indian**

Hinduism, oldest and third largest religion in the world (Mullangi, 2005) has its own distinctive beliefs about health. Anthropologist Richard Shweder (2008) studied a Hindu town in Orissa, India and pointed out the different definitions and approaches to health in the Hindu culture. In India, “even the most enlightened of medical scientists will tell you that religion is observed for better health,” while in the United States, “the very idea of religion is opposed to the idea of science and medicine” (p. 63). Where the author worked in India, Western medicine is highly welcomed and respected in treatment for the sick but it is respected as “only one worthy tradition of medicine among many” (p. 66).

As mentioned before, because there are different beliefs about the definition of health and where illness comes from, the tertiary care approach for different populations also differ. For Shweder (2008) and the location of his research, the diagnostic situation was complex when
physical suffering occurred. Collectivist cultures have their own notions of morality which include the moral codes to community, autonomy, and divinity (Triandis, p. 916). For instance in Hinduism, biology is not the only illness-causing world to deal with since there is also the world of the gods, the spirits, and other human beings. All three of these worlds interact through the governing of karmic rules and cause physical suffering. Therefore, healers for illnesses do not only include the nurses and physicians but also possibly Brahman priests, Ayurvedic doctors and astrologers.

An interesting point that this author made about the Hindu belief in health is that the West’s view of the superstitious Hindus as passive and lacking a sense of control of their physical fate is one of the greatest misunderstandings. As mentioned by Shweder, “when things go wrong for the people in rural India, they wonder about their spiritual debts and believe there is always something they can do to empower themselves and improve their prospect for the future” (p. 75). This is a reminder for those who believe that diseases are from purely physiological causes to think twice about judging those who turn to spiritual assistance in times of distress. It is not ignorance as the common nursing diagnosis assesses “knowledge deficit r/t lack of information on disease processes” but rather a proactive effort based on the beliefs with which patients were raised with. Hence, the compassionate nurse’s role is to “com-pati” or suffer together with patients by understanding their effort to try to alleviate pain the way they know best.

Another observable factor of collectivist societies is the community’s desire to be present in its members’ lives. When an individual is suffering, it is usually not a problem just for the person but also for his/her community. Miller (1997) observed in a study between Indians and American that helping an in-group member is seen as a duty for Indians while it is seen as a
matter of personal choice by the Americans. In fact, the level of favorability for a sibling was significant to whether an American helps a sibling or colleague while the Indians were not affected by liking. This is explained by the idea that “morality among collectivists is more contextual; the supreme value is the welfare of the collective” (Triandis, p. 916).

Even though the compassion or desire to suffer together with an individual in collectivistic cultures may appear to be most ideal for a hurting patient, it can be taken too far and cause lack of professional progress and privacy as the next study will demonstrate.

**Vietnamese**

A narrative study by Killingswoth, Kokanovic, Tran and Dowrick (2010) walks through the experiences of three Vietnamese women in Australia who were diagnosed with mental illnesses. It is often argued that Western medical responses to illness are to take the disease out of intimate social contexts. However, that objectivity may be beneficial in some cases, such as in the experience of these women. After being diagnosed with schizophrenia, Nhu, Ahn, and Linh suffered hardship from denial of family members and avoidance from community members due to the fear of bad spirits and karma inherent in their illnesses.

Nhu moved to Australia when she was 23 to live with her husband. After he found out that she was raped as a teenager, he became abusive and distant, leaving her with his family who did not treat her well. She started hearing voices that told her to commit suicide and was ultimately diagnosed with schizophrenia and depression. According to Nhu, “Vietnamese people tended to see her psychosis as an inducement to blame, not to care. Most Vietnamese people would say it’s because of the bad karma or ghost that inhabit the person; they wouldn’t understand that it’s caused by mental illness” (Killingswoth et al., 2010, p. 114).

Ahn, 22 years old, began having schizophrenic breaks after an attempted attack by an
older neighbor. Her mother stopped talking to her because she believed that Ahn was under the influence of a curse. Ahn credited her understanding of the disease as a psychological illness to her New Zealand and Australian doctors even though she found it difficult to ignore the cultural spiritual etiology. According to Ahn, “the Vietnamese custom is to keep the bad things and show only the good, and mental illness is not a good thing” (p. 116). In her account, Ahn established a strong differentiation between the Australian health-care system that was understanding of her problem and the Vietnamese tradition that was not. This was also a theme with Linh when she was diagnosed with schizophrenia. Even though she did not directly credit the Australian health system as accepting or caring for her, she stated that “the way Australians act is more ok that that of the Vietnamese, not as discriminating toward us [i.e., the mentally ill people]” (Killingsworth et al., 2010, p.118).

In the context of collectivist vs. individualist, Hu and Ho (as cited in Killingsworth et al., 2010) noticed the value collectivist cultures put on the importance of face. A moral person behaves through rules set for them by the society. If the individual deviates from the prescribed rules, he/she loses face, not only for the individual but for the whole community. Morality in collectivist cultures comes from what the group expects (as cited in Triandis, 2001). As the women told their stories, they brought light to the benefit of the individualistic professional approach to care in the West. As Ahn said, “One’s illness is like one’s ulcer. It’s like an ulcer you have, if you tell the truth the doctor can cut it up in order to know about your sickness. With the Westerners they tell the truth” (p.117).

**Ethnographic Study**

**Methodology**

The methodology of this research was through participant observation only. Participant
observation is a method widely used in anthropological research where researchers study the locals’ daily activities in the original community. Becker and Geer (1984) defined participant as the act of “gathering data by participating in the daily life of a group or organization” (as cited in Roper & Shapira, 2000, p. 13). Researchers take detailed notes of interactions and informal conversations.

During the preplanning stage, this researcher obtained IRB approval through Messiah College for this study. The study was conducted in 2012, while the researcher served first as a volunteer in a rural Ghanaian malaria clinic and subsequently in a community health clinic in Northern India. Observations were then recorded in a secured journal kept with the researcher to maintain confidentiality and anonymity for the study. Even though the nurses in both Ghana and India were proficient in English, not every interaction was translated to the researcher so the efforts to verify personal observations were difficult.

Observations

The intention of both the Ghanaian and Indian observations was to study the relationship between the health care providers and their interactions with patients who visited the clinic. The Ghanaian observation was difficult because interactions were in Ewe (a Ghanaian dialect) and the head nurse was often hurried with her patients. Many of the administrative workers at the clinic were college graduates on their work rotation to pay off their education and did administrative work while there was only one nurse in the clinic.

Many patients came in with fever and therefore chloroquine was instantly given by the nurse per protocol for assumed malaria with little further assessment. The nurse used a visual aid to educate patients on how to take the medication. The researcher observed the nurse’s frustration with many of the patients. Often times, she would raise her voice at patients and
furthermore it was noted that the office workers tried hard to avoid upsetting the nurse. This was not an exemplary setting for ethnographic observation due to the personal character of the nurse that was an obstacle for extensive cultural observations. To evaluate the observations of this experience, the nurse did not explicitly show compassion, but she did not show professionalism either.

The clinic in India had a more organized system of care than the clinic in Ghana. There were approximately seven nurses who were graduates of nursing schools in New Delhi, one dentist, a doctor who received medical training in Canada, and a housekeeper. The clinic had various health promotion programs, like drug awareness week, which the researcher participated in. Nurses also did home visits for frail patients who are not able to walk to the clinic.

Because this was a Northern region of India near Tibet, this community was entirely Tibetan in ethnicity. The Tibetan culture remained a strong foundation for the community’s way of life. For example, there is a drink called “salt tea” where salt is used instead of sugar in the tea. Due to its popularity, especially with elders who consume the tea multiple times a day, the population has high hypertension rates. Consequently, most of the nurses’ home visits were usually to see frail Tibetan elders with hypertensive diseases. Each visit included medication management and patient assessment. Since this is a smaller community, the nurses and patients were familiar with each other and nurses were all greeted with tea and snacks upon arrival. The nurses took their time with patients, sat down on their beds and conversed with their family. In accordance with Asian culture, when the nurses interacted with patients or addressed the doctor, there was a high level of respect for elders and authority present.

Another interesting observation in this community was the concurrent use of Western and Tibetan medicine. Across the street from the clinic was a Tibetan hospital where Tibetan doctors
and pharmacists who specialized in Tibetan medicine practiced. Tibetan medicine prescriptions were a combination of different herbs rolled into balls, and with the right combination, can help treat diseases. At the hostel where I stayed, the owner’s mother had liver disease and took Tibetan medicine along with Western medication and vitamin injections. When asked, her daughter stated that “it helps her to feel better.” Other beliefs, like the Buddhist prayer wheels, were also used to collect merit and gain health. Every time the wheel is spun, merit is collected and through these good merits one may achieve a healthy and prosperous life.

An example of the collectivist trait often seen in Asian cultures is the community’s involvement in a member’s life. When some patients came to the health clinic, they brought in the latest news and gossip of the community. This could they alert the nurse of someone who is getting sick or not feeling well so that appropriate action can be taken.

**Discussion**

Without trying to make assumptions, it is difficult to conclude any specific cultural behavior. What I observed in these two cultures, however, was in accordance with the collectivistic traits described by Triandis (2001). Often times, health is a community problem and not just for the individual. Families were involved in care and neighbors were also involved in alerting the nurse about those who needed care. Interactions between nurses and patients were much more informal than in the United States. It is important to remember that there are also many other factors that play into the interactions. For example: nurse personality and workload for the day in Ghana and small town socialization, and community-based care in India. In comparison to Western nursing, the nurses in India were more familiar with their patients’ personal lives. However, compassion may be measured differently in each culture—such as an offer for a warm blanket in the United States in comparison to a home visit with momos (Tibetan
dumplings) in India. Going back to the definition of compassion, the nurses in India were cognizant of patients’ discomfort and acknowledged it through a simple pat on the back or lightening up the mood with jokes. According to my observations, the Ghanaian nurse I observed did little to comfort the girl shivering with a fever since the task of inserting an intravenous access into her arm was deemed more important. Then again, this could very much be the personality and mood of the nurse on that particular day.

**Limitations**

The researcher acknowledges the limitations of this ethnography in the lack of time spent at each facility and inadequate language comprehension of Ewe and Tibetan. There were also disadvantages due to the researcher’s nursing student status which contributes to lack of research experience and knowledge. The ethnography was also observation-only with minimal interview so subjective feedback information from nurses is limited.

**Conclusion**

In nursing practice, there is a fine line between the boundaries of professional practice that promotes therapeutic distance and the compassionate care that fosters healing for both patient and provider. Since the concept of “professional boundaries” pertains to an individualist culture, implementation in different settings needs to be considered. There is a dearth of nursing research focusing on the effectiveness of “professional boundaries” versus the more global compassionate care approach. Perhaps further development of interdisciplinary research by nurses should be done in different clinical care settings. Also, development of a standardized tool that measures compassionate care would help to generate data that can be applied for practice and further dissemination.

As the case studies and observations have exhibited, qualitative and subjective data
provide nuanced information of the cultural differences in care. Betterment of patient care requires significant input from the patients who are the receiver of the care themselves. Standardized tools and surveys can be used to analyze patient input from different demographic and care groups to determine better intervention in the practice setting. For academic and research settings, more qualitative data, such as opinions and stories, can be retrieved for further analysis.

The challenge of this research comes from knowing that there is no one perfect model of care that can be applied across all settings. For example, professional boundaries would be more beneficial in an in-patient behavioral health unit than in a community health center. However, nursing should not forget its roots of compassionate care as the field advances technologically and professionally. The individualist cultures can learn a lot from collectivist culture in the connection health care professionals establish with their clients and collectivist cultures can learn from the West in their separation of personal and professional lives.

The next step is now for nurses to develop an awareness of the characteristic of care that they provide and whether they are appropriately compassionate and culturally sensitive. Both models of compassionate and professional care have its advantages and disadvantages but no one culture should be deprived of the benefits of both.
References


