

Guest editorial

How universal are the caring models used by nurses?

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My perspective of nurses' caring in non-western cultural contexts is based on working with a culturally diverse nursing workforce for the past 19 years in Saudi Arabia. I have also conducted ethnographic research with Arab Muslim nurses to explore their values and beliefs about health, illness and healing and the way that these beliefs influenced their caring for Arab Muslim patients in the Middle East (Lovering, 2008). I first questioned my western-dominated nursing model when a Jordanian nurse leader said to me, 'I read about nursing from the West, but I think and feel about nursing from the East.' By this she meant that although she had learned the science of nursing from the west, the values and beliefs she brought to the care of her patients reflected her eastern cultural and spiritual values. She felt disconnection between what she learned from books and the way that she cared for and connected with her patients.

Although various forms of caring for the sick existed well before the time of Florence Nightingale, western nursing developed with the growth of medical knowledge, specialisation and hospital care within the context of societies adapting to industrialisation in the nineteenth and twentieth centuries. Nurses in western societies such as the UK, Europe and North America are raised in a culture permeated with Christian traditions and a belief that nursing care will be delivered from a value system characteristic of the Christian heritage (Narayanasamy and Owens, 2001). This western nursing perspective is promulgated in contemporary nursing literature, which is dominated by authors and editors from nursing academic settings in the UK or North America, where the majority of nursing journals and textbooks are produced. Ketefian and Redman (1997, p. 15) note that 'a Western perspective generally pervades organising concepts and frameworks in nursing and thus is a dominating influence in knowledge development and research' in both nursing and other health professional groups. Holden and Littlewood (1991) suggest that modern nursing is essentially a western professional construct that developed within particular historical circum-

stances, but the universal role of caring will reflect each society's cultural values. However, there remains a lack of recognition and acknowledgement in mainstream nursing that there are alternative caring models to the western nursing perspective.

The classical works of Kleinman (1980) and Good and Good (1981) on explanatory models and a meaning-centred approach to understanding the illness experience help to clarify nurses' culturally specific models of caring. Explanatory models are the culturally based explanations of the meaning of health, the causes of disease, approaches to healing and the roles of others in the healing experience. Nurses and other health professionals bring their cultural beliefs about health, illness and healing to their professional practice and acquire additional models, such as the biomedical model, through their professional training. Medical anthropologists and contemporary nursing literature assume that nurses incorporate their cultural models of health into their professional caring through the process of education and socialisation, when the professional model is expected to replace cultural health belief models.

However, nursing models in non-western cultural contexts, such as the Far East, Native American and Middle East cultures, demonstrate that nurses' cultural values are not replaced by the biomedical model but rather are blended into the nurses' cultural belief systems. This blending of professional models and cultural beliefs ensures that nurses provide care which is based on a world view that is consistent with those who are receiving care, particularly where the western biomedical model is not the dominant health belief model of the population.

The dominance of cultural values as the foundation for nurses' caring models can be seen in Chinese cultures, where illness is perceived as a state of disharmony between the individual and the natural and social environment, and where caring and curative processes are needed to restore balance and harmony in the individual (Chen, 2001; Wong *et al*, 2003). The nursing role encompasses a holistic model of care that

is grounded in traditional Chinese medicine and Confucian notions of *qing* (empathetic understanding, caring or concern for), *li* (truthfulness, responsibility), *zhi* (understanding, knowledge) and *xin* (action, interaction). Although there is some focus on western scientific nursing concepts, the fundamental values of *qing*, *li*, *zhi* and *xin* constitute the epistemic concerns of Chinese nursing (Pang *et al*, 2004). Chinese and Confucian principles of hierarchical relationships and deferral to authority influence the relationships between the nurse and the patient, doctor and colleagues. Chinese cultural values influence the role of the nurse in providing care for the patient. These include the paramount obligation of the family to care for the sick, the concept of losing face if outsiders provide intimate personal care, and the need to promote social harmony (Pang *et al*, 2004; Wong and Pang, 2000).

Taoism is the dominant philosophy influencing Korean nursing. In Taoism, the universe depends on the balance of *yang* (positive or male elements) and *yin* (negative or female elements), and life is considered to be the circulation of *yang* and *yin* (Shin, 2001). Health results from harmony between *yang* and *yin*, whereas illness is due to the loss of harmony and balance in the life rhythms. The nursing role is to recognise imbalance in a patient's condition and to assist the patient in restoring balance and harmony in his or her life. In contrast to the western biomedical focus on disease, the focus of nursing in Korea is on life itself. The goal of nursing is to bring about harmony between *yang* and *yin* and to strengthen the patient's *chung* (the physical materials that make up the body), *khi* (the energy that maintains the life, physical and mental activities) and *shin* (the spirit or soul). Mutual trust and understanding between the nurse and the patient are established by sharing the common philosophy of Taoism (Shin, 2001).

The dominance of cultural beliefs in nurses' caring is seen in the recent development of the Native American nursing model. For Native American nurses, the body, mind and spirit are a whole, with all of the components being interdependent. This holistic world view is lived and experienced in a circular manner (Hunter *et al*, 2006; Lowe and Struthers, 2001; Struthers and Littlejohn, 1999). There are seven inter-related, intertwined dimensions of the phenomenon of Native American nursing, namely *caring*, *traditions*, *respect*, *connection*, *holism*, *trust* and *spirituality*. Balance is achieved in spiritual, emotional, mental and physical health and harmony within the environment. Illness is a disruption of that harmony and balance, and requires healing. The Native American nursing model is consistent with the medicine wheel, signifying the circle of life and all aspects of mental, physical, emotional and spiritual aspects (Lowe and Struthers, 2001), and with the world view of their Native American patients. Thus the cultural and spiritual

values of Native American nurses determine their nursing model, in which professional nursing values are blended into their cultural belief system to ensure consistency with their patients' belief system.

The interrelated aspects of Islam, Islamic health beliefs, the importance of family as the primary social unit, distinct gender roles and the perceived low status of nursing influence nursing in the Middle East. Spirituality as grounded in the Muslim world view is a theme that weaves throughout Arab culture and research on nurses' caring in the Middle East. My study of Arab Muslim nurses' experiences of the meaning of caring (Lovering, 2008) found that these nurses have a religiously informed explanatory model centred on Islam, and in which health is considered to be spiritual, physical, psychological and social well-being. According to this world view, predestination determines the presence of disease and the effectiveness of medical treatment and other healing. The western biomedical model of pathology and the science of curing are subject to Allah's will, as is the patient's response to the medical treatment. Although Arab Muslim nurses acknowledge the technical (biomedical) aspects of their role, their cultural and religious beliefs about health and disease blend with and dominate their scientific caring model in a way that makes sense within their culture. Their religiously informed health beliefs blend seamlessly with their professional caring model and the meaning of caring that is shared with their Arab Muslim patients. Caring is an act of shared spirituality between Arab Muslim nurses and patients. Moreover, the nature of the shared spirituality is fluid, depending on the patient's spiritual needs. One nurse described the nursing role in the words 'We are the angels in the air', which captures the essence of caring as an act of spirituality and central to the nurses' role as guardians of the patients' spiritual and physical health (Lovering, 2008, p. 118).

The history of nursing in Islam underpins the nurses' professional and personal identity and supports acceptance of nursing by societies in the Middle East. Rufaidah Al-Aslamiya, the first nurse in Islam, practised at the time of the Prophet Muhammad (PBUH) in the eighth century (CE). Like Nightingale, Rufaidah set up a training school for nurses and developed the first code of ethics, as well as leading nurses in caring for the wounded during the time of the Holy Wars, and caring for patients in a tent outside the Prophet's (PBUH) mosque. The history of Rufaidah and other nurses at this time is recorded in the *Sunnah*, the recorded words and practices of the Prophet (PBUH) (Al-Osimy, 1994; Jan, 1996). The recognition of Rufaidah as the first Muslim nurse is a very recent phenomenon, as Saudi and other Muslim nurses looked to their religion and history to place the nursing role within their religious framework (Lovering, 2008). Muslim nurses believe that the value of their caring

action is captured by the following verse from the Quran (5:23): 'If anyone has saved a life, it would be as if he has saved all of mankind.'

Developing culturally specific nursing models

Beliefs about health, illness and healing are the foundation of nurses' caring models in all cultural contexts, and culturally derived health beliefs are blended into the professional caring models. A culturally specific nursing model ensures a shared value system between nurse and patient in the provision of nursing care. Nurse theorists, researchers and practitioners are developing nursing models specific to the societies' cultural values in many non-western contexts. Studies in Hong Kong (Pang *et al.* 2004; Wong and Pang, 2000; Wong, Pang, Wang and Zhang, 2003), Taiwan (Chen, 2001), Korea (Shin, 2001) and Japan (Hisama, 2001) have analysed the values and beliefs of nurses and the blending of Eastern philosophy and cultures in nurses' caring models. At summits for Alaska Native and Native American nurses in the USA held in 1997 and 1998, a conceptual model of nursing in Native American culture was proposed to provide a structure for nursing practice, education, research and administration for the provision of healthcare to Native American patients, families and communities in which John Lowe, Roxanne Struthers and Sandra Littlejohn have taken a leading role (Lowe and Struthers, 2001; Struthers and Littlejohn, 1999). In the Middle East, the Gulf Cooperation Council (GCC) Nursing Technical Committee set a strategic goal to implement a culturally congruent nursing model for all GCC countries. At a symposium in May 2012 held in Doha, Qatar, Watson's Theory of Human Caring and the Crescent of Care model (see Lovering, 2012, in this issue) were identified for further development as a nursing model for application in the culturally diverse populations of the GCC region.

These culturally based models form the basis for connection with the health beliefs of the population that is being served, and they are complemented by western ideas that provide scientific knowledge. Understanding the health beliefs of nurses contributes to building theory that explains the practice of nursing in culturally specific contexts and makes explicit the connection with western nursing science. Pang *et al.* (2004, p. 257) have noted that 'a theory of nursing derived from nurses' experiences can reflect indigenous practice values and collective understandings in nursing, which in turn can act as a fertile source of ideas and inventiveness in developing a relevant knowledge base to inform practice.' Thus the science and art

of nursing blend in the provision of culturally specific care to diverse patient populations.

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