Cultural safety and the socioethical nurse*

Martin Woods
Massey University, New Zealand

Abstract
This article explores the social and ethical elements of cultural safety and combines them in a model of culturally safe practice that should be of interest and relevance for nurses, nurse educators and nurse ethicists in other cultures. To achieve this, the article briefly reviews and critiques the main underpinnings of the concept from its origins and development in New Zealand, describes its sociocultural and sociopolitical elements, and provides an in-depth exploration of the key socioethical elements. Finally, a model is presented to illustrate the strong connection between the social and ethical components of cultural safety that combine to produce culturally safe practice through the activities of a ‘socioethical’ nurse.

Keywords
cultural safety, social ethics, socioethical nurse

Introduction
In New Zealand, the construct of cultural safety was originally inspired by the principles of protection, participation and partnership that were derived from the Treaty of Waitangi (1840). This treaty, although not always fully honoured, was the foundational agreement upon which post-colonial bicultural relationships between Maori, the indigenous people of the land, and Pakeha, or British colonists, were built. Cultural safety has subsequently been perceived as a guide for responding to the health problems of many of the world’s most vulnerable or marginalized ethnic groups. That is, where similar experiences of colonization have frequently led to significant health disparities between the aboriginal peoples and more recently arrived colonists. Yet, although it may be argued that a cultural safety approach is of considerable benefit to such groups, it is less clear to others that it has wider international application in all forms of culturally appropriate nursing care. In reply, it will be maintained in this article that cultural safety is a useful ethical response to the sociocultural vulnerabilities that occur within the diverse groups that may be found in any given society. Indeed, it will be maintained that the continuing development of the ethical and sociocultural aspects of cultural safety has a far greater potential to improve the nursing care of all peoples everywhere than was originally presumed. To achieve these ends, it is necessary to revisit the main tenets of cultural safety, and to expand further on its essential social and ethical elements.

Corresponding author: Martin Woods, School of Health and Social Services, Massey University, Private Bag 11 222, Palmerston North, Manawatu, New Zealand
Email: m.woods@massey.ac.nz

*This article is dedicated to the memory of Dr Irihapeti Merenia Ramsden, 1946–2003. Ka hinga atu he tete-kura – ka hara-mai he tete-kura.
Cultural safety

The concept of cultural safety (kawa whakaruruhau) appeared in a formal sense in New Zealand in the early 1990s, when it was used to describe a more focused cultural response to power imbalances between health professionals and the recipients of health care, and Maori recipients in particular. The concept emerged at a time when the government sought better ways to relate the overall aims of the Treaty of Waitangi to various sections of health, disability and social welfare policy documents (a trend that continues to the present day). Yet, the overall effect of such attempts on improving Maori health statistics was considerably less than expected. This phenomenon reflects a similar trend in other colonized countries where, regardless of legislative or policy changes, health statistics continue to reveal disturbing mortality and morbidity figures involving not just ethnic minorities but also other marginalized groups. Clearly, it was argued, for several vulnerable groups in any given society, and most certainly for Maori in particular, definitive action was required at both localized and operational levels. In New Zealand one such response to this need arrived in the guise of cultural safety, and the then Nursing and Midwifery Council adopted cultural safety education in all nursing and midwifery courses in the early 1990s. Some years later, the concept was modified and enlarged by the Nursing Council towards an overall strategy for improving nursing care for all New Zealanders. As a result, all nurses practising in New Zealand are now required to reflect upon the main aims of cultural safety, which are broadly supported through the widespread use of the Nursing Council’s standards and guidelines.

A cultural safety approach essentially challenges the traditional role of nurses as fully competent cultural practitioners. That is, nurses are encouraged to practise from a starting position of accepted cultural ignorance or limited awareness rather than competency. This requires nurses to abandon any idea that they are able to ever fully comprehend their patients’ cultural life ways and practices. Instead, they are encouraged to respond according to a carefully reflected and honest appraisal of the impact of their own cultural attitudes, history and life experiences on their patients’ intrinsic rights and legitimacy in maintaining their own cultural practices. This fascinating and often misunderstood reversal of the role of nurses as ‘culturally competent’ providers of care (where, basically, patients’ culture is still seen as ‘other’ or different, and nurses adapt their ‘normal’ practice accordingly) is therefore regarded as a significant and sometimes controversial development. Indeed, even though it is maintained that the use of cultural safety promotes and safeguards the well-being of patients (who are, after all, living their culture rather than observing it), several nurses have testified that this requirement is easier said than done within the sociocultural restraints often experienced in health care institutions. Nevertheless, in an attempt to avoid unsafe cultural practices (i.e. any action that ‘diminishes, demeans or disempowers the cultural identity and wellbeing of an individual’) nurses in New Zealand are encouraged to respond appropriately when delivering care to all people who may otherwise feel alienated or demeaned within the health care setting.

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. In general, responses both within New Zealand and overseas have been either respectfully subdued or highly animated. This is mainly because there are considerable differences of opinion about the value and international transportability of cultural safety for use within nursing, and nursing education especially. For instance, in Canada, some argue that the notion of cultural safety may indeed serve as a useful teaching aid, but because of differences in its particular (post-colonial) origins, and also because it is maintained that (Aboriginal) people should not be solely responsible for defining culturally safe health services, then the concept has flaws. In Australia, such arguments are mirrored by those who posit that cultural safety is an interesting and potentially useful concept, but that it is ‘plagued by significant theoretical and practical weaknesses’. These differences and weaknesses are often thought to occur because the cultural safety approach is significantly divergent from other more established and accepted approaches, such as transcultural health care or nursing.
Nevertheless, it may be argued that the concept of cultural safety has been successful in a variety of educational and practice-focused ways. For instance, it has provided a critical tool that may be used (perhaps dubiously) to extend the notion of transcultural nursing within a postcolonial age, and it has been recognized as an influence in the development of increased recognition and responses to personal nursing prejudices. Significantly, it has also been acknowledged and recommended by the respective New Zealand, Australian and Canadian nursing (and/or midwifery) councils and affiliates, and also by the International Council of Nurses, which recommends the concept for use in all nursing education programmes. The impact of cultural safety may also be perceived, albeit obliquely at times, in the culturally-related sections in the New Zealand, Australian and Canadian codes of ethics for nurses. Overall, it could be argued that cultural safety fulfils the requirements of a sociocultural concept that is recognized in nursing education, policies and codes of ethics, but as yet remains underdeveloped and little explored as a distinctive socially orientated ethic for nursing. It remains necessary to examine closely both the social and the ethical aspects of cultural safety, and the potential links that connect them, before finally promoting a model of the main elements of culturally safe practice.

The social elements of cultural safety

From the outset, cultural safety offered an alternative perspective on cultural diversity, arguing (initially from its bicultural foundations) that the historical effects of colonization and ongoing social structures systematically disadvantaged indigenous groups of people, and that these effects must be recognized in health care delivery. In this endeavour, it went ‘well beyond culturalist notions of cultural sensitivity to power imbalances, individual and institutional discrimination, and the nature of health care relations between the colonized and colonizers, at the micro, mido, and macro levels’ (p.127). To achieve this, it was argued that both the dominant cultural and political dynamics of society had to be very carefully re-evaluated to allow for the significant ‘mind shift’ that needed to occur within the delivery of health care services. This required all nurses to apply themselves to the task through a strong degree of self-reflection aimed at a greater appreciation of the need to address the culturally relevant social and ethical dimensions of their practice. In New Zealand, these dimensions were initially bicultural, but over time they became much broader to embrace wider and more diverse interpretations of the meaning of culture and sociocultural practices.

Sociocultural practices

In recent times, cultural safety has been expanded to provide an approach that delivers safe cultural care to all recipients of nursing services by protecting their cultural identity, well-being and practices. In a cultural safety approach, the term ‘culture’ extends well beyond presumed ‘cultural norms’ (i.e. as a world-view, lifestyle, or learned belief and value system that guides behaviour and creates shared meanings within a group of people) in preference for an approach that sees culture as a complex and fluid sociopolitical construct that is best understood in relational terms (i.e. through history, experience, gender and social position). Once recognized as such, nurses are compelled to do more than merely exhibit recognition, awareness and even sensitivity towards distinctions such as an individual’s or a group’s beliefs, values and practices. This is because cultural practices within the sociopolitical dimensions of society are too wide ranging and complex to ever really allow nurses to fully predict or attempt to standardize their patients’ (presumed) cultural needs in such a fashion. They will always vary considerably between not only different individuals and groups within society, but between individuals and professions, institutions and organizations. For instance, differences in cultural practices are especially noticeable within health care institutions because the cultural practices of nursing and medicine may easily overwhelm the cultural needs of others. This problem is further compounded when taking into account the notion that any given individual exhibits a variety of cultural
behaviours simultaneously (e.g. age, gender, sexual orientation, occupation, socioeconomic status, ethnic origin, migration experience, religious/spiritual beliefs, disability and others). Consequently, different cultural practices may create tensions for all, but especially for those minorities or socially excluded individuals or groups who are already vulnerable within the system. In retrospect, the required ethical response from nurses is more likely best served in the form of a mutual understanding of sociocultural practices within the wider health-related environmental culture, where the vulnerable recipient of care feels culturally safe because the provider is honest enough to seek guidance where necessary. To achieve these aims, culturally safe care should always be defined by those who receive the service and not by nurses. It is inevitable that, for this to occur, a deliberate adjustment of the imbalance of power between nurses and patients is required through a reappraisal of the sociopolitical dynamics of health care.

**Sociopolitical dynamics**

Redressing the sociopolitical issues of power, vulnerability and control within health care services is a deeply embedded and essential element within the concept of cultural safety. Its careful application has the capacity to promote a more equal partnership between patients and nurses by ensuring that patients feel comfortable enough to assess from their own cultural perspective the (cultural) care offered. Such a partnership is ideally based on mutual respect; that is, nurses value patients’ cultural needs, but at the same time patients respect nurses’ role in maintaining both cultural and physical well-being. This manoeuvre subsequently affects the relationship between nurses and patients because it alters the processes, environments, behaviours and outcomes of nursing care. Subsequently, in New Zealand, through education and the widespread incentive of maintaining Nursing Council competencies, the central focus of cultural safety has been considerably broadened to include those social, political and cultural factors that are associated with responding to the needs of people from all cultures and subcultures.

This extension to the original aim of cultural safety goes well beyond notions of ethnic awareness, sensitivity or even culturally ‘congruent’ nursing care in meeting patients’ ‘cultural needs’, and deep into the realms of a more diverse application of the sociopolitical nuances of cultural responsiveness within a more balanced partnership. In turn, it is argued, this degree of diversity and political responsiveness provides nurses with a better tool to move their gaze from negative stereotypes, deficit explanations and victim blaming, to recognising the strengths and capabilities that [indigenous] people possess to enable self-determination of priorities and to develop self-management strategies (p.xii). It follows that such a change is not only sociocultural and political but also ethical because it promotes the welfare and well-being of the vulnerable recipients of nursing care.

**The ethical elements of cultural safety**

In New Zealand, as in other nations, huge changes have occurred throughout the sociocultural development of a rapidly growing multicultural society. Such changes demand a greater awareness and responsiveness towards the cultural differences between each individual and/or groups of individuals, and especially the shared beliefs and practices of various minority social, ethnic, religious and gender groups in society, such as young people, elderly people, and those who are mentally ill or disabled. However, the values, ideals and basic rights of such groups have often been overlooked, ignored or minimized because, as is common in western or postcolonial countries, any arguments from a cultural or ethically relativist perspective are often overridden to favour those of the more prevalent views of western ethnocentrism and moral universality. This phenomenon continues to fuel a persistent and convoluted debate in nursing, especially within the teaching and practices associated with nursing ethics. For nurses, the problem of operating within a system that tends to promote rights-based and/or principles-/rules-based ethics in the face of a rapidly changing
social environment remains a considerable challenge. For instance, 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. This difficulty is perhaps compounded rather than alleviated by nursing attempts to attach universalistic notions of shared values or practices derived from the multicultural or transcultural concepts in nursing care.17

Yet, irrespective of the dominance of prevailing ideologies within health care, and continuing debates about the overall purpose and direction of nursing ethics, there will always remain a requirement for nurses to respond ethically to the sociocultural needs of their patients, and perhaps especially to the specific needs of patients who belong to aboriginal, minority or marginalized groups. It follows that such an approach would value collectivist ways of autonomous decision making as well as individualistic ways, appreciate alternative viewpoints regarding the meaning and practice of justice, and protect the traditional and minority rights as well as the civil liberties of all.38 Indeed, if: ‘Everything fundamental in ethics derives from communal values, the common good, social goals, traditional practices, and co-operative virtues’ (p.362),39 then ethical concepts such as social justice and empowerment, the maintenance of individual and/or collective cultural autonomy and identity, and mutual trust and respect are crucial. All are possible within a cultural safety approach, which now may be seen to reflect a type of social treaty or contract based on key ethical elements originally associated with a greater appreciation of indigenous values, but expanded to ensure the inclusion of ethical consideration and support for the values and beliefs of all groups in society. In essence, cultural safety contains a number of key ethical elements that mainly reflect a social ethics approach, that is, one that is capable of reflecting communal values, traditional practices, and co-operative virtues within a multicultural society.40 Hence, based on the combination of the main sociocultural, political and derived ethical elements of cultural safety, the key ethical attributes of such an ethic would be as follows.

Promoting social justice and empowerment

The concept of social justice is often used to imply that there is a fair and equitable distribution of benefits and burdens in a society.41 Such a view of justice depends largely on the notion of the distributive paradigm of justice; that is, justice as a personal right based on the practice of individual freedoms within the usual societal limits. This type of interpretation, so common perhaps in the neoliberal societies of previously colonized western nations (such as New Zealand, Australia and Canada) is not an interpretation that is commonly experienced within indigenous or other culturally affiliated minorities. In these settings, social justice implies that, within the different social, economic and political contexts in which people exist, ‘difference’ should be treated with ‘difference’; that is, according to the different cultural needs of the recipient of nursing care rather than nurses’ need to maintain their own ‘nursing’ culture,3 or the culture of medicine, or any other arguably predominant culture. Most hospital inpatients are already culturally disadvantaged from the time of their admission until the time of their discharge because they need medical and nursing care that they cannot normally provide for themselves. They are separated from their own cultural contexts and subject to the requirements of health professionals within their own cultural contexts; and they are each part of other cultural and subcultural groupings (e.g. gender, economic, religious, etc.) that may go unrecognized without deliberate effort on behalf of nurses. Such imbalances require not only awareness and sensitivity on the part of nurses, they require attention to social justice using empowering practices.

Empowerment implies a multidimensional social process that helps people to gain control over their lives and thereby increases their own capacity to respond to those issues that they deem important.42 It is a process that fosters the power of individuals and communities to increase their own spiritual, political, social or economic strength.43 To empower particular individuals or groups is not only to reduce those sociocultural discrimination processes that have excluded them from decision-making processes, but to encourage an
autonomous and identity-preserving response in any way that the individual or group regards as culturally appropriate. Consequently, for this to occur, a significant degree of individual and/or collective autonomy is required.

Maintaining individual/collective cultural autonomy and identity

The concept of autonomy is broadly seen as the capacity of individuals to shape the conditions under which they live. It implies an individual’s, or a group of individuals’ ability to plan, pursue, participate in and evaluate their own choices in social life. The term may therefore be used to refer to the self-determination of one individual or culturally affiliated groups of individuals within collective bodies such as minority groups and indigenous peoples. Cultural autonomy strongly relates to cultural knowledge and identity, which in turn dwells within the traditions, language and practices of a given cultural group. The upkeep of these traditions and practices is therefore of importance in every culturally affiliated group, but especially so for indigenous cultures (such as Maori) who still retain cultural memories of past colonial experiences that often saw them denied such basic autonomous rights, the subsequent demise of their language and knowledge, and, most devastatingly, their loss of identity and prestige. This problem has occurred in several indigenous societies around the world, and remains an issue that should be of moral concern to nurses everywhere.

It is generally well known that in traditional societies, collective cultural membership matters more than individual membership and much importance is placed upon shared decision making. In such ways, cultural knowledge is shared and identity maintained. In other societies, especially neo-liberal ones, the individual is regarded as a fully autonomous being and great store is placed on the legal maintenance of individual rights and freedoms, privileges and protections. It follows, then, that for members of dominant ‘cultural’ groups (e.g. the middle and higher socioeconomic classes), health care institutions such as hospitals (where the main values and practices remain firmly focused around dominant social cultures that include medicine) offer at least some cultural similarities and opportunities to maintain individual identity and status. In the case of less dominant cultural minorities, this possibility is usually far less likely. They may be at least doubly disadvantaged in that they could easily lose any cultural authority, power and influence that they may otherwise possess, and they may lose control over their own cultural practices because of the nature of their illness and an inability to respond in ways more familiar to them. When this occurs, the greatest threat to the (cultural) safety of individuals is a danger to their identity. Hence, for those receiving nursing care, the maintenance of cultural identity always requires the consideration of a significant degree of either individual or collective autonomy, as every instance of choice denied to one may be regarded as an instance of control imposed on all.

For some, the effect of cultural indifference and ignorance is therefore sometimes perceived as being disrespectful of not just the individual, but of others within that individual’s cultural group, who, like Maori, may feel that their cultural identity has been ‘trampled upon’. This situation has parallels in all cultural and subcultural affiliations such as older people, teenagers, gay people, people who are mentally ill, and many others. They too need to have their cultural mores maintained to remain ‘situated’ and authentic within their own spheres of influence. Thus, in nursing practice, lack of respect for the cultural autonomy and identities of individuals and/or groups could lead to the most damaging of all possibilities within the nurse–patient relationship, that is, the diminishment or extinguishing of trust and mutual respect.

Trust and respect

Trust is a desirable and necessary ethical element of any relationship between nurses and patients, families or communities. Undoubtedly, the maintenance of trust itself is a vital social phenomenon in all traditional societies, being developed not by promises or expectations but by the observable actions of others. These
actions include factors such as an ability to meet others face to face, to look, listen and speak at appropriate times, and to be generous with both time and self. Subsequently, it may be argued that this particular requirement is obtained only through nurses’ closer attention to their own attitudes and responses within the entire social environment. This crucial difference means that nurses need to accept that they are bearers of a culture that may be exhibited through the use of professional power, and that it is not necessarily enough to know and be sensitive towards the needs of others; they must act on these needs ethically within a relationship of mutual respect and trust. It follows that to work as nurses within indigenous and other socially diverse groups requires them to place themselves in a position based on trust, and to strive continuously to maintain that trust as, without it, ethical nursing practice cannot take place.

Trust tends to develop in any relationship in which respect is shown from one individual or group to another and, culturally speaking, may grow in those circumstances only when different cultural practices are not only tolerated but also maintained as far as possible. For nurses, as any other health care professionals, this presents difficulties because the maintenance of culturally respectful practices may not always be straightforward within the all-embracing cultural practices of the health care context and the culture of nursing itself. In such instances several issues arise concerning the limits to which nurses are prepared to go to support what are, to them, unsafe practices. Yet such practices are not necessarily so, and may instead reflect an unwillingness even to attempt to adjust because of nurses’ own ‘cultural imperialism’ or lack of critical reflection rather than a genuine difficulty in adjusting practical caring methods. For instance, the absence of nursing cultural respect may lead to a loss of trust when elements such as language, the role of traditional medicine and/or healers, religious belief systems and practices, and birthing and death rituals are ignored or suppressed. All of these are cultural rights and elements within the maintenance of cultural identity, which itself is a necessary part of every individual’s life ways.

Yet, these nursing-related factors based on the establishment of a trusting relationship may not necessarily make a significant difference to recipients’ response to nursing care if patients still perceive themselves to be powerless within an alienating culture. The cultural context of health care itself is therefore a major difficulty for nurses because they have to attempt to reduce some of the isolating effects of such a culture, which in itself is no simple task. Cultural safety enables nurses to achieve this end by combining key social and ethical elements together to enable safe and effective care to take place.

**The socioethical nurse and culturally safe practice**

Nurses are frequently regarded as being caring and compassionate, skilful, knowledgeable and resourceful professionals who aim to provide appropriate or effective care when meeting the health-related needs of society. Even though nurses are universally encouraged to share a common moral purpose in meeting the individual and wider cultural needs of every patient and every community, the need to morally ground and critique that purpose in both historical and present day societal structures is sometimes less apparent. To be involved in promoting healthier nations, nurses must first be involved in promoting healthier individuals within their social groups and communities. As all individuals and groups within a society are socially constructed within sociocultural and sociopolitical margins, it also follows that the social patterns relating to such things as class, gender, culture and status are of considerable importance in the individual lives of all. Understanding and incorporating these patterns therefore requires considerable effort and emphasis by nurses if their practices are ever to be deemed culturally ‘safe’. Furthermore, if nurses are to successfully use the concept of cultural safety, it is desirable that they reflect on the contemporary challenges to the influence of the individually focused and principle driven fixation of western ethics, and concentrate upon ethical responsiveness that is based on a deeper understanding of the social, cultural and political contexts in which people exist.
Such an ethic is now offered (represented in the model in Figure 1) that provides a visual representation of the basic elements that make up the socially and ethically derived practice that is cultural safety. Briefly, the model illustrates the sociopolitical and sociocultural aspects of cultural safety allied with the necessary socially orientated ethic. This social ethic is driven by three major elements: social justice and empowerment, individual/collective cultural autonomy and identity, and trust and respect. The combination of these social and ethical elements should lead to culturally safe practice.

Culturally safe practice should result when nurses incorporate sociocultural and political knowledge with the moral elements of a socially orientated ethic, thereby becoming ‘socioethical’ nurses. Of greatest importance is the requirement to maintain and support patients’ cultural identity and autonomy, which, as previously argued, may be subsumed or overwhelmed by the nurses’ or the institutional culture without due care. A balance must be struck because differing perceptions and responses to cultural phenomena heavily affect the degree of trust and well-being that patients may exhibit. Without trust, nursing care may be ineffective, and without the preservation of self-esteem or prestige, patients’ well-being will be diminished. Culturally effective nursing care requires that nurses are not only respectful of patients’ individualized cultural identity,
but also regardful of their membership of sociocultural groups that reflect the collective responses of shared ways of being. To ignore or make light of these essential sociocultural requirements may result in ‘adequate care’ on a nurse-perceived level, but unsafe care from patients’ cultural perspective.

Yet, if culturally safe nurses are to empower the recipients of their care by protecting patients’ cultural identity and autonomy, it must also be accepted that nurses need to find ways to respond within the confines of the power hierarchies that exist in health care systems. This is a difficult task for nurses, but, if cultural safety is to be promoted as a desirable approach to assist them in what has always been the central aim of their profession, they must find ways to promote it within a focused and comprehensive ethic that remains true to both the profession and the expected commitment to humanity alike.

The overall actions of individual doctors and nurses within health care institutions are assessed by the recipients of care regarding both relational intimacy and public integrity, and therefore a blend of personal moral and social integrity is required to effectively reflect nurses’ role in society. In this may be seen a clear convergence of the moral integrity of nurses and the socioethical elements of cultural safety. Furthermore, because cultural safety is underpinned by the key moral elements of social justice, empowerment, individual/collective cultural autonomy, and trust and respect, nurses are able to respond to the convergence of both personal and societal responsibilities. In doing so, they maintain and strengthen relationships with patients that are based on mutual trust within a socially aware ethic. In short, if nurses are to act in morally competent and committed ways as perceived by those to whom they offer nursing care, then they must use this ethic in a variety of personal and collective ways. These ways should reflect an ability to share a socially connected ethic through appropriate attention and responsiveness to particular situations that their patients face, not just because of the trusting relationship that exists between nurses and patients, but because nurses have the desire to adjust the caring context to be culturally appropriate for both patients and communities.

Conclusion

A culturally focused ethic would, in a broader sense, reflect the collective moral ideals of nursing and human-kind, being simultaneously a relational and a socially orientated ethic. Such an ethic would be framed within social realities as much as philosophical and practical ones, but it would also be grounded within the sociocultural practices of individuals. It would meet individual and collective need through culturally congruent care reflective of and responsive towards individual differences rather than a sometimes generalized response based merely on ethnic presumptions. It would also address issues of ‘power’ and control, recognizing that all individuals have a right to health and for their health care needs to be met, but at the same time it is important to be mindful that this is not necessarily through the same means. Flexibility in response to the vagaries of indigenous and non-indigenous cultural mores is therefore required. Effectively, a socioculturally focused ethic in nursing would be driven by nurses who were not merely responding to the need for such an ethic because of laws, policies or guidelines, but because they believe in the inherent morality of culturally safe nursing care. This requirement would be best served by an ethic that situated individuals within a community as socially interconnected and culturally affiliated beings, and through recognition of the embedded nature of received wisdom within cultures. For nurses world-wide, this implies that a notion such as cultural safety cannot really be advanced without shifting the nursing focus from individual perceptions and actions towards a collective and socially orientated position. Human rights, social justice and cultural safety remain problematic in many countries around the world, but nurses, as members of a socially aware, caring and ethically committed profession, cannot morally ignore those issues involving members of various cultural groups who are restricted from participating in society in their own culturally defined ways, and/or who receive less than satisfactory care within their institutions and communities. Regardless of universal or national laws, policies, or even culturally safe guidelines, it is necessary for all nurses to refocus their gaze on socially inclusive and culturally safe practices through a socioethical response.
Conflict of interest statement
The author declares that there is no conflict of interest.

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