

Exploration of Multicultural Student Education on Ethical Issues in an Australian Undergraduate Nursing Curriculum



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Abstract:

Background: Australian undergraduate nursing courses and their student profiles vary greatly, and so does the class's cultural and racial diversity. Student nurses will bring their own cultural identity, values, and opinions with them to class, both online and face-to-face. For the educator, there are many deliberations around being culturally considerate with such diverse groups, particularly when ethically centered topics can make cultural considerations challenging. This can contest both the students' and educators' beliefs and customs and may cause personal discomfort in some form. The purpose here is to explore the discomfort and potential issues the educator may face in delivering and managing such education forums.

Methods: This project uses an autoethnography narrative methodology with the implementation and analysis of a reflective journal and incorporates theories inclusive of the Pedagogy of Discomfort, Theory of Deontology, and Critical Resistance Pathways.

Results: The resulting journal spanned 3 months of the educators' reflections on cultural interactions across a multicultural public health class of 290 students and from interactions with health and academic peers. Analysis of the entries found indications that a person's cultural norms tended to form the core basis of responses and attitudes to culturally confronting topics, different perspectives from students and academics in health can lead to discomfort on discussion of ethically confronting topics, and racism was not always rebutted or acknowledged.

Conclusion: Practical implications for working safely across cultures have been presented with six core areas identified for tertiary education sectors and nursing educators to consider. These areas are focused on improving the educators' ability to address culturally conflicting situations during education delivery, navigating course/unit content, and reflecting on their own cultural beliefs and norms and those of their students and peers.

Keywords: Autoethnography, Multicultural, Educators, Ethics, Nursing students, Tertiary health education sector.

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1. INTRODUCTION

Within the tertiary health education sector, there are many topics and issues to be discussed that can be considered confronting, potentially offensive and certainly challenging for student groups in association with their

cultural beliefs. University education has extended itself to ensure equity of access for the varying student cohorts, and thus, often, classes consist of students who will present with varying levels of maturity, life experiences, and cultural belongings and beliefs. It can be readily imagined that within student forums where topics are

culturally confronting, developing teaching methods that are inclusive of many different cultures within one cohort is problematic. If students are offended in these cases, it can be questioned if this means the educator is being culturally inconsiderate.

This project sought to examine the role of the educator in these situations aligned with the Pedagogy of Discomfort [1]. This involved deliberation into ethically or culturally confronting topics in health explored in an autoethnographic narrative study. From the perspective of the educator, one needs to question how ethically challenging topics can be delivered with a culturally considerate approach when there are so many cultures and differences to be considered. Pedagogical approaches need to contemplate how important it is to challenge diversity of opinion based on culture and personal beliefs if they may be offensive to another culture and question what the responsibility of the educator is for these situations. Note that Australian curriculum legislation supports controversial issues being addressed, for example, with the introduction of the Controversial Issues in School Policy [2, 3].

The foundation of this analysis is based on public health education delivery to undergraduate health students with the exemplar class from a Bachelor of Nursing course. This group of students is required to work closely with people whose cultural beliefs have the potential to challenge their own. What is often neglected is the educator's role in facilitating education around this area and their level of understanding that this can be personally confronting for undergraduate students. Often, there is no guide or preparation for the educator on how to approach such topics or reflection on how their own perspectives may leave them in an uncomfortable position. They may rely on the university code of conduct and other governance documents to provide the foundations of their actions. The overarching purpose of this study is to review those culturally confronting interactions that will arise in a public health class with a group of multicultural undergraduate nursing students through the academic/ teacher perspective. This involved the academic maintaining a journal of their reflection on these, along with other culturally related interactions in the undergraduate nurse health and academic setting, as an autoethnographical narrative.

2. BACKGROUND

Culturally-centric teaching is not a new concept, and within higher education platforms, there are often policies to ensure educators are being inclusive and considerate of all student groups [4, 5]. However, in areas, such as health, there can be topics that are problematic for the educator to deliver as they may personally challenge and possibly affront students. This, in turn, can leave the educator feeling uncomfortable and unsure of how to proceed. Culturally safe approaches may incorporate reflecting on how a person feels regarding their own culture and a social identity theoretical approach [6, 7].

In support of the educator's responsibilities, there are

a number of guides that have been developed over the years to provide direction on the inclusion of cultural diversity in course design and delivery with the aim of meeting students' needs better [8, 9]. These identify principles, such as taking the learner's perspective, being aware of minority groups, and encouraging student self-reflection, and empathy to facilitate respect [9]. However, in large multicultural student cohorts and with internal and external enrolments, it is not feasible to identify and acknowledge the diversities of all the learners. What can result from such diverse classes is students voicing opinions that may not be culturally considerate, and this also remains the educator's responsibility to address.

Another consideration is that of the international student, many of whom are trying to find new social networks in Australia without losing contact with their cultural identity [10, 11]. The concept of culture shock for this group is quite real. Although international students have opted to attend another country for their studies, they may not have considered how the differences in culture will affect them. For the educator, there is a responsibility to try to or aim to prepare these students to be critical thinkers as they enter the Australian health care system, one which may be very different from the one in the student's home country. This means there is potential for the educator to introduce concepts that may create further culture shock for the students and/or cause conflict and spark discrimination within them.

Another area where discomfort is possible to occur is when teaching students about health disparities faced by Australia's First Nations populations (the Indigenous people of Australia who were first on the land and considered the traditional owners of the land), and there are First Nations students (who may or may not disclose their self-identify) within the multicultural student cohort. Often, there is generalisation when discussing such topics, *i.e.*, *First Nations people do not exercise enough*, encompassing the entire population group in this health statistic. There is also much literature available that presents health disparities faced by Australia's first nations people, which portray negative aspects of health. These may highlight higher rates of domestic violence and increased levels of risk-taking behaviours, such as nicotine and alcohol use, as well as other topics, which can lead to controversial discussions [12]. Within the Australian nursing curriculum, it is stipulated by the external course accreditation body, the Australian Nursing and Midwifery Accreditation Council, that First Nations health is a mandatory part of the curriculum [13]. Thus, the educator is expected to be prepared and deliver this education in a culturally sensitive method in classes with diverse genders, social classes, races, and cultural backgrounds and be able to deal with the resulting discussions and feedback.

The overall recommendation from The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives is to recognise that First Nations people are culturally, linguistically, and ethnically diverse and thus, when addressing health topics, the educator needs to

understand that one approach will not suit any entire group [14]. In reviewing Taylor and Guerin's (2014) recommendations on how to talk about the topic of Australian First Nations health, it is apparent that to avoid discomfort for Indigenous students, the educator needs to understand the greater frameworks around intercultural interactions [15]. However, this is based on educating Indigenous health students and does not really accommodate the other issues that may arise when First Nations students form part of a diversely multicultural group from many parts of the world.

There have been explorations into the healthcare barriers for those of different cultures and races primarily focused on racism [16]. The educator has the responsibility to ensure that racism has no room in the classroom and such views are alleviated, which means there may be a requirement for this to be openly discussed. Therefore, the educator requires a level of confidence and self-assurance in their own practices and knowledge to confidently facilitate such sessions and ensure the cultural safety of all involved.

3. METHODOLOGY

To explore the role of the educator in dealing with ethically confronting topics within a multicultural class, a qualitative methodology has been adapted in the form of an autoethnography narrative. This methodology involves self-reflecting on lived experiences in the health community and tertiary education sectors, drawing from conversations had with both students and teaching colleagues in the areas of multicultural student cohorts and ethical confrontations within higher education delivery for undergraduate nursing students. An autoethnography narrative provides a methodology that seeks to systematically analyse one's own personal experience with the purpose of identifying and expressing cultural experiences [17]. Given the core topic of focus is embedded with exploring cultural considerations, this methodology presents an opportunity to reveal some of the dilemmas faced by the educator in ethically and culturally confronting situations [18]. It promotes self-reflection and offers the opportunity to outline significant experiences [19].

This form of research offers the advantages of participant observation and allows a deeper understanding of how and why people may act as they do [20]. However, there can be a loss of objectivity due to close contact with participants, who in this case are the students and teaching peers. By incorporating both internal and external student cohorts, there can be a greater level of objectivity, as not all students are known to the educator. The inclusion of peers was deemed necessary to explore and record other experiences in order to look beyond the personal and potential for biased understandings. The number of peers who participated has not been recorded as these were documented anecdotally and did not recall individuals to protect privacy.

Another area to consider in such a research method is the power differentials among universities, educators, and

students. In this case, it could be assumed that students' dialogues, whether online or in class, maybe censored to please their educator. There is also the consumer-provider power relationship between the university and the student to consider [21]. Such relationships have always existed and are, therefore, acknowledged here. However, in educating health students, there is a foundational aim to educate and empower them to be advocates both for themselves and their patients/clients and to recognize that the students are adults [22]. Thus, students' actions and responses within the classroom are assumed to be of their own accord.

The autoethnography narrative was formed over a three-month period and incorporated recording deep reflection on past and present experiences in written journal entries by the educator interacting in a multicultural health environment. This included personal dealings whilst delivering education to a multicultural class that incorporated what could be considered confronting topics in public health. To gain student perspectives, a public health course embedded in the BN program was designed to explore ethically confronting topics being delivered to 290 internally and externally enrolled students. The course focused on current local and global public health issues and policies and incorporated topics considered ethically confronting, such as abortion, mandatory reporting of domestic violence, and euthanasia. The unit analytics were reviewed to present a visual representation of student enrolments and foundational diversities, which included International and First Nations student numbers as well as the gender of students.

The educator's interpretations of their own personal reactions, the student's interactions and contributions were transcribed. These were analysed to identify where incidents of cultural conflict did or could potentially arise and reviewed in alignment with the theories of pedagogy of discomfort, critical resistance pathways, and the theory of deontology. The focus of the analysis at this point was on the educator and their responsibility in how they cope with both their own and student's discomfort whilst being mindful of cultural safety. This aimed to recognise incidents where cultural safe practices can be problematic and identify methods the educator could take to improve cultural safety within the class for both themselves and their students.

As per the Charles Darwin University Human Research Ethics Committee, this research was deemed exempt from human research ethics review.

4. THEORIES INCORPORATED INTO THE STUDY

4.1. Pedagogy of Discomfort: Educator Self-awareness

In facilitating the nursing student journey, the educator is striving to create critical thinkers and problem solvers, to prepare these students for what it is like in the real world of health. There needs to be recognition that there will be discomfort and differences in how situations are perceived, and it has been identified that this can

extend to not just the students but also the educator [23]. Boler and Zembylas (2003) developed the Pedagogy of Discomfort, and within this theory, they have acknowledged that educators are human too, and when addressing ethically confronting topics, they may also experience discomfort [24]. However, it is also identified that despite these discomforts, there is a moral obligation to address incidences when it is obvious that opinions are inappropriate, racist, homophobic or otherwise against the general moral beliefs of society (acknowledging these may differ across societies). An interesting question proposed asks what criteria may exist to ensure educators are ethically considerate: *“How do we ensure ethical responsibility on the part of the educator for possible emotional repercussions of these fraught dimensions of pedagogy [25]?”*

The theory around the Pedagogy of Discomfort acknowledges that the educator needs to have self-awareness of what is appropriate but must also understand that to teach confronting ethical health topics, such as abortion or euthanasia, there needs to be a level of discomfort introduced within the student forum along with encouragement of self-reflection. For the purpose of this autoethnography narrative, it is acknowledged that for nursing students to really understand the full picture of such areas in health, they need to be exposed to differences of opinion. The challenge is conducting this in such a way that when their *cherished beliefs and assumptions* are questioned, the individual is not damaged [26]. For the exemplars being studied within the context of nursing, this lends to the educator facilitating a learning experience that asks the student to engage in critical inquiry into their own beliefs and customs and to develop flexibility and maturity in how they respond to and perceive others. This theory instructs that this form of inquiry should be done collectively rather than individually, acknowledging there can also be a vulnerability in the group context for the student.

4.2. Critical Resistance Pathways: Navigating Conflicting Ideas and Opinions

Another area to consider in the pedagogy of discomfort is that of critical resistance pathways, as presented by McEldowney (2003), which examines the concept of shifting from oppressing or being oppressed to critically resisting oppression [1]. Again, this is an important skill and understanding for an educator to have when addressing topics and issues in class that have the potential to incite racist or other oppressive views. As it merges with the Pedagogy of Discomfort, it challenges the educator to be aware of dominant student groups that may override other students in portraying their point of view. This puts the educator in a position to recognise their responsibility to speak up and intervene when required. It also then begs the question of how many educators are confident enough in their own knowledge and beliefs to take on such responsibilities and interventions, as it can take certain skills to unpack this in a class context.

4.3. Theory of Deontology: Managing the Evolution of Ethical Beliefs

If we focus on the introduction of ethnic studies into the curriculum with only an afterthought to the educators and teaching strategies used, the future is fairly predictable. My guess is that two decades from now, ethnic studies will exist, but they will be a shell with all content sucked dry by pedantic instruction more concerned with form than substance. Perhaps ethnic studies will go the way of Latin and Greek, given time and dull educational leadership [4].

Thankfully, the above prediction does not appear to have come to fruition in Australian undergraduate nursing courses, but that cannot be confidently stated for all curricula. The Theory of Deontology has been included here as it refers to the normative ethical notion that there is wrong or right and this impacts much of the approach to decision-making by health students in response to ethical issues. As identified by the above quote, ethical debate and education form a necessary part of education for health students however often the educator may not be prepared to address controversial topics due to their own inexperience, cultural discomfort or lack of understanding of the topic area. There is an analytical concept to address when approaching such topics, which can help look at the grey zone, an area often missed with a deontological approach to ethical dilemmas. One is to understand the need to ask questions about why such health inequities exist and explore this in a social and scientific context to find causations. The second is to look at a normative ethical approach that asks us to consider why we would care about such an issue and which part of the inequity we should care about [27]. This introduces the educator to choosing a teaching methodology that considers the learning outcomes and learners' needs, with an aim to accommodate both knowledge and attitudes. Developing a community of practice is one methodology that, if fostered and supported, could provide a beneficial environment for students to explore such themes in relation to confronting ethical topics.

5. RESULTS

The cohort of 290 students, which represents the number of enrolments in the public health unit incorporated within this study (student demographics presented in Table 1), presented a considerable number of students with culturally diverse and non-English speaking backgrounds, with 25% of students being international enrolments. In addition to this aggregated information, the international student cohort included students from the following countries: Philippines, India, Nepal, Zimbabwe, China, Malaysia, Vietnam, and Greece (note that of the 75 International students enrolled, only 27 had identified their country of origin with all others opting to leave this information blank).

The analysis of the journal involved reviewing 27 entries across 3 months (a total of 10 250 words), and this included the authors' interpretation and reflection on anonymous student posts to discussion boards. These

students' posts were in response to ethical questions in which their responses could be considered culturally driven or conflicting. A total of 56 discussion posts in response to topics on abortion policy, differences in euthanasia laws across Australia and mandatory reporting of domestic violence laws implemented in Australia were reviewed for the cultural context in their response.

Table 1. Data obtained via the online learning platform to demonstrate student enrolments for one semester.

| Enrolment Type | Male | Female | Total |
|--|------|--------|-------|
| Domestic student enrolments Both internal and external enrolments | 38n | 169n | 207n |
| International student enrolments *Within this university, international students are required to enroll internally only | 27n | 48n | 75n |
| First Nations students Both internal and external enrolments | 2n | 6n | 8n |
| Total | 67 | 223 | 290N |

The core points that emerged from the journal related to:

- Indications that a person's cultural norms tended to form the core basis of their responses and attitudes to culturally confronting topics.
- Different perspectives from students and academics in health can lead to discomfort in the discussion of ethically confronting topics.
- Racism was not always rebutted or acknowledged.

6. DISCUSSION

Given this student cohort, the educator needs to consider how they can process this information when preparing to teach issues around ethically challenging topics, such as abortion, euthanasia, racism, or cultural suppression of women. There needs to be consideration of how the educator designs their sessions to be inclusive, inoffensive yet challenging, informed and honest. In some cases, topics may even define some cultural practices as illegal and could, therefore, isolate population groups.

As health workers, and particularly in the case of nurses, the key aim is to provide and enhance quality of life and provide unbiased care. A core element that was explored with the educator's peers was considering the question: how do we approach those who we can see/have different perspectives on cultural choices and may not be in a position to provide that care based on their evident bias? An incident recalled within the autoethnography narrative outlines the following encounter:

There was a registered nurse working with students from the class I teach who was providing our care. The nurse disclosed she was from interstate, trained at a different university to the one I am employed by and was here on her graduate placement. I asked her about the construction work going on at the front of the hospital. I was aware there was some re-development being undertaken to ensure a more culturally approachable and

welcoming space given our large First Nations population within the Northern Territory, but I had not really looked into what the plan for the space was. Her response was confronting and challenging for me to process. In the nurse's opinion, "it was a waste of money to make it nicer for Aboriginal and Torres Strait Islander peoples as they would not appreciate it anyway." This really made me consider how she was educated with a nursing degree to come to the conclusion that money spent on creating a culturally inclusive environment could be a waste. Is this a personal opinion? Has it been developed since she was working in the Northern Territory, having arrived from a city in the Southern States? Did she look at me as a middle-aged white woman and assume that I would share this opinion with her? What is she talking to her colleagues and student nurses about? Is this opinion being shared within the workspace, and is it part of the culture within this department?

This opens a passageway to address critical resistance pathways and contemplates responses to such incidences. Attitude change in relation to racism in the health environment is necessary and can mar healthcare access and effectiveness [28-30]. Although the above incident happened outside the classroom, there are students involved, and the parent/educator needs to decide how to respond to the display of racism and cultural ignorance. To take the critical resistance pathway, the educator needs to act to bring about social change, and if this occurred in the learning environment, it could be considered negligent for the educator to allow such comments to go unchallenged [1]. In such cases, it can be difficult to identify where the teaching responsibility ends or does it end even out of the classroom?

When dealing with examples of existential racism, there is often resistance or lack of acknowledgment that attitudinal change needs to occur, and this can be particularly evident in a multicultural environment where there may be minority groups [31]. To assist the educator with addressing this form of incident, the Pedagogy of Discomfort acknowledges the educator is in a difficult position but identifies the need to address members of both the dominant and marginalised cultures to examine their hegemonic values [23, 24]. In this case, it could mean introducing a forum where students can start to discuss some of the discomforts around racism in their education journey with their educator by reflecting on their own cultural beliefs. Being open and addressing the subcultural racial discrimination that takes place are just as important as affirming the existence of more dominant forms of racism, such as segregation and will help break down the barriers to critical resistance for these future health practitioners. As for the registered nurse who is already practicing in the above example, a short note to the facility complaints department hopefully brought about some education and change in attitudes before there was a negative influence on nursing students within the department.

In reality, the educator needs an action plan for when forums become misinformed and offensive and often, this

will only eventuate from experience, observation, and participation within the forum [32]. The educator needs to recognise that it is not about installing their own beliefs and values; it is about recognising the rights of others and still having the ability to negotiate those situations that need intervention in a productive and effective fashion. If the educator cannot do that, then one could question if they really should be teaching health as they run the risk of harming, misinforming or misjudging others as acknowledging health students' needs is necessary to recognise their responsibilities as future health professionals. Recommendations include tapping into other professionals who may have more experience, if required, in these areas and learning from observation and participation. The right approach starts with not installing one's own beliefs but recognising the rights of others.

One step that can be undertaken by the educator is using the phrase "what do you understand?" It sounds simple, but this opens a platform for students to share opinions and allows room for feedback and guidance. Being selective and choosing appropriate terminology to address confronting ethical issues can appear less judgemental. To put this into perspective, an example has been provided on the topic of abortion. Within the public health unit, nursing students are asked to explore the Australian abortion/voluntary termination of pregnancy health policy and provide an opinion about their understanding of whether they believe this is a good health policy or not. Using an online discussion forum, student responses have taken the form of not actually addressing the principle of the policy but instead disclosing whether they are either pro-choice or pro-life. This may be due to the formation of the question and requires the development of less directional responses within this area. However, students could choose to be uncommitted in their policy response and weigh up both aspects of the argument. Students are provided with the following questions:

6.1. Abortion

You may notice that this is not a health statistic presented in Australia's Health 2022. This is due to inconsistency in abortion policies throughout Australia, and thus, recording such data appears to be problematic [33]. What is your understanding of the Australian abortion policy?

Examples below have been taken from two students with differing personal beliefs about the abortion debate:

6.1.1. Student Response to Abortion (Pro-choice)

"I would describe my personal views as pro-choice, believing that I believe best practices and policies would allow for abortions to be an available option to all individuals irrespective of their personal situation, length of pregnancy or geographical location."

My knowledge and opinion on this topic were developed after supporting a close friend in her decision to terminate her pregnancy in the NT late last year. Having experienced the health system by her side, I was shocked that women are made to question their decisions, leaving them feeling unsupported and having added

anxiety from having to wait for the procedure to be conducted. The current system in the NT has to change to provide a more standardised and regulated process that aids and supports women instead of penalising and chastising women for taking control of their bodies and lives (Student Discussion Post A)."

6.1.2. Student Response B Against Abortion (Pro-life)

"My stand on allowing abortion is always on the NO side. I believe how our parents brought us will always have a strong influence on this issue. Although I have been in a broken family where my mother has been a great influence on my life, specifically on the spiritual side, my mum has instilled in my conscience the importance of life. Everything has a reason, and only God can take life away."

"My personal view, as I am a pro-life supporter and anti-abortion, this abortion issue needs to be looked at by considering different circumstances of the women. It is better to place a policy for women to go through counselling and then decide whether to go with personal rights and access to abortion. If the Australian jurisdiction can build a policy that can balance both a human right and, at the same time, provide advocacy to respect the lives of unborn human life, many of the abortion issues that end up in destroying lives can be saved (Students Discussion Post B)."

Considering these students are going to be nurses within the Australian health care system, there is potential that they will be looking after women who have gone through or are considering an abortion. A consideration the educator may have to address is: *Does this mean that the nurse who is pro-choice will provide better care for a woman who has a history of abortion than the nurse who is pro-life?* More importantly, given that abortion is accessible for women in Australia, is it the educator's responsibility to counsel nursing students who are against this policy to ensure they understand their responsibility once they are registered for the provision of care within the Australian health setting, regardless of their personal values and beliefs? As demonstrated by the Theory of Deontology, the students have primarily taken a pathway to explore the abortion policy in looking at whether it is right or wrong according to their own beliefs and life experiences. There is a grey zone to be explored here too, and the formation of the question in asking what the students understand has encouraged them to look further than their own cultural considerations of the topic. Often, this may not be the case, as demonstrated by the next student response, which provided a brief point form of why they disagree with abortion rather than look at the policy:

I Disagree

1. Religion: every baby is a gift from God.
2. Human rights: the unborn baby has the right to live.
3. Should not kill the innocent life.
4. The woman needs to take responsibility for her own actions if they fall pregnant.

6.1.3. (Students Discussion Post C)

Again, there is absolute potential for the Pedagogy of Discomfort to arise as we address an issue that can expand to include aspects of cultural suppression of choice for women, religious dominance, and prejudice against a minority consisting of women who have had abortions. Zembylas (2015) re-examined the Pedagogy of Discomfort and linked this with the ethics of classroom safety [34]. The underlying theory states that social injustices do exist and need to be explored within the classroom to allow student growth and understanding of real situations. Furthermore, discomfort may be necessary for transformation and growth to occur, and if the educator is too safe in their delivery, then the students' growth can be hindered. Therefore, educators may need to become critical and strategic in how they address such issues as the abortion debate. In this case, the educator presented a synopsis of women's rights and the freedom of choice they have in Australia and added this to the discussion. Portraying the legalities of the situation can help remind students that they are also bound by these as registered health practitioners, and although constructive opinions are welcome, the reality is that women can access abortions in Australia regardless of their religion or cultural background.

6.2. Practical Implications for Nursing Educators

There has been much presented that highlights the issues and likelihood of encountering culturally confronting incidents in the class environment. The practical interventions that have resulted from the analysis of these experiences have highlighted six core areas for tertiary education sectors and educators to consider to improve their ability to address culturally conflicting situations during education delivery. It is important to have these discussions with health students to ensure they are informed and prepared to encounter such issues in practice.

1. The tertiary education sector's responsibility is to provide cultural safety training to staff and students. This should be offered regularly, recognising that cultural safety is considered to be a lifelong learning process.

2. Acknowledge the different cultures within a class forum and allow students to navigate their own cultural beliefs and norms in alignment with expectations presented in the health curriculum.

3. Introduce reflective practice to students and encourage them to use this, particularly in relation to establishing empathy.

4. Introduce the pedagogy of discomfort early in the semester or session and set reasonable boundaries for students to explore diverse opinions. This may include a discussion guide that encourages respect and reflection on other opinions.

5. Be responsible with the education of health students ensuring they understand their obligation to adhere to their associated registration standards and the law.

6. Choose topics and formulate questions for

discussion that will allow personal growth and development of the ability to deal with conflicting circumstances and provide advice on how to navigate these in the real world.

CONCLUSION

Reflecting on how to accommodate the diversity of cultures when dealing with ethical dilemmas in higher education opens a number of areas that need to be considered. The educator needs to be self-aware and prepared to address uncomfortable situations by incorporating an approach that is inclusive and acknowledges the legal responsibilities of health students practicing in Australia. There needs to be recognition that there are vulnerable students amongst cohorts, and differences in opinions should be managed and negotiated to provide meaningful learning experiences rather than confrontational and oppressive events. The formation of an autoethnography narrative allows educators to explore how they have addressed such areas within their practice and to learn from those experiences to improve both their own and students' learning outcomes. By developing skills to address critical resistance pathways, the educator becomes empowered and can develop abilities as a role model to direct social justice within their multicultural student cohort.

Considering the focus of being culturally considerate with so many different cultures to accommodate, it is apparent that there is no one solid answer or guide that will fit every educator's situation. Within the few ethically confronting topics explored within this context, there are hundreds more left that may yet be encountered by the educator in higher education and that may cause discomfort and personal cultural challenges. Recommendations for the educator are, therefore, to recognise the existence of the Pedagogy of Discomfort and work towards education delivery that incorporates an open and safe place to explore diverse opinions. Such advancements can facilitate reflection and analysis for students of their own cultural acceptance and consideration behaviours, thus leading to better outcomes in the classroom and beyond in the Australian health system.

ETHICAL STATEMENT

As per Charles Darwin University Higher Research Ethics Committee guidelines, a review of educational practices and projects at the undergraduate level does not require ethics review or approval. This project received an ethics review and was deemed exempt from the Human Research Ethics Review.

CONSENT FOR PUBLICATION

Not applicable.

AVAILABILITY OF DATA AND MATERIALS

The data supporting the findings of the article is available in Zenodo at <https://zenodo.org/doi/10.5281/zenodo.10273297>.

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CONFLICT OF INTEREST

The author declares no conflict of interest, financial or otherwise.

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