# Nursing Ethics

**Utilitarian and common-sense morality discussions in intercultural nursing practice**

Ingrid Hanssen and Lise-Merete Alpers

The online version of this article can be found at:

Published by:

**$SAGE**

Additional services and information for *Nursing Ethics* can be found at:

**Email Alerts:** http://nej.sagepub.com/cgi/alerts

**Subscriptions:** http://nej.sagepub.com/subscriptions

**Reprints:** http://www.sagepub.com/journalsReprints.nav

**Permissions:** http://www.sagepub.com/journalsPermissions.nav

**Citations:** http://nej.sagepub.com/content/17/2/201.refs.html

>> Version of Record - Feb 25, 2010

What is This?

# Utilitarian and common-sense morality discussions in intercultural nursing practice

**Ingrid Hanssen**
Lovisenberg Diaconal University College, Oslo, Norway
**Lise-Merete Alpers**
Lovisenberg Diaconal Hospital, Oslo, Norway

## Abstract

Two areas of ethical conflict in intercultural nursing – who needs single rooms more, and how far should nurses go to comply with ethnic minority patients' wishes? – are discussed from a utilitarian and common-sense morality point of view. These theories may mirror nurses' way of thinking better than principled ethics, and both philosophies play a significant role in shaping nurses' decision making. Questions concerning room allocation, noisy behaviour, and demands that nurses are unprepared or unequipped for may be hard to cope with owing to physical restrictions and other patients' needs. Unsolvable problems may cause stress and a bad conscience as no solution is 'right' for all the patients concerned. Nurses experience a moral state of disequilibrium, which occurs when they feel responsible for the outcomes of their actions in situations that have no clear-cut solution.

## Introduction

The different ways in which people think about health, illness and health care present nurses with the challenge of human diversity. Among the ethical challenges described in intercultural/transcultural nursing are racism[1–3] and conflicting values, traditions and situational understanding that create nurse–patient problems.[4–7] That the latter kinds of problems may also cause conflict among nursing staff tends to be ignored. This, however, is a topic that needs be discussed because a 2002 study[7] indicated that such conflict may cause nurses to experience moral stress/distress[8,9] or stress of conscience.[10]

In particular, two ethical issues were found to cause tension among nursing staff: (1) who needs single rooms more – ethnic minority patients with numerous visitors, or very ill or dying patients? and, (2) disagreement among nursing staff about the extent to which they should comply with extraordinary wishes or demands by ethnic minority patients and/or their families. A recent two-part study[11,12] revealed that these problems are still very real. We cannot identify these or related issues discussed anywhere else, in spite of the fact that practical problems may cause serious tension among nursing staff when these issues become ethical dilemmas through lack of resolution.

---

**Corresponding author:** Ingrid Hanssen, Lovisenberg Diaconal University College, Lovisenberggt 15 B, 0456 Oslo, Norway.
Email: ingrid.hanssen@ldh.no

These empirical studies triggered our interest and constitute a starting point for our discussion. The 2008–2009 study[11,12] gives an indication of the size of the problem, while the 2002[7] study supplies qualitative data given as examples in the discussion section.

## Theoretical framework

Although a common definition of 'culture' is 'the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular group that guides their thinking, decisions, and actions in a patterned way' (p.13),[13] we understand culture as a *process* rather than a constant, and as a relationship *between* groups because ethnic identities exist only in their relationship to others. Cultures mark ways in which groups construct differences through both self-identification and categorization of others.[14]

The 2002[7] interviewees rarely mentioned any ethical principles when discussing their ethical predicaments, a finding supported by Slettebø[15] and by Sørlie.[16] Instead they weighed the needs of the many against the needs of the few – or the one – or they would talk about their 'gut feeling' of right and wrong, a feeling that seemed to play an important part in their decision making. It seemed appropriate to discuss the study's findings in the light of theories mirroring the interviewees' mode of deliberation as closely as possible. Utilitarian and common-sense theories of ethics were found to fit well with the nurses' deliberations for the dilemmas discussed in the present article.

According to John Rawls:

> [t]he two main concepts of ethics are those of the right and the good; ... The structure of an ethical theory is, then, largely determined by how it defines and connects these two basic notions. Now it seems that the simplest way of relating them is taken by teleological theories: the good is defined independently from the right, and then the right is defined as that which maximizes the good (p.15–16).[17]

Utilitarianism is such a teleological theory, a form of consequentialism where ethical value is judged according to the welfare or benevolence produced.[18] One strives to achieve the greatest aggregate welfare or good for everyone in a society – or a hospital ward – but what produces welfare for one patient may collide with the welfare of another.[7] Nurses must often prioritize their care based on utilitarian judgements: whose need is greater; or which situation is more critical?

Many such conflicts offer more than a utilitarian aspect, however, for common-sense morality aspects also tend to sneak in. Philosophers' views regarding common-sense morality differs, and some even deny its existence.[19] Sidgwick[20] argues that utilitarianism gives the best theoretical account of common-sense convictions, but Rachels[21] perceives the feeling of right and wrong, obligation, etc. as a strong point in common-sense morality, while this is missing in utilitarian thought. Others turn to the Golden Rule to explain 'natural' or common-sense morality,[22,23] and, while Reid (1710–1796) held that common-sense morality 'embodies principles whose truth everyone can see intuitively and can readily apply',[24] Davis claims that '[a]ppeals to ... "moral common sense" cannot plausibly be thought to provide a valid theoretical or normative litmus test for a moral theory' (p.212).[19]

Nurses seem to decide how to act based on deliberations on the particular situation at hand and the different factors influencing it. Studies show that nurses 'mostly narrated from a relational ethical perspective' (p.5),[16] and that they built their ethical considerations on 'a feeling that something was wrong' and on casuistic thought and personal experience.[15] This indicates that to discuss certain ethical dilemmas in nursing from a common-sense morality point of view, may be useful.

Common-sense morality seems to be closely related to what researchers describe as 'conscience'.[25,26] Conscience also corresponds with feelings related by interviewees in the 2002 study.[7] Conscience is a driving force in nurses' contact with patients, families and colleagues, according to Sørlie et al.[26]

As morality is a social construction, evolving from a community's experiences, particular institutional arrangements and deliberations, common morality may be different in different communities.[27] Hofstede divides national cultures into being mainly individualistic or collectivistic, as 'a single, bipolar, dimension is a useful construct ... for subsuming a complex set of differences' (p.xi).[28] In individualistic societies 'the ties between individuals are loose: everyone is expected to look after himself or herself and his or her imme-diate family', while in collectivistic societies people 'are integrated into strong, cohesive in-groups, which ... protect them in exchange for unquestioning loyalty' (p.51).[28]

Such differences in outlook are mirrored in a society's moral thought. In small scale or traditional (col-lectivistic) societies morality tends to be perceived as a process – as a means to an end – expressed through the quality of various interhuman relationships, characterized by values such as friendship, family loyalty, empathy, altruism, trust etc., rather than observation of abstract deontological principles. In modern, non-traditional (individualistic) societies, relationships between people are less close, less intense, and of less importance, on both individual and societal planes. Morality is perceived as a goal in itself rather than a means to an end, and is expressed through compliance to rules rather than through the quality of the relationships.[6]

## Research methods

The 2002 study[7] was a qualitative empirical study using narrative interviews and field observations of nurses working on 12 wards in two Norwegian hospitals, and concerned working with non-western patients. All nurses on the wards who had a minimum of two years' work experience and some intercultural nursing experience were invited to participate (strategic sampling). All who volunteered were included (23 nurses: 2 men, 21 women. Nursing experience ranged from two to over 10 years.. In the interviews (tape recorded, lasting 20–90 minutes) the respondents were encouraged to recount their experiences through the telling of patient stories. The tapes were transcribed verbatim.

As the issues discussed in this present article figured prominently in many of the 2002 narratives, they were integrated into the 2008–2009 combined questionnaire (qualitative and quantitative) and focus group interview (qualitative) study.[11,12] This two-part study was conducted at a medical and a psychiatric unit, each with several wards, in a Norwegian city hospital with 30–40% ethnic minority patients. All nurses working half time or more were invited to participate. Medical unit respondents numbered 145 (17 men, 128 women aged 23–50+), 90% of whom were nursing staff with nursing experience of 0–10+ years. There were 100 psychiatric unit participants (19 men, 81 women aged 20–50+), 75% of whom were nursing staff with psy-chiatric nursing experience of 0–10+ years.

As no instrument measuring nurses' intercultural competence was identified, a questionnaire was devel-oped. Three audio recorded focus group interviews with a total of 18 nurses from the two units (6 + 5 medical and 7 psychiatric nurses, each group interviewed once) were conducted to ensure that the questionnaire con-tent was pertinent to these interviewees' nursing practice. Participants were recruited through information given at staff meetings by the second author. All volunteers – all women – were included. Transcriptions were verbatim. Additionally, a professor of intercultural co-operation and 12 health care personnel (men and women) with Norwegian, Eastern European, African and Asian backgrounds, all with intercultural experience, were interviewed. Some of these were known experts; others were suggested by these experts ('snow balling'). These latter interviews were not audio recorded, but rich notes were taken.

The questionnaire contained 35 statements and was divided into six sections: (1) Nurses' experience and knowledge; (2) Collaboration, attitudes and conduct; (3) Illness, health behaviour and pain; (4) Communi-cation; (5) Death and dying; and (6) Culture, religion, and diet. Each statement had six-point Likert-type response alternatives: (1) I don't agree at all; (2) I don't agree; (3) I neither agree nor disagree; (4) I agree; (5) I very much agree; and (6) I don't know. In addition, there were four open-ended questions. Two nursing

college tutors and an expert on quantitative research read and commented on the questionnaire, causing some changes to be made before a small pilot study was carried out to ensure the questionnaire's validity and reliability. The pilot study also led to some changes before the study proper was commenced.

### Data analysis

The 2002 interviews[7] were analysed thematically. The themes evolved from the various interview texts.[29] The analytical focus was ethical dilemmas in intercultural nursing practice. For the 2008–2009 study the 35 questionnaire statements were used as analytical categories for both the quantitative and the qualitative data (open-ended questions and focus group interviews). The electronic analytical tool SPSS-15 was used for the quantitative data.

### Some critical remarks

One of the 2008–2009 study's strengths is that it was based on knowledge gleaned from a previous empirical study.[7] However, in questionnaires respondents cannot elaborate on their answers. We tried to reduce this problem by conducting focus group interviews before producing the questionnaire, and by including three open-ended questions and an 'Other comments' category. A few respondents used this latter category to express frustration that standardized statements tend to 'generalize' human beings.

### Ethical considerations

Both studies were approved by the Norwegian Social Science Data Service. Interviewee confidentiality and the right to withdraw were ensured throughout the entire research process, from data collection to written texts. The 2002 study was approved by a Regional Committee for Medical and Health Research Ethics. The interviewees were informed about the study both orally and in writing and signed a written informed consent form. The 2008–2009 study was approved by a hospital Privacy Ombudsman for Research. The respondents placed their unmarked, anonymous questionnaires in a communal envelope on the ward, which was then collected. The focus group interviewees were informed about the study both orally and in writing. They did not sign a consent form but were told that participation was voluntary.

## Findings

Only the four statements of section 2 of the 2008–2009 study touch upon the issues discussed in this article. These are briefly presented below to illustrate their relevance in intercultural nursing practice. The 2002 findings will serve as illustrations in the discussion section.

### Who needs single rooms more?

Is it a patient with many visitors who may disturb others, or a very ill or dying patient who most needs the ward's perhaps only single room? The statement: 'Conflict may arise between consideration for ethnic minority patients/families and for Norwegian patients, for instance, regarding the need for a single room', was pertinent only for the medical unit nurses because the psychiatric unit consisted of day care wards only (Table 1).

Table 1 shows that 51% of the nurses agreed that there is conflict regarding who most needs single rooms etc., while only 15% disagreed with the statement, and 13% did not know; 22% neither agreed nor disagreed.

One focus group interviewee said that: 'One may understand *why* patients have so many visitors; but many visitors are still a challenge. Fifty or so visitors are a problem since you cannot get to the patient.' Visiting

**Table 1.** Conflict may arise between consideration for ethnic minority patients/families and for Norwegian patients, for instance, regarding the need for a single room

| Response | No. respondents (medical unit nurses) | % |
|---|---|---|
| I don't agree at all | 14 | 10 |
| I don't agree | 7 | 5 |
| I neither agree nor disagree | 31 | 22 |
| I agree | 41 | 29 |
| I very much agree | 31 | 22 |
| I don't know | 19 | 13 |
| Total | 143 | 101 |

**Table 2.** I always try to comply with ethnic minority patients'/families' wishes

| Response | Respondents (medical unit nurses) | % |
|---|---|---|
| I don't agree at all | 6 | 4 |
| I don't agree | 9 | 6 |
| I neither agree nor disagree | 29 | 20 |
| I agree | 56 | 39 |
| I very much agree | 39 | 27 |
| I don't know | 4 | 3 |
| Total | 143 | 99 |

children – especially very young children – may constitute a particular difficulty: 'The children can be very active, and it can be difficult to understand why they need to be kept away while nurses carry out procedures.'

Another issue discussed by the focus group interviewees was that many family members find it hard when they are not allowed to stay on the ward very late or overnight. This becomes a problem when visitors do not respect that 'patients need their rest', particularly when 'family can be quite loud and disturb other patients'. Nurses may find this frustrating and some feelings of irritation may occur.[7]

## To comply with wishes and demands

The statement: 'I always try to comply with ethnic minority patients'/families' wishes' was presented only to the medical unit nurses (Table 2).

Table 2 shows that 66% of the respondents said that to some extent they try to comply with patients' and/or families' demands, while 10% disagreed with the statement. An additional 20% neither agreed nor disagreed.

Both units' nurses responded to the statement: 'I feel that we go too far to comply with ethnic minority patients'/families' wishes' (Table 3).

Forty-one percent of both units' nurses responded that they indeed go too far to comply with ethnic minority patients' and/or family members' demands and wishes; 23% of medical unit nurses and 25% of psychiatric nurses neither agreed nor disagreed with this statement, while 28% and 32% disagreed respectively.

The responses to the statement: 'There is disagreement on the ward regarding how far one should go to comply with ethnic minority patients'/families' wishes' showed that a majority of the nurses do not agree with this statement, namely, 43% of the medical unit nurses and 58% of the psychiatric nurses, and only 17% and 13%respectively agreed, and 23% and 20% respectively neither agreed nor disagreed (Table 4).

**Table 3.** I feel that we go too far to comply with ethnic minority patients'/families' wishes

| Response | Medical unit nurses | | Psychiatric unit nurses | |
|---|---|---|---|---|
| | No. | % | No. | % |
| I don't agree at all | 23 | 16 | 12 | 12 |
| I don't agree | 18 | 12 | 20 | 20 |
| I neither agree nor disagree | 33 | 23 | 25 | 25 |
| I agree | 38 | 26 | 29 | 29 |
| I very much agree | 22 | 15 | 12 | 12 |
| I don't know | 11 | 8 | 2 | 2 |
| Total | 145 | 100 | 100 | 100 |

**Table 4.** There is disagreement on the ward regarding how far one should go to comply with ethnic minority patients'/families' wishes

| Response | Medical unit nurses | | Psychiatric unit nurses | |
|---|---|---|---|---|
| | No. | % | No. | % |
| I don't agree at all | 34 | 23 | 21 | 21 |
| I don't agree | 29 | 20 | 37 | 37 |
| I neither agree nor disagree | 33 | 23 | 20 | 20 |
| I agree | 20 | 14 | 9 | 9 |
| I very much agree | 4 | 3 | 4 | 4 |
| I don't know | 25 | 17 | 9 | 9 |
| Total | 145 | 100 | 100 | 100 |

## Discussion

Although ethicists compare different theories and point out where they conflict, nurses work in practical settings in which they tend to combine different philosophies to solve the ethical problems and dilemmas at hand. As discussed above, we find both utilitarian and common-sense morality considerations to be important in nurses' deliberations.

### Who needs single rooms more?

Nagel[30] argues that one's primary responsibility within an interpersonal relationship is to that one person. This is a view widely endorsed among nurses[16,31] because of the relational quality of caring for others. However, in the situations discussed here, nurses are equally responsible for all involved patients on the ward. As opposed to less complex patient–nurse contexts, it would go against utilitarian morality to consider only the one or the few in your personal care. Relational proximity, therefore, does not alone solve this problem. According to both common-sense morality and utilitarianism there are principles to be considered before actions can be taken for the sake of the common good. Nurses want to respect all patients as individual persons and treat them as an end and not as a means to an end. Furthermore, they want to respect patients' value system and cultural integrity. Additionally, thoughts about the sick role and how patients should behave as ill

persons, and how nurses should behave towards ill people, will influence each involved person's behaviour, attitude and expectation in a given context.

Collectivist values may create a very different patient to work with than the individualistic values of independence and autonomy[4] and tend to lead to an other-reliant and dependent coping style. A collectivist or traditionally orientated patients' predominant coping style may be to turn

> to others for help and advice. In doing so, the need for others' help is not directly communicated; rather, it is understood and acted upon without being verbally articulated. The expected help must be offered with persistence and force and, whether the seeker acknowledges the need or not, the offer must be repeated (p.892).[32]

Both this other-reliance and religious demands may cause patients' family members to rally around them.[4]

Older Norwegian hospitals tend to have 3–4-bedded patient rooms and very few single rooms. These are generally assigned to very ill or dying patients, or patients who need to be isolated. When it is difficult to decide who is in greater need of a single room – the most ill patients or patients with numerous visitors – a practical problem is turned into an ethical dilemma owing to hospital architecture because this constitutes a physical surround that nurses often find blocking them from doing the right thing for their patients. Lützén et al. claim that previous research 'seems to ignore, or at least not to take into account, how health care policies and the organization of care impact on nurses' daily work and their moral obligations to patients' (p.319–20).[8]

Even if one of the cultural factors to be considered is the amount of familial care and support an ethnic minority patient may need, patients' need of rest may take precedence if that need is judged to be greater. Moral intuition within common-sense morality would suggest that the duty to uphold life and shield patients from harm overrides other principles in situations seen as harmful. However, this decision may be harder to arrive at in a more intuitive 'mode' than within the framework of utilitarianism if the nurse feels strongly about aspects of the situation, for instance when actions to further beneficence or non-maleficence make autonomy suffer, something nurses may feel strongly about, as they see it as affecting their respect for the person.[7] To avoid moral stress nurses' decisions must be defensible both to themselves and to both groups of patients.

Half of the medical unit respondents agreed that conflict arises on the wards regarding this question, and an additional 22% seem to indicate by their 'neither agree/nor disagree' answer that conflict may occur now and then (Table 1). According to utilitarian theory, the greater gain for some may compensate for the losses of others. The needs of the many may outweigh the needs of the few. Hence the utilitarian questions would be: Will the increase in the well-being of the patient majority suffering from noise by an ethnic minority patient's many visitors decrease the well-being of that patient? Would the patient majority's increase be greater than the other's loss? These are important questions in utilitarian deliberation, and nurses must answer these questions according to how they read a given situation and context.

The rational thing to do according to a utilitarian view – whether forcing noisy guests to leave the ward or allowing 'disruptive' behaviour – may give nurses a bad conscience because they are also in sympathy with the 'losing' party, whichever party that is.[7] From a utilitarian point of view, such feelings are irrational.[24] Emotions, however, are important to nurses as long as they enhance their sensitivity to others and do not turn into sentimentality. Hence both reason (here: utilitarianism) and feelings (common-sense morality) are important guides to moral conduct. Reason without feelings may become mechanical, with no place for individuality. Emotions need to be coupled with reason because feelings may otherwise be difficult to separate from ethical thought.

This conflict, then, contains both a utilitarian and a common-sense morality aspect. Furthermore, Norwegian patients tend to judge the 'fairness' of room assignments according to how ill various patients are, and

nurses tend to weigh fairness judgements and their 'gut feelings' against a particular patient's needs versus the needs of other patients.[7] Ethnic minority patients' family members may make the same judgement based on who has more visitors, intrafamily loyalty, empathy with 'their' patient, and a need to stay in close touch with and support their ill family member.[4]

### To comply with wishes and demands

Regarding the statement: 'I always try to comply with ethnic minority patients'/families' wishes' (Table 2), 66% of the medical unit nurses said they try to comply with these wishes. When 20% of the respondents give a neither agree/nor disagree response, this may indicate that some wishes are more difficult – perhaps even impossible – to comply with, while others are easier to respond to in a positive manner.

Furthermore, some wishes or demands may be handled in a positive manner whenever the ward is not overly busy, but not when it is short staffed, busy, and populated with patients who need a lot of nursing care. Hence, the responses may indicate that the answer is context related and based on utilitarian thinking: that is, the focus is on the greater need(s) in a given situation seen in relationship to the existing resources. According to Sørlie et al.[26] conscience motivates nurses to provide high quality care. They demand a lot of themselves to live up to patients' expectations and demands.[7,26] However, a bad conscience or moral stress may result if circumstances force choices upon them that do not produce high quality care.

Disagreement among nursing staff about how to react to various wishes and/or needs may cause conflict:

> It is difficult because one day they are given leave, and the next day another nurse is on duty who finds it to be too much, and they are not given leave. And then they complain: 'We were allowed to do this yesterday' (p.95).[7]

Patients or family members who are more impatient and demanding than the nurses are used to may also cause strife.[7,11] When faced with these kinds of problems some nurses call for rules and regulations, while others seem to be more willing to 'play it by ear' according to the situation and have a more common-sense morality approach.[7]

### Short term versus long term consequences

Even if one should agree that it makes theoretical sense to add up levels of well-being in different individuals when the interests of various groups of patients collide, the question is whether it can be done in practice, and if so, how it can be done. How are nurses to know what is the greater good or harm in complex intercultural situations? In the simplest form of utilitarianism the best outcome for the greatest number of people equals the best possible total outcome, as long as the magnitude of the suffering of the few does not outweigh the gains of the many. Refusing a few patients' right to comport themselves in their traditional way will, according to this rationale, be right if the aggregate harm of the few (the ethnic minority patients) is not greater than the welfare shared by the rest of the patients. The harm done one way or the other cannot be decided without taking long term consequences into account.

If allowing collective or traditional coping styles is seen to be of paramount importance to one group of patients' welfare, the fact that others are inconvenienced and upset may be of less comparative consequence. Maximum welfare may be obtained through disregard for the needs of the many majority culture patients if the needs of the few ethnic minority patients outweigh them. The question is how one can weigh the long term consequences against the short term ones. What kind of measure should be used? In addition, do nurses have the cultural knowledge necessary to make these kinds of decisions? Furthermore, on wards with very seriously ill patients, their need for rest and quiet will often outweigh the needs of the others. However, nurses

do not merely act and react on the basis of weighing needs and potential well-being. They also react on feelings of right and wrong and of what constitutes good nursing care.[7,15]

## Conclusion

Nurses tend to regard feelings as part of the sensitivity necessary to be aware of an individual's suffering and needs. Without such awareness ethical choices would become mechanical and impersonal instead of attuned to a situation. As common-sense morality is relational in outlook, with its focus on right and wrong, obligations, duties, etc., it is more open to feelings than utilitarianism, which is singularly unemotional in character. In the nurse–patient relationship it is difficult to stay emotionally uninvolved when the work entails responsibility for and great physical proximity to individual patients. Furthermore, it is difficult to see how it is possible to be sensitive and empathic towards patients without somehow listening to one's feelings and 'gut' reactions. Even if common-sense morality has no clear-cut answer about what categories of human activities or interpersonal bonds are seen as sufficient to generate special ties between people in the ethical sense,[24] nurses would say that nursing is an activity that creates such a bond.

Questions concerning room allocation, noisy behaviour, demands that one is unprepared or unequipped for, and so on, may make it hard, if not impossible, for nurses on such wards to cope in an optimal manner because of physical restrictions, other patients' needs etc. Studies have shown that nurses may experience stress when they are not able to provide what they see as good nursing care or do what they know is right, or when they are forced to act contradictory to their conscience.[7–10,33,34] This sense of disequilibrium between one's ethical values and beliefs and what one is able to achieve tends to be seen as a result of obstacles like lack of time, supervisory reluctance, an inhibiting medical power structure, institutional policy, or legal constraints,[9,30,33] as well as pressure to do more with less, and low staff-to-patient ratios.[9] Moral distress can lead to frustration, anger and guilt, and often causes nurses to avoid patients[7] and even to leave nursing.[22,26] A sense of failed responsibility may also occur.[26] Factors leading to moral distress 'may contribute to a nurse's feeling of powerlessness to act in some situations and a perception that nursing administration as well as peers are non-supportive' (p.376).[34]

Scheffler says that '[m]any moral dilemmas take the form of conflicts between considerations of justice, rights, or fairness on the one hand, and considerations of aggregate well-being on the other' (p.249).[35] This seems to be a correct 'diagnosis' of the dilemmas facing nurses in the contexts discussed here. The emphasis for patients and families is on duty, collective welfare and harmony, and typically this 'applies only to the in-group and usually does not extend to out-groups' (p.33).[36] Western nurses with 'egalitarian commitment values'[37] may find it frustrating and hard to accept the lack of consideration for people outside the family or in-group that this collectivist mind-set may lead to.

Aggregate well-being, sensitivity towards the other person, or principles cannot supply nurses with a truly happy solution to some of the dilemmas they face. Moral dilemmas 'arise when two (or more) clear moral principles apply, but they support mutually inconsistent courses of action. It seems terrible to give up either value, and yet the loss seems inescapable' (p.6).[38]

Although the ethical problems and dilemmas discussed in this article are not necessarily unique to intercultural nursing, they tend to become more noticeable when culture is part of the equation. Individual nurses' ethical and intercultural competency constitute important factors in solving problems such as the ones discussed in this article. Even so, it is not enough. Collaborative efforts are necessary. Besides trying to solve a problem when it occurs, afterwards, the nursing staff need to discuss what happened, what measures where taken to solve the problem and to what extent these were successful, what was learned, and how can similar problems be handled next time? Interculturally experienced colleagues or colleagues with a similar cultural background as the patient in question may offer valuable insights into such discussions. In addition,

interculturally knowledgeable individuals called in to in-service sessions etc. may see the problem(s) in question with fresh eyes and expertise.

What would result from such collaborative efforts depends on context and circumstance. It is to be hoped that they would make nurses better equipped to care for ethnic minority patients in an open-minded and ethical way. They may also make it possible to lay down some rules in cases where this is necessary. Patients with many visitors may for instance have to accept being 'parked' in the corridor next to their room when entertaining family members, so that they do not disturb their 'neighbours'. Nurses could also work together to find polite and acceptable ways of limiting visiting hours and numbers of visitors when this is necessary for the welfare of patients. In this way, the experience of a moral state of disequilibrium, which occurs in situations with no clear-cut solution, may be dispelled, and an equilibrium between consequences and utility (utilitarian thinking) on the one hand and duty and a feeling of what is right (common-sense morality) on the other may be developed.

## Conflict of interest statement

The authors declare that there is no conflict of interest.

## References

1. Johnstone M-J, Kanitsaki O. The spectrum of 'new racism' and discrimination in hospital contexts: a reappraisal. *Collegian* 2009; 16(2): 63–9.
2. Shaha M. Racism and its implications in ethical-moral reasoning in nursing practice: a tentative approach to a largely unexplored topic. *Nurs Ethics* 1998; 5: 139–46.
3. Ang I. The curse of the smile: ambivalence and the 'Asian' woman in Australian multiculturalism. *Feminist Rev* 1996; 52(2): 36–49.
4. Hanssen I. An intercultural nursing perspective on autonomy. *Nurs Ethics* 2004; 11: 28–41.
5. Spence D. *Prejudice, paradox and possibility: nursing people from cultures other than one's own* [Dissertation]. Palmerston North: Massey University School of Health Sciences, 1999.
6. Johnstone M-J. *Bioethics – a nursing perspective*. Sydney: Harcourt Saunders Australia, 1999.
7. Hanssen I. *Facing differentness: an empirical inquiry into ethical challenges in intercultural nursing* [Dissertation]. Oslo: University of Oslo Institute of Nursing, 2002.
8. Lützén K, Cronqvist A, Magnusson A, Andersson L. Moral stress: synthesis of a concept. *Nurs Ethics* 2003; 10: 312–22.
9. Slater D, Brandt L. Combating moral distress. *OT Pract* 2009; 14(2): 13–17.
10. Glasberg A-L, Eriksson S, Norberg A. Factors associated with 'stress of conscience' in healthcare. *Scand J Caring Sci* 2008; 22: 249–58.
11. Alpers L-M, Hanssen I. *Sykepleieres kompetanse om etniske minoritetspasienter*. (*Nurses' competency regarding ethnic minority patients*.) Oslo: Lovisenberg Deaconal University College, 2008 (in Norwegian).
12. Alpers L-M, Hanssen I. *Etniske minoritetspasienter i psykiatrien – en studie av helsearbeideres kompetanse*. (*Ethnic minority patients and psychiatric health care – a study of health care personnel's competence*.) Oslo: Lovisenberg Deaconal University College, 2009 (in Norwegian).
13. Leininger MM. Culture care diversity and universality theory and evolution of the ethnonursing method. In: Leininger MM, McFarland MR (eds.) *Culture care diversity and universality: a worldwide nursing theory,* second edition. Sudbury, Massachusetts: Jones and Bartlett, 2006, p.1–41.
14. Mulholland J, Dyson S. Sociological theories of 'race' and 'ethnicity'. In: Culley L, Dyson S (eds) *Ethnicity and nursing practice*. New York: Palgrave, 2001, p.17–37.
15. Slettebø Å. *Strebing mot pasienters beste*. (*Striving for patients' best interest* [Dissertation].) Oslo: University of Oslo Institute of Nursing, 2002 (in Norwegian).

16. Sørlie V. *Being in ethically difficult care situations* [Dissertation]. Umeå: Umeå University, 2001.
17. Rawls J. Classical utilitarianism. In: Scheffler S (ed.) *Consequentialism and its critics*. Oxford: Oxford University Press, 1988, p.14–19.
18. Williams B. *Ethics and the limits of philosophy*. Cambridge, Massachusetts: Harvard University Press, 1985.
19. Davis N. Contemporary deontology. In: Singer P (ed.) *A companion to ethics*. Cambridge, Massachusetts: Blackwell, 1994, p.205–18.
20. Sidgwick H. *The methods of ethics*, seventh edition. Indianapolis, Indiana: Hacket, 1981.
21. Rachels J. *The elements of moral philosophy*, second edition. New York: McGraw-Hill, 1995.
22. Preston R. Christian ethics. In: Singer P (ed.) *A companion to ethics*. Cambridge, Massachusetts: Blackwell, 1994, p.91–105.
23. Midgly M. The origin of ethics. In: Singer P (ed.) *A companion to ethics*. Cambridge, Massachusetts: Blackwell, 1994, p.3–13.
24. Schneewind JB. Modern moral philosophy. In: Singer P (ed.) *A companion to ethics*. Cambridge, Massachusetts: Blackwell, 1994, p.147–57.
25. Jensen A, Lidell E. The influence of conscience in nursing. *Nurs Ethics* 2009; 16: 31–42.
26. Sørlie V, Kihlgren A, Kilhgren M. Meeting ethical challenges in acute nursing care as narrated by registered nurses. *Nurs Ethics* 2005; 12: 133–42.
27. Rest JR, Narvaez D, Thoma SJ, Bebeau MJ. A neo-Kohlbergian approach to morality research. *J Moral Educ* 2000; 29: 381–95.
28. Hofstede G. Foreword. In: Kim U, Triandis HC, Kâgitcibasi C, Choi S-C, Yoon G (eds.) *Individualism and collectivism: theory, method, and applications*. Thousand Oaks, California: SAGE, 1994, p.ix–xiii, 51.
29. van Manen M. *Researching lived experience*. London, Ontario: State University of New York Press/University of Western Ontario, 2001.
30. Nagel T. War and massacre. In: Scheffler S (ed.) *Consequentialism and its critics*. Oxford: Oxford University Press, 1988, p.51 –73.
31. Nortvedt P. *Sensitive judgement*. Oslo: Tano Aschehoug, 1996.
32. Meleis AF, Jonsen AR. Ethical crises and cultural differences. *West J Med* 1983; 138: 889–93.
33. Corley MC, Minick P, Elswick RK, Jacobs M. Nurse moral distress and ethical work environment. *Nurs Ethics* 2005; 12: 381–90.
34. Fry ST, Harvey RM, Hurley AC, Foley BJ. Development of a model of moral distress in military nursing. *Nurs Ethics* 2002; 9: 373–87.
35. Scheffler S. *The rejection of consequentialism*, revised edition. Oxford: Clarendon Press, 1995.
36. Kim U. Individualism and collectivism: conceptual clarification and elaboration. In: Kim U, Triandis HC, Kâgiticibasi S-C, Choi GY eds. *Individualism and collectivism: theory, method, and application*. London: SAGE, 1994, p.19–40.
37. Schwartz SH. Beyond individualism/collectivism. In: Kim U, Triandis HC, Kâgiticibasi S-C, Choi GY eds. *Individualism and collectivism: theory, method, and application*. London: SAGE, 1994, p.85–119.
38. Jameton A. *Nursing practices: the ethical issues*. Englewood Cliffs, New Jersey: Prentice Hall, 1984.