Nursing Philosophy: Foucault and Cultural Diversity Issues in the Nursing Field

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Cultural diversity is a highly important issue in nursing education and nursing practice today. This study is a philosophical approach to the power relationship between a health care provider and a care recipient. The main purpose of this paper is to analyze the relationships between nurses and ethnic minority patients based on the discussions of some Foucauldian concepts that are related to cultural diversity. Based on the analysis, this study provides some suggestions for cultural competency in nursing practice.

Key Words : Nursing philosophy, Cultural diversity, Foucault

INTRODUCTION

Ethnic minority patients, who are from a racial or ethnical group different from the larger group, often have their own values and beliefs. In terms of nursing ethics, cultural diversity is a highly important issue in nursing education and nursing practice today (Cook, 2003). A way to approach cultural diversity is the promotion of cultural competency, which is identified as "the capability to provide nursing care effectively in cross-cultural situations regardless of personal values and beliefs that differ from those of the patient" (Villarruel, 1995, p. 18). Cultural competency in nursing has been supported by concepts based on the practice of advocating patients and the professional nursing ethics (Donnelly, 2000).

Notions of Michel Foucalt (1926-1984) might be applied to explain the power relationships between nurses and ethnic minority patients and provide some suggestions in approach to cultural competency. This study is a philosophical approach to this power relationship. The main purpose of this paper is to analyze the relationships between nurses and ethnic minority patients based on the discussions of some Foucauldian concepts. This study will provide some suggestions for cultural competency in nursing.

ANALYSES of the POWER RELATIONSHIPS

1. Foucauldian Notions
Knowledge and Power

'Scientific' knowledge is often considered value-neutral. It also assumes that scientists pursue 'truth,' in order to explain nature, and their work seems isolated from power relationships. However, Foucault claims that knowledge implies power and maintains that these two concepts, knowledge and power, are inseparable (Foucault, 2003). In his book, The History of Insanity, Foucault demonstrates how this knowledge-power dynamic works to govern people. He explains the historical processes of how mental abnormality has been identified and regulated in modern society. The scientific knowledge of psychopathology justified the treatments that doctors provided psychiatric patients. And the discourses of psychiatry endowed doctors with the power to perform the psychiatric interventions, even by force (Foucault, 2003). According to Foucault (2003), in this knowledge-power relationship there are innumerable discourses and power sources. This means that there is not sole or absolute power to govern society. Rather,

people are governed by micro-powers, which exist all around themselves (Foucault, 1994). Therefore, modern society is not able to be explained in terms of just a few axes of power relationships such as bourgeois-proletarians or the ruling-the ruled.

In nursing practice, nurses have more information about health and disease. Nursing knowledge itself can be a governing power over patients. The terms and language that nurses speak to one another are often not understandable by patients. Diagnosis and intervention are decided based on a nursing knowledge system that most people outside of the nursing disciple do not understand. The nursing discipline has paid greater attention to the power relationship between health care providers and patients, as seen in the terms 'patient-centered cares' and 'patient empowerment', than any other health care professionals. Nevertheless, based on Foucaldian view, nursing knowledge makes nurses privileged over patients in the nurse-patient relationship.

Disciplines to Produce 'body'

In the process of modernization, human beings have been trained by means of the power of disciplines (Foucault, 1994). In his book Discipline and Punish, Foucault explores the way micro-powers control social bodies all the time. He looked at power relationships in various institutions such as prisons, schools, hospitals, and military to describe how power is used in these institutions to govern people. Foucault (1994) notes that each institution has its own goal of transformation: prisons change criminals to 'good citizens' schools produce students who have useful knowledge; hospitals change sick people to healthy people; and military change non-military people to military people with fighting skills. According to Foucault (1994), each institution's goals and the systems that support those goals are supported by discourses such as economics, criminology, education, biomedicine, and politics. At the same time, the training process of all of these institutions focuses on minimizing the political power of the subjects. The disciplinary systems promoted by these institutions train subjects (inmates, students, patients, soldiers) to be obedient, docile, and powerless (Foucault, 1994). However, people exercise their rights superficially by means of a representation system that is based on modern law. Foucault (1994) explains how these techniques of power are used to govern people in modern society and how body is fabricated and governed in the web of micropower.

As Foucault (1990) points out, in modern society, many academic, institutional, and social fields have produced discourses to control their members. The concept of bio-power focuses on the idea of a power mechanism over life. In his book The History of Sexuality Volume One, Foucault discusses how power controls life. He contends that population and sexuality are governed by the discourses of demography, biology, hygiene, medicine, psychology, and ethics (Foucault, 1990). For example, some sexual behaviors were prohibited because they were defined as 'sins' in medieval times and 'unhygienic' in modern times.

In the health care system, there are numerous rules that each patient have to follow. When hospitalized, a person learns how to act as a patient. They learn meal and medication time. At night, side rails have to be up. 'Side-rail-up' had been a nursing intervention for patients' safety based on nursing knowledge taught in nursing institution. Although current studies found that the side-rail-up practice does not decrease incidence of falls, it is still practiced in many hospitals (Cody, 2003). If patients do not follow rules, patients often are named 'non-compliant'. Explicit and implicit rules in hospitals and clinics decide how patients behave. Patients deviant from rules are stigmatized as 'non-compliant' or other terms. A patient who practices ethnically unique health behavior may be stigmatized as 'non-compliant' or 'unhygienic' based on microbiological knowledge.

Subjectification

According to Foucauldian view, subjectification is the way in which people converse themselves into subjects (Rabinow, 1984). In the process of reaching a level of knowledge (and therefore power), a distinction of self (subject) from others occurs (Foucault, 1990). In order to reach this distinction, a subject must refer to others as 'objects' using the subject's own language or own knowledge. When the subject's knowledge has more power than the object's knowledge, the subject's explanation, with his/her own language about the object, becomes the common explanation. As this process is reiterated, the subject's language or knowledge obtains more power than others' because it is able to explain a larger part of society. Then, this language becomes more 'valuable' or 'truthful' than the language and knowledge of the others. On the other hand, when the subject's language has less power than others', she is objectified by the others' language. Therefore, the aim of competition among dis-

courses is to win the power to objectify 'others.' Furthermore, the subjects of discourses continuously pursue more power in order to subjectify the 'self' and not be objectified by others.

Complementary and alternative medicine (CAM) could be an example of 'objectifying others' with his/her own language. In the nursing discipline, recently, complimentary and alternative medicine (CAM), such as herbs, acupuncture, and Qi therapy, is studied. Many nurses and researchers are trained to practice CAM. The National Center for Complementary and Alternative Medicine under the National Institute of Health in the United States support clinical trials adopting CAM (NC-CAM, 2007). CAM was considered a belief-based medicine while conventional medicine a science-based medicine. CAM was considered a less reliable medicine than conventional western medicine because it was not explained with the language of western medicine-which mainly relies on the language of modern science such as biology, physics, and chemistry. Because conventional western medicine had more power than CAM, it could use their language to explain what CAM was and decide the value of CAM based on their own knowledge. Even today, the way to prove the effects of CAM is to follow the way of western conventional medicine. Randomized controlled trials test if a CAM method such as herb or Qi therapy is effective to improve health conditions which are measured by biophysical changes such as a cellular immune function change. If the body change is unable to be measured with the knowledge system of conventional medicine, the CAM method is decided as 'not effective'. If the 'Yin-Yang' theory or the 'Qi' theory, major theories of traditional oriental medicine, were governing or powerful discoursis for medicine in modern society, the effectiveness of each CAM method could be decided within its own language and theory. However, currently CAM is an object, which is explained by the language that conventional western medicine uses.

In the nursing practice, nurses have a power to name and categorize symptoms and behaviors of patients with their own language of nursing science. Nurses could also identify others based on the system of nursing knowledge. If a patient from an ethnically different culture takes herbs which are not commonly used in the dominant culture, the patient is at risk to be called 'patient with unhealthy behavior' or 'non-compliant patient'.

2. Nurse and Ethnic Minority Patient Relationship and Cultural Competency

Power Relationship between a Nurse and an Ethnic Minority Patient

Power relationships between nurses and patients were discussed based on the notions of Foucault; knowledge and power, disciplines to produce 'body', and subjectification. Here are summaries of reasons that nurses' power is predominant over the ethnic minority patient. The first two reasons are applicable to all patients regardless of ethnicity. First, hospitals are governed by scientific disciplines, which represent the technology of power. Nurses have authority that is vested in them as a result of hospital regulations and principles as described above. Second, nurses, because of their professional training, have more powerful language to explain health issues. This language is based on the discourses of nursing, biomedicine, psychology, hygienic, etc. Third, the knowledge and expertise that members of ethnic minority populations have about health care might be very different from the nurses' knowledge and expertise. As mentioned earlier, when facing patients from different cultures, nurses could easily use their own language and interpretations to distinguish and identify characteristics of other cultures. For example, a nurse may think that a health or hygiene belief based on a patient's ethnic background is odd or even 'unhygienic. Finally, when ethnic minority patients do not speak English as well as native English speakers, they have less power because of the language barrier. When patients reflect an inability to express verbally in the English-only institution, they are at a power disadvantage. In this case, patients' needs are easily distorted because they are explained only in terms of the nurses' language. Regarding description on 'Subjectification', ethnic minority patients, who do not speak English well, are more at risk to be objectified by nurses who are native English speakers. Moreover, English is in the main language for communication in the US, so not speaking English is deviant from regulations, as discussed on 'Disciplines to produce 'body''. Therefore, not speaking English also makes the subjects politically less powerful than the English-speaking people in the US.

Current Cultural Competency Training in Nursing

The position statement of the American Nurses Association (ANA, 1997) regarding cultural diversity in nursing practice suggests that nurses should appreciate:

i) how cultural groups understand life processes; ii) how cultural groups define health and illness; iii) what cultural groups do to maintain wellness; iv) what cultural groups believe to be the causes of illness; v) how healers cure and care for members of cultural groups; and vi) how the cultural background of the nurse influences the way in which care is delivered (p. 1).

In addition, efforts for cultural competency in nursing practice and education have been robustly made. Studies have made recommendations for cultural-competency-training in nursing practice and education (Donnelly, 2000). They suggest that health care institution, nursing service administration, and nursing education should be sensitive to cultural diversity (Donnelly, 2000; Leonard, 2001). Most of the efforts for cultural competency are designed to improve the awareness of cultural differences and to enhance nurses' communication skills, especially with patients from diverse ethnic backgrounds. Finally, regarding the care of ethnic minority patients, ethical and legal aspects are components of cultural competency training (Donnelly, 2000).

CONCLUSION

This study examined power relationships between nurses and ethnic minority patients during the caregiving process. Being sensitive to cultural differences and improving communication skills are important issues for obtaining cultural competence. However, there should be some prior understandings on power relationships. Based on Foucault's notions, some suggestions for cultural competency in nursing are provided.

First, nurses should be aware nurses' privileged knowledge and power over ethnic minority patients in several ways such as nursing knowledge, fluency in language that is used in health care settings, and familiarity to rules governing health care settings. With this understanding, nurses may be more aware of how vulnerable ethnic minority patients are in these power relationships in such clinical settings as hospitals, clinics, and nurse practitioners' offices. Current cultural competence training stresses nurses' sensitivity to cultural difference, but this vulnerability of ethnic minority groups in the healthcare setting should be further emphasized.

Second, since current cultural competency training has focused on creating awareness of cultural differences, this awareness needs to differentiate distinction from comparison. Being aware of the cultural differences may lead to competition among different knowledge. As discussed with an example of CAM, a minority patient who practices his/her own health behavior such as herbs or some rituals can be recognized as unscientific behaviors. When knowing the difference, people easily make comparisons and try to use a system of knowledge to support why theirs are superior- at least not inferior- than others. When a representative of one culture meets a representative of another culture, a distinction of the 'self' from 'others' takes place. The 'self's' culture is compared to the 'other's' culture. Members of each culture will try to identify members of another culture with their own language. Representatives of different cultures will compete in terms of which culture's knowledge, expertise, techniques and apparatuses are more powerful. Nurses should be aware of this tendency of 'objectifying others' in competition of discourses and try to value different cultures equally.

Finally, every step that is taken to deliver culturally competent nursing care needs to be examined if any effort hasbeen made to provide power to patients. Nurses should try to decrease the gap between nurses' and patients' power and, if possible, try to give patients equal or similar power as nurses. As a system, health care institutions, such as clinics and hospitals, need to be open to discourses of ethnic minority patients, and if possible, try to make it equally open to health care providers and patients. Considering features of power relationships of Foucault, to make even an egalitarian space in the health care delivery system might be a state that could not be attained. However, continuos efforts to make an egalitarian environment should be made. Current cultural competency practices often include the training of bilingual or bicultural health care providers. This practice might be a basic step to reach to a goal of an egalitarian environment equally open to everyone.

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