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Cultural Safety in Nursing Education and
Practice in Aotearoa New Zealand

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Dedication

To the memory of

Kathleen Vera Grace Richardson, 1913-2003

and

Irihapeti Merenia Ramsden, Te Awe Awe o Rangitane and Tikao o Ngaitahu,
1946-2003.

Abstract

The Nursing Council of New Zealand introduced cultural safety into the nursing education curriculum in 1990. Since that time it has impacted on nursing education and the delivery of nursing and health care in a profound way. There is very little research exploring application of the concept in nursing practice and that is what this thesis explores.

Cultural safety has as its central focus, the nurse and the person for whom she or he cares within complex fields of health care relationships. This thesis argues that culturally safe care is open to multiple interpretations depending on the lens through which safety is perceived and care is interpreted, and applied in everyday practice. The narratives of 16 registered nurses suggest that both safety and care relate to an idea of protection carried out in everyday care. During times of illness or threatened change in health, a person's sense of self and safety, can be vulnerable to professional and institutional practices which may put their sense of identity and well being at risk. The self-conscious provision of culturally safe nursing takes account of the need to protect identity and requires that the nurse have a practical understanding of professional and structural factors influencing health care.

This thesis draws on the theoretical work of Pierre Bourdieu (1972, 1984, 1990, 1998, 2000) and Margaret Somers (1994) and focuses on identity, fields of practice, power and reflexivity. These concepts resonate with key organising themes within cultural safety discourses and guided the research process. An abductive research strategy (Blaikie, 2002, 2010) was used to shape and guide the analysis process.

The research identifies that culturally safe nursing is not the sole responsibility of the individual nurse and this thesis moves the concept away from a focus on individual nurses and individualised relationships between the nurse and the patient. It extends understanding of cultural safety education and practice by drawing on Bourdieu's concepts of fields, *doxa*, and relational networks of power and how these factors shape practice. It examines ways nurses within different health care fields use resources that are available to open up or close down possibilities for them to create the conditions to provide culturally safe care. The thesis identifies how the participants negotiated these contradictions and illustrates how culturally safe care has the potential to aid the demonstration of safe and effective nursing care in all fields of health care.

Key words: Cultural safety, nursing, identity, narrative, field, *habitus*, power, *doxa*.

With gratitude

This thesis is the end point of a process that probably began when I first entered nursing some years ago. On completing the work I have discovered some answers to questions I was asking which usually began with “what is going on here”? On completing the thesis I find there are different questions to be answered. This thesis has taken me down many paths and many adventures, none of which I could have embarked on without the company of very good supervisors, friends, family, colleagues, protagonists and the odd antagonist.

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Chapter one: Cultural safety: Overview and positioning

Nursing and midwifery courses in this country should produce excellent nurses and midwives who are able to nurse or apply midwifery care with safety in any cultural environment. However, because of the serious health status of the indigenous people of Aotearoa and the real possibility of the disappearance of their culture and language, cultural safety *must* begin with *Tāngata Whenua*¹ (Ramsden, 1992, p.21)

1. Introduction

The Nursing Council of New Zealand (NCNZ, 2005/2009) introduced cultural safety into the nursing education curriculum in 1990. Since that time it has impacted on nursing education and the delivery of nursing and health care in a profound way. Cultural safety is a nursing concept, constituted through the values and beliefs that construct a particular field of health care, which can conflict with more established notions of health care located in humanist understandings of care delivery. This chapter offers an introduction to the thesis by providing a background to the origins of cultural safety and its positioning within nursing and health care in Aotearoa² New Zealand. I position cultural safety within a historical context to demonstrate how history has shaped the research question ‘how registered nurses learn about, and apply, cultural safety knowledge in nursing practice’. I provide an overview of the thesis, justification for the research and conclude the chapter with an outline of the thesis.

When providing culturally safe care the provider of health care is asked to reflect on their personal and professional power positions in the delivery of care in order to understand the way power influences nursing interactions and health outcomes. Culturally safe care is identified as such by the recipient of care. Translating the concept into practice is complex and is shaped by different influences and practices such as; the cultures and identities of the nurse and the person for whom she or he cares; interdisciplinary relationships; the setting within which health care takes place, its structures, philosophies of practice and beliefs about illness and well being.

This thesis attempts to move cultural safety away from a focus on categories essentialising gender, ethnicity, sexual orientation, age or disability, to an understanding of the way cultural safety is embedded in, and shaped by, relational fields comprising settings, networks, resources, dispositions/attitudes, practices and relationships. Nurses interviewed for this research project

¹ *Tāngata Whenua* - *person of the land* member of a marae community or locality through a line of occupying ancestors. With capital letters the Māori people of Aotearoa New Zealand (Metge, 2010).

² The Māori name for the north island of New Zealand. Te Wai Pounamu is the name given to the south island. Currently, Aotearoa describes the whole of New Zealand. In this thesis Aotearoa is used in the thesis title to give recognition to the Māori name for New Zealand. For ease of reading *New Zealand* is more commonly used except when it is appropriate to use both.

reflected back on how they learnt about cultural safety, and how everyday practice has reframed what they learnt. Cultural safety, like many other aspects of practice, is taught to people with varying starting points for hearing and understanding what is at stake. The personal pasts and positioning of participants influences their level of uptake including their intent to use in practice what they have been taught in the classroom. Narratives of participants suggest that the practice environments in which they worked provided varying levels of support for cultural safety ranging from a little in some places to none at all in others. Nurses interviewed for this research project came to see cultural safety and the quality of nursing care as closely intertwined. These nurses attempted to moderate the care environments in order to increase the potential for culturally safe care which they equated to improved patient outcomes. Drawing upon, and extending, Ramsden's (1992, 2002) arguments about cultural safety, this thesis argues that cultural safety is also about the culture of nursing and the cultures of the settings in which nursing takes place.

Cultural safety is a conceptual framework designed to guide health care delivery identified as safe by the person receiving that care. The concept has detractors and supporters and can mean different things to different people with meaning being shaped by the cultural, personal and professional lens through which it is being viewed. Cultural safety arose out of an internationally and nationally turbulent political time of social conflict, identity politics and socio-cultural change. In chapter three of this thesis I argue that cultural safety is at risk of being subsumed into less socio-political paradigms of care in situations where there is an identified element of difference within care delivery. This thesis offers a critical examination of cultural safety in light of a twenty-first century health care environment in Aotearoa-New Zealand. Cultural safety has an identified political dimension and the trend toward privileging transcultural nursing theory and cultural competency threatens to de-politicise cultural safety within this country by subsuming the concept within discourses of ethno-specific care, cultural competency, cultural awareness or cultural sensitivity. This thesis draws upon and expands Ramsden's (1992) ideas about power and safety in health relationships to develop an understanding of how settings also influence the delivery of culturally safe care. The quote from Ramsden (1992) at the beginning of this chapter states that cultural safety in Aotearoa New Zealand should begin with Māori³ and this is where I have chosen to begin this thesis. Cultural safety surfaced within nursing in response to a unique set of political struggles involving tensions between Māori and the dominant Pākehā⁴ grouping. The original political intent, to ensure social justice and equity in health care, remains relevant to contemporary interpretations of cultural safety even though the political dimensions has been

³ Māori – ordinary, normal, usual. Originally used by iwi (Māori) to describe British settlers who were unusual or 'not ordinary' because of their skin colour, size and mode of transport, that is, sailing ships.

⁴ Non-Māori, a New Zealander originally of British/European descent who feel that their roots are in Aotearoa New Zealand (Metge, 2010)

weakened over time. The following section provides an overview of the historical context in the development of cultural safety within Aotearoa New Zealand.

1.1 The historical positioning of cultural safety in Aotearoa New Zealand

The concept of cultural safety is situated within the socio-political context of Aotearoa New Zealand society. Several significant events occurred over a short space of time to produce discursive narratives of resistance, protest and change. Since the signing of Te Tiriti o Waitangi in 1840,⁵ (see appendix 1), Māori had been calling for action by the Crown to fully honour the intent of Te Tiriti (Lashley, 2000). These calls intensified as a result of intersecting national and international events originating in the 1960s. These events gained momentum during the 1970s and 1980s and included the civil rights movement, women's liberation movement, global student and worker unrest and anti-racism movements. In Aotearoa New Zealand Ngā Tamatoa (Young Māori Warriors) protested against threats to Māori culture and identity and violations of Te Tiriti o Waitangi, with this protest being influenced by underlying social, economic, political and ideological forces of global capitalism (Poata-Smith, 2001). The decade of Māori development (1984-1994) highlighted historical issues related to access and equity for Māori using health services (Durie, 1992; Ellison-Loschman, 2001; Ramsden, 1993a). The 1988 Māori Woman's Welfare League research into the health of Māori women brought forth previously under-recognised health issues for Māori women (Murchie, 1984). Accompanying these protests and challenges to the status quo, mainly church-based Pākehā activists called for Pākehā to confront their white privilege and address Pākehā racism (Huygens, 2007; McIsaac, 2000; Nairn, 2000). Collectively, these events surfaced the reality of health disparities between Māori and Pākehā. The wider community could not ignore the growing negative health status experienced by Māori (Murchie, 1984) and radical calls were made for Government to take action to address health inequities (National Council of Māori Nurses/Te Kaunihera⁶ o nga Neehi⁷ Māori, 1987; Ngāta & Pōmare 1992; Poata-Smith, 2001; Walker 1990).

State sector reforms initiated by the Fourth Labour Government of 1984, and continued more rigorously by the Fifth National Government of 1990, coincided with Māori articulating the need for improvement in the status of Māori health. The political reforms were designed to open up

⁵ Te Tiriti o Waitangi, commonly referred to as New Zealand's founding document. The Tiriti is in both Māori, Te Tiriti o Waitangi and English, the Treaty of Waitangi. In this thesis the Māori language text is used. Both are used as Māori chiefs signed both but the majority signed the text in their own language and therefore both are valid. The legal term 'contra proferentum' is used and the Māori text is used to avoid any ambiguity between texts.

⁶ Māori word for Council

⁷ Māori word for Nurse

the New Zealand economy to meet the needs of an emerging global market. While the reforms were seen as providing opportunities for Māori development and control over health services, they also further marginalised Māori through increased unemployment and a decrease in social welfare benefits. Competitive models brought about by the free market, deregulation and privatisation led to devolution of responsibility from state sector departments (Easton, 1997; Kelsey, 1990). Theoretically these changes provided opportunities for greater community and consumer involvement. In practice, years of marginalisation, suppression and exclusion from Government decision-making processes meant that Māori, who were already economically depleted as a result of colonising practices of the nineteenth century and twentieth century's, were left with diminished social resources with which to engage with State institutions.

Other significant events bringing Māori concerns to the fore included the land march of 1975, led by Māori kuia⁸ Whena Cooper in protest against the alienation of Māori land. The land marches led to the setting up the Waitangi Tribunal in 1975 where Māori land claims relating to breaches of the Te Tiriti o Waitangi⁹ by the Crown could be investigated. The 503 day occupation of Bastion point by Ngāti Whatua and their supporters, protesting against confiscation of Ngāti Whatua¹⁰ land in 1977 -78, served as a critical consciousness-raising event and rallying point for protest (Lashley, 2000). Shortly after Bastion Point, in 1981 the South African Springbok Rugby Union¹¹ tour of New Zealand took place, providing a nationwide rallying point for protest against South African apartheid policy. This tour not only raised awareness of the plight of black South Africans, but also revealed a deepening schism between Māori and Pākehā New Zealanders. For many Pākehā, the frustration experienced by Māori for rights and recognition was heard and taken on board. Pākehā antiracism groups, influenced by activist Christian groups, left wing political movements and one key Government department turned their attention to working with Māori to address racism and discrimination (Herzog and Margaret, 2000; Huygens, 2007; Nairn, 2000; Network Waitangi, 2008; Department of Social Welfare, 1986). Parallel to these events some Pākehā, who could not tolerate Māori visibility and calls for Māori self-determination, began to express publicly and openly their deep-seated, long simmering racism. Such prejudice was directed not only toward Māori but toward any group seen as not upholding the values and beliefs of Pākehā, for example new immigrants from the Pacific and from Asia. Thus, the thin veneer of racial harmony in Aotearoa New Zealand began to crack.

⁸ Female kaumātua (male or female person of senior social status) can be used to describe and address grandmother or grandfather (Metge 2010).

⁹Aotearoa New Zealand's founding document first signed at Waitangi, a place in the Bay of Islands. It is an agreement between the British Crown and Tāngata Whenua of Aotearoa New Zealand. It was signed in 1840 in response to the British Government's plans for extensive land development, to ward off French attempts to annex the country, to protect Māori and regulate the behaviour of British immigrants through British Governance.

¹⁰ People of the land of Tāmaki Makaurau. Tamaki Mākarau – name for Auckland.

¹¹ This tour polarised opinion and sparked widespread protest against the racially segregated polices of South Africa.

Two decisive events in the 1980s shifted calls for self-determination and full Māori participation in Government decision-making from a protest arena to the legal and policy-making arenas of social life in Aotearoa New Zealand. The first event was a meeting of Māori leaders at Tūrangawaewae¹² in 1985 (Blank, Henare & Haare, 1985; Henare, 1990) to discuss the current status of Te Tiriti o Waitangi. An outcome of this hui was the affirmation of Te Tiriti o Waitangi as a living modern text, a founding document and a framework upon which to build a bicultural New Zealand society. The second event involved the publication in 1988 of the four-volume Royal Commission Report on Social Policy which provided a detailed analysis of New Zealand society. The Royal Commission Report was considered important for Māori development as it introduced the concepts of partnership, protection and participation as a way of making Te Tiriti o Waitangi current, applicable, *and* acceptable to all Aotearoa New Zealand citizens. The concepts were seen to equate with the historical articles one, two, three and four of Te Tiriti o Waitangi and provided a modern template for applying Te Tiriti o Waitangi within Aotearoa New Zealand Government institutions. The concepts were taken up by health care planners and became known as the *three 'P's*. While the recommendations of this report failed to be translated into action with the election of the Fifth National Government in 1990, the report did provide an examination of issues related to the redistribution of wealth, incomes and social justice in an increasingly deregulated society (Easton, 1997). Easton also noted that, although the recommendations were sidelined, the report offered a snapshot and an analysis of all sections of Aotearoa New Zealand society and provided direction for the possible development of a robust welfare state in the face of growing international economic free market trends and demands. Before demonstrating a relationship between these events and the development of cultural safety, it is important to reflect for a moment on the role of consciousness-raising in the reclaiming or reasserting of identity of Māori and other marginalised individuals and groups.

1.2 Identity and a politics of difference

Identity politics and a politics of difference arose out of processes of consciousness-raising that emerged from emancipatory movements centred in South America (Freire, 1972) and the feminist movements of the 1960s (Morgan, 1968). Smith (1999) considers Friere's contribution to consciousness raising in the Māori struggle for emancipation being the provision of an intellectual space and structure to identify critical issues impacting Māori self determination. Within these spaces Māori were able to strategise ways for dealing with tensions arising out of a

¹² Tūranga (standing place) waewae (feet) A place to stand. The headquarters of the Māori king and iwi Tainui, near Hamilton, North Island.

colonised/colonising relationship. Walker (1990) saw Māori protest as arising from urbanisation and an increasingly alienating society recognisable in techniques used to maintain a structural relationship of Pākehā dominance and Māori subjection. Friere (1972) observed that understanding the actions of an alienating culture leads to an ability for the alienated to transform action into freedom from alienation. Poata-Smith (2001) notes that while consciousness raising is a factor in the process of transformation, a raised consciousness does not evolve as a result of the acquisition of knowledge. Poata-Smith suggests that it is the experience of *fighting* against suffering that is the basis of revolutionary ideas and not the *intensity* of the oppression that determines consciousness. Similarly, attitude change is considered key to affecting a shift in consciousness by nurses, towards patients marginalised by health care services and yet a raised consciousness does not necessarily translate into culturally safe practise.

For women consciousness raising grew out of the women's movement of the 1960s and was responsible for drawing attention to difference and how difference played out in the lives of individuals (Firestone, 1971; Hanisch, 1969; Morgan, 1978). Women from the second and third waves of feminism in the 70s, 80s and 90s (Butler, 1992; Chodrow, 1989; Sarachild, 1978) claimed the power of consciousness raising in emancipating women and making them free from oppressive patriarchal structures. Consciousness-raising groups provided spaces where women could share experiences that were unique to them and where they could realise that their experiences were not isolated or unusual. In sharing these understandings women were able to see their experience in the wider social context of patriarchy or universal truths. In this way, their personal experience was translated into a political consciousness and the reclaiming of a self-identity through the sharing of common experiences and a sense of solidarity with others.

Consciousness-raising became a way for marginalised and disenfranchised groups to collectively and separately reclaim and assert their own identities as distinct from the imposition of grand narratives of gender, race, sexuality or Western knowledge traditions. In this context consciousness raising was not the sole domain of women; the process enabled previously subjugated and colonised knowledge to be articulated and made visible within wider public discourses (Freire, 1972; Lawler, 2008) and opened up the way for a new epoch of thinking and theorising class, race, gender and sexuality. The political shifts in consciousness espoused by Friere (1972) and the feminist movement evolved into different movements of identity politics and a politics of difference.

Identity politics and a politics of difference are concerned with the emancipation of marginalised groups in society. By asserting difference, the group or person is asserting their uniqueness in the world (Young, 1990). By asserting their uniqueness, the previously marginalised group becomes visible in the wider society and this visibility, by definition, challenges the dominant group in relation to how this group perceives, judges and treats them. Time and hindsight have produced a critique of identity politics and politics of difference as mirroring essentialist notions of self associated with grand narratives (Benhabib, 2002; Kenny, 2004; Lawler, 2008; Somers, 1994). Identity politics and a politics of difference however, initially provided an avenue for resisting grand narratives and notions that there is one universal truth shared by all people in the (Western) world.

1.3 Consciousness of difference and cultural safety

In 1982 and 1983, the New Zealand feminist magazine *Broadsheet* published a series of articles by feminist Māori activist Donna Awatere. These articles brought the Māori experience of colonisation to the fore and resonated with feminists who were challenging their own oppressive patriarchal regimes in relation to gender. The articles, published in book form in 1984, crystallised years of the pain and struggle for Māori self determination and the right to have control over their own resources (Awatere, 1984). Awatere's work served as a rallying point for young Māori, Kaumātua and Pākehā to challenge and resist discriminatory and racist Government structures and policies.

The events described above, as well as calls by Māori and others for change, were not happening in isolation. They were part of a wider global call for change, which had been gaining momentum since worldwide student and worker unrest and the revolt of French students in 1968. This unrest led to the rejection of, and challenge to, traditional Western intellectual and philosophical ideas and thought.¹³ Eighteenth century Western paradigms of thinking and knowing were being subjected to critical scrutiny and this process disrupted the construction of knowledge across political, cultural, economic, social and artistic life. The critique was focused on the general values and ideals of the seventeenth century enlightenment and the claims to a universal truth or grand or master narratives. Such narratives constructed and produced knowledge about the way cultural rules, structures and beliefs are arranged and organised into a

¹³ See Pierre Bourdieu, *habitus*, 1984; Michel Foucault, *power/knowledge*, 1969; Ferdinand Sassaure, *binary oppositions*, 1986 (Culler, 1976), Jacques Derrida, *deconstruction* 1976; Jurgens Habermas, *hermeneutics, critical theory*, 1968; Martin Heidegger, *phenomenology*, 1962; Maurice Merleau-Ponty 1983; Hans Gadamer, *hermeneutics*, 1969 (Harrington, 2001) and artists Andy Warhol 1962 (Indiana, 2010), Judy Chicago 1997. Black women; Angela Davis, 1971; bell hooks, 1981; Audre Lourde, 1986. Gay black men such as, James Baldwin, 1962. Critical theorist educators, Friere, 1972; Mezirow, 1977. Educators Friere, *consciousness raising*, 1972; Giroux, 1978. Feminists Judith Butler, 1987; Robin Morgan, 1978. Gay men, Ken Plummer, 1981; and lesbian Sarah Hoagland (1989).

shared, coherent, rational society (Lyotard, 1979). According to enlightenment ideals, it is assumed that all members of that society share the values and beliefs of the dominant group. Webb, Schirato and Danahar (2002) note that a grand narrative does not take account of other narratives that are gender, culture or group specific and therefore cannot be taken as applying to all. Challenges to a universal truth and a critique of sameness provided the theoretical context for a politics based on individual differences and shared characteristics within a group, while the emergence of cultural safety drew attention to experiences of marginalisation and the politics of difference.

The following two statements express the essence and depth of feeling experienced by Māori in terms of their own marginalised status in Aotearoa New Zealand society. In challenging the grand narrative of Pākehā culture, Donna Awatere said:

Māori Sovereignty is the Māori ability to determine our own destiny and to do so from the basis of our land and fisheries...it can be interpreted as the desire for a bicultural society, one in which taha Māori receives an equal consideration with, and equally determines the course of this country as taha¹⁴ Pākehā, It certainly demands an end to monoculturalism. (Awatere, 1984, p.10)

Linda Tuhiwai Smith (1999) similarly challenges the grand narrative:

... it appals us that the West can desire, extract and claim ownership of our ways of knowing, our imagery, the things we create and produce and then simultaneously reject the people who created and developed those ideas and seek to deny them further opportunities to be creators of their own culture and own nation. (Smith, 1999, p.1)

Irihapeti Ramsden asserted the impetus for cultural safety arose from the:

Effects of colonisation and the growing awareness through the 1970s and 1980s of the ongoing and long-term impact of the colonisation process on Māori health outcomes and was a critical impetus for the development of cultural safety (Ramsden, 1995a, p.12)

1.4 Cultural safety: Past and present

The need for cultural safety in nursing and health care lies deeply within the fabric of Aotearoa New Zealand society and the colonised/coloniser relationship between Māori/Tangāta Whenua

¹⁴ Side, edge margin, dimension. Taha Māori, the Māori dimension introduced into the school curriculum in the 1970s and 1980s (Metge, 2010).

and Pākehā. Because it derives from an environment of social protest, resistance and challenge to cultural dominance, cultural safety sits uneasily in a health care environment attuned to more benign traditional humanist notions of care, compassion and service. The need for cultural safety arose originally in response to growing negative Māori health statistics and a recognition of the marginalising effects of Pākehā dominated mainstream health services on the cultural well being of Māori health when they came in contact with health services (Ramsden, 2002).

Philosophically and theoretically, cultural safety occupies *in between spaces* within mainstream health services and is influenced by critical theory, post colonialism, indigeneity, postmodernism, and humanism. Multiple theoretical positioning means that in practice, cultural safety is viewed and interpreted in relation to different perspectives, realities and contexts. Chick captures the idea of discursive multiplicity when, speaking from a perspective of recording historical narratives of nursing and midwifery in New Zealand, she suggested that, “more likely there are multiple truths depending on whose voice and view is allowed to shape the narrative”(Chick & Rodgers, 1997 p.1). Chick’s view could apply equally to cultural safety as the concept can be interpreted differently, depending on whose voice and view shapes the cultural safety narrative.

Cultural safety was developed as an organising concept aimed at educating mainly Pakehā European nurses about the need for attitude change and an awareness of power in health care relationships with Māori clients (NCNZ, 1992, 1996, 2005/2009). Nursing and health services are still dominated by Pākehā although there is a growing cultural diversity within nursing and New Zealand society. The NCNZ guidelines as they stand do not fully take account of this changing demographic. Cultural safety is positioned within historical coloniser/colonised relationships of power and marginalisation and the guidelines could be read as behaviour and attitudes of the dominant white group that apply to all nurses regardless of culture or ethnicity.

People using and delivering health services today are from increasingly diverse ethnic backgrounds. Partly as a consequence of earlier protest movements, consciousness raising and increased health awareness, individuals and groups are much more discerning about what their health needs are in the context of who they are and how they live their lives. It was recognised at hui Waimanawa, one of several hui¹⁵ conducted to explore the health service needs of Māori, that people no longer expected to have to leave their identities at the door of the health service when they became ill or sought health care (Ramsden, 1990a). Therefore people brought their difference with them into health care services and expected this to be recognised.

¹⁵ Māori term for meeting

Globalisation or global economic integration collapsed former national economies and with this came freer trade, freer capital mobility and easier migration (Daly, 2006; Easton, 1997; Feller, 2006). Held, McGrew, Goldblatt and Perraton (1999) note that globalisation is a framework for identifying the widening, deepening and speeding up of global interconnectedness. This interconnectedness increases the likelihood that an event in one part of the world will have an effect in other parts of the world. This process has an effect on the ways people relate to each other and the way they exercise power over one another. This means that there is more likelihood that difference will play a bigger part in how people relate and in relationships.

Feller (2006) notes that the catalysts for migration are many and varied and are “rooted in a myriad of social, economic, political and human rights push and pull factors” (p. 509). The ongoing presence of violence, state oppression, an increase in the level of mobility of populations sometimes as a result of displacement from homelands, combined with the reclaiming of indigenous rights, brings with it a need for rethinking ways of building community and health care relationships” (p.509). While the dominant power holders have gone some way toward achieving an understanding of difference and an attitude of cultural tolerance of the perceived other, there is still little commitment to establishing more equitable social power relationships by making changes to the social power structures. Growing evidence that health services were not meeting the health care needs of Māori clients, together with shifts in migration patterns brought about by global events lent strength to a need for change in the way health care structures met the health care needs of people using health services

1.5 Defining cultural safety

Originally, the need for cultural safety arose out of concern on the part of Māori nurse educators, Māori nurses, iwi and hapū¹⁶ and supportive Pākehā, about the social inequities between Māori and Pākehā and the quality of health care being delivered to Māori populations. The concern was that the health care system was not providing adequate or appropriate care consistent with the cultural health needs of Māori using health services. A concurrent concern was the low recruitment and retention rate for Māori within nursing, the majority of whom exited before completing the programme. Initially, the focus of cultural safety was on the need for nurses and other health professionals of mainly European ancestry, to examine the influence of their personal and professional culture on the health and wellbeing of the people for whom they provided care. Within a short space of time it was recognised that the cultures of all health

¹⁶ A descent group associated with a particular territory and Marae which takes collective action for certain purposes (Metge, 2010).

professionals influenced the health and well being of *all* people using health care services in Aotearoa New Zealand, therefore, the concept was broadened to include all people who might be at cultural risk from the attitudes, values and practices of health professionals. However, in reality the focus of cultural safety was usually on the dominant European Pākehā health professional.

Between 1986 and 1990, mainly Māori nurse educators, clinicians and Māori community members met to discuss how to provide cultural safety education for nurses. At one key Māori student nursing hui, Waimanawa 1988 (Ramsden, 1990a) the words *culture* and *safety* were first brought together. During one forum Māori nursing students expressed concern about the safety of Māori clients in health care services and, for Māori students in technical institutes' nursing education programmes. One student is reported to have said legal safety, ethical safety, safe practice/clinical base and a safe knowledge base were all very well to expect from graduate nurses, but what about cultural safety? (Wepa, 2005 p.17). Another student said that if she was not safe as a student in her technical institute then how could her whānau feel safe when they go into hospital. These heartfelt statements lit the flame of cultural safety in New Zealand nursing and served as a catalyst for dramatic change within the profession. Subsequent hui with iwi and Māori health providers debated the term to determine what it meant for Māori. One outcome of these hui was the development of an initial definition which stated that “cultural safety would be met through actions which recognise, respect and nurture the unique cultural identity of tāngata whenua, and safely meet their needs, expectations and rights” (Hill, 1991). From these hui a framework of cultural safety incorporating Māori health related concepts and values into health care education was developed. In 1992 the NCNZ embedded cultural safety into the nursing education curriculum with a set of principles outlining the structure of a cultural safety education process (Wood & Schwass, 1993). The contribution to the original development of cultural safety education by Māori nurses, educators and supportive Pākehā cannot be underestimated. However, since its inception, there has been a tension between what and how it is taught and its implementation in nursing and health care services.

Initially the focus of cultural safety was on Māori health because Māori narratives of health care, supported by epidemiological data, exposed the way in which health services did not adequately meet the needs of Māori clients (Dew & Davis, 2004; Durie, 1992; Harris et al., 2006; Harwood & Tipene-Leach, 2007; Murchie, 1984; National Council of Māori Nurses, 1987; Ngāta & Pōmare, 1992; Robson & Harris, 2007; Royal Commission on Social Policy, 1988). One consequence of the reported Māori experience and epidemiological evidence has been the

creation of an environment of deprivation and health disparity between Māori and Pākehā based on cultural difference rather than on the responsiveness of a health service to provide appropriate acceptable health services. Reid, Robson and Jones (2000) challenge the ideas of health disparity and deprivation and while monitoring disparity serves a useful purpose to assist intervention and address inequity, a universalist approach to care mitigates opportunities to act to address disparities and eliminate inequity. Reid et al. (2000) suggest a universal approach to health care is the dominant approach and assumes the same service for all. It does not take individual or cultural needs into account and consequently tends to put the focus of deprivation and disparity onto individual or cultural difference. A universal approach ignores structural barriers to service and ignores the culture and inherent values of the health care service which may impact on care. Services based policies informed by cultural deficit models are found wanting when service outcomes fail. In this case the failure of the service is blamed on the client or the group and not the structure of the service being provided resulting in the perpetuation of stereotypes and myths about health inequities and disparities.

Cultural safety was introduced in part as a way to address the culture of the health provider as much as the recipient of care. Definitions of cultural safety have undergone further changes since its inception to accommodate the changing demographics of populations using health services. The current definition is:

The effective nursing of a person or family from another culture, and is determined by that person or family.

Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socio-economic status; ethnic origin or migrant experience; religious or spiritual belief; and disability.

The nurse delivering the nursing service will have undertaken a process of reflection on her or his own cultural identity and will recognise the impact that her or his personal culture has on her or his professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual. (Nursing Council of New Zealand, 2005/2009, p. 4)

The above statement positions cultural safety within the international goals and aspirations of nursing, that is, the nursing agenda to provide safe care for *all* people using health services. However, the requirement for the nurse to undertake a process of reflection on his or her own culture sets cultural safety apart from this shared goal. Self-reflection in a cultural safety context extends the concept beyond other frameworks used for working with difference currently in use, for example, culturally congruent care (de Souza, 2008) and transcultural nursing (Leininger,

1995). In cultural safety, the focus of learning is as much on the nurse as subject, as it is on the person for whom the nurse cares; this implies that a relationship is a priori for culturally safe practice. This context provides a focus for this research: to explore how registered nurses take up and apply cultural safety knowledge in their everyday nursing practice and relationships. The NCNZ statement does not take into account the settings in which culturally safe practices are enacted. The relationship between practice and settings is considered in the following section of the chapter.

1.6 Cultural safety practices and settings

The original intent of cultural safety education for nursing in Aotearoa New Zealand is as relevant now as it was when it was first developed. However, it has a history of being unevenly applied in education and practice with a focus on ethnicity as a sole determiner of difference. Therefore it is not surprising that the political contexts of cultural safety, such as power and difference, are more easily understood within community health settings, Māori health settings and other culture-specific situations. It is within these settings that a range of factors impinging on health care delivery, such as poverty, marginalisation and disadvantage, are more visible to the community nurse, illustrating that ethnicity and illness are not the sole determinants shaping health care. Within bricks and mortar health care institutions the focus of care is on the individual and their presenting illness, where the provider of care and not the recipient of care primarily determines the shape of care, the way relationships happen and how care is delivered. In a hospital setting there is a tendency to view people in the context of the prevailing values and needs of the institutional culture rather than in the context of the person's life world. This means a person within a hospital setting risks being viewed as 'other' or as 'exotic' to the values and needs of the institution. While other factors affecting health may be taken into consideration (for example poverty or marginalisation), these may be seen as a background to the purpose of hospitalisation and the treatment of illness or condition the person is presenting with, rather than as possible factors influencing their illness.

A key goal for nursing care delivery within a large institution is to be able to elicit health information from a person in order to implement appropriate interventions and management plans. Communication problems may arise if the person is unable to provide this information in a way that is economical in terms of time, or is unable to understand information given to them for some reason. This is more likely to happen when there is an obvious cultural difference between the recipient of care and the provider of care. Thus ethnicity or culture may be

interpreted as creating problems of understanding and communication. This may mean other factors influencing care, such as power imbalances and the attitude or the way in which the care provider is disposed toward the person, may be overlooked. Cultural safety makes the power of the health professional visible by turning the gaze of the recipient of health care toward the behaviour and attitude of the health professional. Professionals unused to having to consider their power positions in the delivery of health care can interpret this as *too* political or radical. Therefore cultural safety can be viewed as threatening because making power visible has the potential to challenge the dominance of those who have most power in health care relationships. Because cultural safety arose out of concerns relating to the access, treatment and participation of Māori within settings, international interpretations have attempted to understand cultural safety against a multicultural background. This will be more fully discussed in chapter three (Anderson, et al., 2003; Johnstone & Kanitsaki, 2007; Leininger, 1996). Underpinning cultural safety in New Zealand is Te Tiriti o Waitangi, cultural safety outside of this context will be viewed differently according to the context within which the interpretation takes place. This has implications for how cultural safety is applied in other cultural contexts and it is my view that different interpretations and perceptions of cultural safety will give rise to tensions about what cultural safety is, and how, where, when and by whom it is interpreted and applied. Confusion relating to interpretations of cultural safety means that from the outset I want to anticipate, and address, a potential misreading of ideas about cultural safety in this thesis. It is not intended for the analysis of cultural safety in this research to be read as replacing Māori understandings of cultural safety. Instead I see the thesis as providing another lens or conceptual tool for thinking about power, difference and context which may be placed alongside Māori understandings of cultural safety. I therefore offer the ideas in this thesis in the spirit that it is for Māori to determine the relevance of a settings-approach for indigenous understandings of power and difference within the context of health care relationships.

Central to the development of this research is my thesis that there is a relationship between cultural safety, health and the settings and context within which health care happens. I propose that culturally safe care is an outcome of health care delivery arising out of an engaged and considerate relationship between a nurse and an individual or between groups of people. This interaction is shaped and influenced by intersecting relationships, values and beliefs at work in defined settings and fields of practice, all of which are brought to bear on the experience of the person receiving health care. This thesis will provide a broader understanding of culturally safe care in nursing practice, made visible by bringing both micro and macro understandings of culturally safe care into everyday nursing practice.

At the micro level of cultural safety the guiding principles of a culturally safe relationship are; the recognition of cultural and personal difference by nurses and the people for whom they provide nursing and health services; a critical understanding of the influence personal and social histories and contemporary life experiences have on the health and wellbeing of individuals and groups. Cultural safety requires a practical understanding of how power shapes health care relationships and the skills required to intervene to reduce the impact of negative or potentially harmful effects of power on a person's health outcomes. At the core of this understanding is an intelligence and an embodied sense of compassion guiding an intent to promote health and manage processes of treatment. All interventions a nurse administers are accompanied by this conscious intent to assist, support and maintain a person's sense of cultural and personal wellbeing, self worth and integrity as they undergo care and treatment. The nurse does this by creating relationships engendering trust, which aid in protecting and promoting the identity and wellbeing of the person receiving health care.

While culturally safe care is shaped and influenced by the values and attitudes of the setting within which it takes place, the nurse can be placed in positions where she may not be able to uphold her own nursing or personal values and beliefs in the delivery of culturally safe care. This research provides an analysis of how power works to enable or constrain the provision of culturally safe care within different health care settings. Such settings are comprised of networks of relationships within which varying degrees of support for cultural safety may be provided. Rather than maintaining relationships engendering trust, safety and protection a nurse may instead have to uncomfortably support and enact practices which contradict her commitment to cultural safety. While cultural safety offers a nurse an analysis of power and its impact on health care, having this insight may also create moral distress for the nurse, as she may be a lone voice advocating for her client. To be effective and be able to apply culturally safe knowledge consistently requires that nurses be equipped with skills to work effectively and collectively within hierarchal power-laden health relationships and structures.

1.7 Overview of the research

It is now a little more than 20 years since cultural safety was introduced into nursing and it is time to examine how the concept transfers from education to practice. Although it is acknowledged as being a critical element in nursing, there is little research exploring the experience of applying the concept in practice generally and in different settings specifically. I wanted to consider the extent to which cultural safety is understood, accepted and acknowledged

as an important element of nursing knowledge and how this knowledge is applied. To find evidence to support or refute this claim, I needed to talk with nurses to find out from them what they considered culturally safe nursing to be and how in their nursing they created places of safety for their clients when providing health care and services. I wanted to know how the participants learnt about and recognised cultural safety knowledge in their actions and to what extent the practice setting determined nursing actions considered culturally safe. Cultural safety can focus on the actions of the individual nurse, therefore I also wanted to know how nurses managed networks of relationships that were either enabling or constraining to their work. Finally I wanted to know how participants identified factors supporting their practice and how they advocated for resources needed for ensuring that culturally safe nursing is delivered.

To do this I needed to engage with a broad range of individual nurse clinicians in different health care settings. Initially I expected that I would be able to focus on the application of cultural safety within practice, without attending particularly to education. However, as I developed the proposal for the thesis I realised that the process of applying cultural safety to practice would need to involve attention to, and reflection on, how cultural safety education is reframed to fit a person's positioning and location. For this research, I sought registered nurses who were willing to share their stories of how they applied cultural safety knowledge in practice. The result is a qualitative research project which explores the narratives of 16 nurses who talk about learning and applying cultural safety in nursing practice and which provides an analytical explanation of nursing in relation to cultural safety and nursing practice.

This narrative research study is underpinned by intellectual thought which draws on philosophical ideas from post-structuralism, critical theory, constructivism, post-modernism and humanism. Narrative analysis derives from traditional sources such as literature, the study of texts and ethnography studies. Riessman (1993) notes that ethnographies incorporating first person accounts provide descriptions of outside events and narrative analysis, while drawing on these traditions is distinguished by an interpretive drive and the manner in which the researcher stories the narrator's interpretations of events. Riessman suggests that because narrative analysis foregrounds human agency and imagination, it is "well suited to studies of subjectivity and identity" (p.5).

Blumenreich (2004) notes that poststructural representations of stories differ from conventional analyses of narratives which seek to identify common themes among participants. Poststructural analysis does not stabilise meaning or offer a single interpretation. Rather, poststructural

analyses of narratives elicit aspects of situations which are part of complex journeys that unfold over time and emphasise an open-endedness of both the narrative and the meanings attributed to them. As a researcher I am party to, and beholden to take responsibility for, stories I hear about registered nurses' subjective experiences of applying cultural safety knowledge in everyday nursing practice by acknowledging that each experience is personal and unique, and there is not one story serving as a template for all others.

To gain an informed understanding of cultural safety and generate new knowledge of the concept in everyday nursing practice, I applied a critical template of analysis to the research data. The approach to analyses in relation to theory was shaped by the participants' narratives resulting in an eclectic critical template utilising two theorists to guide analysis. This template drew on Somers' (1994) ideas about narrativity and identity construction, and Bourdieu's (1972, 1984, 1990a, 1990b, 1998; Bourdieu & Wacquant, 2005) concepts of space/field, *habitus*, capital and *doxa*. While there is some overlap between the theoretical ideas presented by each theorist, individually each provided a particular analytical lens for the data and collectively their ideas and concepts assisted me in constructing a critical analytical explanation of cultural safety in practice.

A poststructural approach alone raises issues of relativism which risks masking or overlooking the place that power, politics and culture play in the production of stories. Nursing theories engaging culture as an approach to care have also been criticised for conforming to a relativistic model with claims that if all values are subjective in nature then nothing can be judged as right or wrong and to do so implies a fixed objective moral position (Kikuchi, 2005). The work of Somers (1994) and Bourdieu (1972, 1984a, 1984b, 1990a, 1990b, 1998, 2000) assisted in demonstrating that not all discourses or contexts are equal. Bourdieu's work, for example, emphasises the way in which fields, such as health care settings, provide actors with differential access to resources and opportunities, depending upon the forms of capital that are privileged within the field.

Narratives of health, illness, and meaning are unpredictable and contingent, unfolding over time (Holloway & Freshwater, 2007). In this research the same applies in the context of the researcher-participant relationship. Any one story of cultural safety in nursing practice consists of layered subjective narratives evolving from within contexts of identity, culture and social setting. They are shaped by the position and perception of the storyteller and co-created in relationship with another person. Similarly the experience of providing and experiencing culturally safe care is subjective and it is not a stable concept with predictable, predetermined

boundaries. A theoretical narrative approach is consistent with notions of unpredictability and subjective interpretation. Somers' (1994) theoretical positioning, which links identity and *narrativity*, is a useful framework for connecting story and context because Somers' work encompasses relational aspects that resonate with cultural safety and structural aspects which embed narratives within wider systems and structures of health relationships. Phibbs (2008) suggests that Somers' analysis "could involve attention to the way that stories about identity are embedded in relation networks that are simultaneously personal, local and global" (p.47).

1.8 Positioning the research in a nursing context

As mentioned previously in this chapter, the initial focus of cultural safety was on the health relationship between Pākehā and Māori, as Pākehā health care professionals were over represented within the health care system and Māori were over represented as recipients of health care. Increasingly, the profile of the registered nurse today is more culturally diverse and the nursing environment is not the sole domain of Pākehā nurses in health services. The cultural identities of nurses and the environments within which nursing happens in Aotearoa New Zealand are as diverse as the people who use health services. Diversity of the nursing population is not recognised in the wording of the NCNZ Guidelines for Cultural Safety, The Treaty of Waitangi and Māori health in nursing education and practice (2005/2009), which could be interpreted as meaning that attitude change is the concern of the Pākehā partner.

While some nurses may not have an understanding of their culture, or have a clear sense of who they are, there are other nurses, for whom identity is deeply embedded in their traditional cultures and is expressed within contemporary society in an ongoing and integrated way. This does not preclude an examination of nursing culture on health care delivery, but it can ignore the fact that for some nurses their very presence in Aotearoa New Zealand has come about precisely because of cultural or ethnic conflict in their countries of origin. Anecdotal evidence suggests that while they have a deep understanding of their culture, they may not have a full understanding of nursing culture within Aotearoa New Zealand. Similarly, for Māori entering nursing in greater numbers, reflecting on their culture will take a different form from that of the Pākehā nurse.

While the Pākehā nurse with early European origins maintains a numerical dominance within major health care institutions, the bicultural relationship between Māori and European Pākehā and the inherent inequalities in this relationship need to be attended to in an ongoing way. At the same time, this original relationship as set out in Te Tiriti o Waitangi has to be maintained and

grown in the context of greater cultural diversity within health service providers and health service recipients.

The shift of focus from the client to the nurse has placed nursing in New Zealand within an overt political paradigm disrupting the traditional grand humanist narratives of nursing knowledge which have been largely imported from North American thinking and influences. Traditional notions of nursing put forward by twentieth century nurse theorists such as Leininger (1978), Raile Alligood and Marriner Tomey (2010), Watson (1990) and nineteenth century nurse reformists Florence Nightingale (1860), although relevant to nursing are coming under the scrutiny of critical paradigms of care. Cultural safety brings to the fore the need for a nurse to be more of an active political agent in the delivery of health care. Nightingale emphasised that to heal, people needed to be in the best possible condition for nature to act them (Nightingale, 1860). For Nightingale for *nature to act* meant providing adequate ventilation, lighting, appropriate nutrition, rest and good hygiene. In the 21st century, this goal still holds true but with the added dimension that healing can take place if the identity and well being of a person is sustained and protected. Cultural safety demands that the nurse engages in ongoing moment-to-moment reflexivity and an analysis of power/knowledge structures.

This research will demonstrate how cultural safety education provides a framework for applying nursing knowledge in practice which, according to the NCNZ (2005/2009) will assist in the assessment of health needs and provide care and support for people as they manage their health. The research then, investigates those aspects of nursing which concern attitude, relationship, communication, personal, cultural and institutional power through attention to how nurses work to create culturally safe environments which protect a person's cultural identity at several levels between self and other and health care institutions.

1.9 Justification for and significance of the research

There is little research exploring the way registered nurses apply cultural safety in their nursing practice. This research will provide an analytical explanation of how cultural safety guides nursing practice, including how education and health care settings shape and influence the delivery of culturally safe care in everyday nursing. Cultural safety is a concept that has largely stayed within the realms of nursing education. While there is a small but growing body of research within Aotearoa New Zealand relating to cultural safety (Aschebrock, 1994; Clear, 2000; Clear & Carryer, 2001; Gibbs, 2005; Laracy, 2003; McEldowney, 2002; McKinney, 2005;

Ramdsen, 2002; Richardson, 2000; Richardson & Carryer, 2005; Spence, 1999; Warren, 2003; Wepa, 2003), research focusing on cultural safety in nursing practice is minimal (Fitzpatrick, 1997; Giddings, 2005; Pere, 1997).

Cultural safety is an important component of nursing in Aotearoa New Zealand. However, with the presence of other cultural concepts in health care (for example, competency, congruency, culturally-specific models); cultural safety is at risk of being marginalised or misrepresented. One of the greater risks is that international cultural care nursing discourses will overshadow the intent of cultural safety and neutralise its political potency. Cultural care theory, commonly known as transcultural care, derives from Madeleine Leininger's (1979) work. While Leininger was one of the first nurse theorists to consider the role of culture in nursing, her work tends toward a Eurocentric view of culture as *'other'* and the culture and power of the nurse remains largely unexamined. On its own, a cultural care theory model and the subsequent development of the transcultural nursing movement does not fully accommodate the complexity of providing nursing care in cultural contexts and in Aotearoa New Zealand. An examination of culture in nursing encompasses an examination of power and difference.

Cultural safety is positioned within education and is designed to educate nursing students to understand how difference and power shapes health care relationships. Cultural safety provides students with knowledge and skills recognising and respecting the cultural identities of people for whom they care. They are then able to apply this knowledge and these skills as a registered nurse, to safely meet the needs and expectations of people using health care services. To embed cultural safety within nursing practice, and promote cultural safety theory in the international nursing arena, the concept needs to be critically examined from a practice perspective as well as an educational stance.

This research will contribute New Zealand nursing knowledge to theory relating to the development of cultural contexts of care. It offers international nursing a theoretical, progressive and radical repositioning of how difference is constituted in everyday nursing actions and activities within the nurse-person relationship. Culturally safe care is based on the premise that the recipient of care defines safety. However there is no research about what this really means and I anticipate that the practice focus of this study will contribute to future research focusing on the experience of the recipient of health care.

A second argument addressed in this research is that cultural safety is positioned within nursing and midwifery, and that other health care disciplines do not always see the wider ramifications of cultural safety in their own disciplinary practice. The research will move the concept from education to practice and this means that it will be more accessible and visible to other health professionals. For cultural safety to be made explicit in the Aotearoa New Zealand health care environment, the concept needs to be seen as a legitimate body of knowledge shaping health care delivery at all levels of the New Zealand health care system. Disseminating the results of this research at nursing and multidisciplinary conferences means that understandings of the application of cultural safety in practice will be promoted and potentially enacted in context.

Thirdly the key argument for undertaking this research is to demonstrate and emphasise the importance of a settings approach to cultural safety and the delivery of culturally safe care. Cultural safety tends to be viewed as a generalised concept, which can be applied evenly in any health care setting; the research will show that values and attitudes, as well as historical and contemporary factors, will be what determines the way cultural safety knowledge is applied.

1.10 Summary

The concept of cultural safety emerged from within nursing during a critical time of social change during the 1970s and the 1980s in Aotearoa New Zealand and officially appeared in the New Zealand nursing curriculum in 1990. For the most part, cultural safety within Aotearoa New Zealand education and nursing has been narrowly interpreted as being synonymous with culture or ethnicity.

The socio-political climate within which cultural safety originally emerged has shifted and a critical and political framing of attitude change and difference is not so acute in the minds of younger Aotearoa New Zealand educated nurses going into clinical practice, or in the minds of immigrant nurses from other countries for whom cultural safety is an unfamiliar concept and whose ideas of difference are informed by multiculturalism. For Māori nurses it is fundamental to how they practise at all levels of the health care service and is critical for the delivery of safe, person-focused care. Some of the challenges put down to the status quo in the 1980s by individuals and groups at a turbulent time of change have been realised by Māori. The impact of globalisation has made inter-country movement more flexible while human rights violations and war leading to displacement of whole populations has contributed to the Aotearoa New Zealand

socio-cultural-political landscape becoming one where diversity and self-determination are key determinants of how health care is delivered.

Culturally safe nursing takes place within different kinds of health care environments which have evolved from the 1980s and 1990s. These environments are more complex at all levels of functioning; technologically, relationally, socially, politically, culturally, and structurally. Nursing knowledge and nursing practice is determined by different scopes of practice rather than a stable nursing hierarchy and order, where 'one size fits all'. Nurses are more autonomous in their practice and the makeup of nursing personal is more culturally diverse than it was in the 1980s. Overall nursing takes place in a much more political environment where power and knowledge is more visible in health relationships at all levels.

In this thesis I want to build on Irihapeti Ramsden's influential work on cultural safety by identifying current understandings of cultural safety in clinical practice and extend this understanding by exploring the way difference is determined by social structures (fields), as well as *habitus*. I will do this by examining registered nurses' narratives of learning about, and applying, cultural safety in everyday practice and by analysing the interplay between culture, identity difference, institutional structures and power within different practice settings. A narrative methodology underpinned by the theories of Somers and Bourdieu will guide my exploration and produce an analysis of cultural safety in everyday nursing practice. The analysis of cultural safety provided in this thesis supports the concept as an appropriate framework to guide the delivery of safe health care and services in different settings which maintain a person's sense of integrity and identity during times of illness and change as they negotiate health care services in Aotearoa New Zealand.

1.11 Overview of the study

Chapter one: Cultural safety – Introduction and overview

The first chapter provided a definition for, and a chronology of, the development of cultural safety in nursing. Key international and national events were highlighted to historically contextualise cultural safety within Aotearoa New Zealand. The research, arguments and methodology were outlined. Tensions within current understandings of cultural safety were identified and the potential contribution of this research to the future of nursing in Aotearoa New Zealand was considered.

Chapter two: Cultural safety - The Aotearoa New Zealand context

An overview of the cultural safety literature within Aotearoa New Zealand is provided in this chapter. The literature review database search for chapters two and three is documented within the chapter. The cultural safety literature may be divided into two distinct phases. The first covers the contentious period during which ideas about cultural safety were developed and integrated into nursing education. Irihapeti Ramsden, and her work on cultural safety, is considered as a key driver within this process. The second phase moves away from controversy surrounding the place of cultural safety within the nursing curriculum to consideration of how to effectively teach and apply the concept within nursing education and practice. The works of key Aotearoa New Zealand authors are reviewed in order to offer insights into ongoing attempts of theorise cultural safety from the perspectives of education and nursing practice. The overview of the local literature provides the context for chapter three which considers cultural safety in relation to the international nursing literature.

Chapter three: Cultural safety: In dialogue with the international literature

This chapter brings cultural safety into dialogue with international literature to draw out tensions between cultural safety and transcultural care, culture specific care and cultural competence. It examines a small selection of North American and Australian literature to show how researchers and nurse academics in an international context interpret cultural safety in Aotearoa New Zealand. An examination of literature identifying local and international tensions is included to illustrate how cultural safety evolved as a site of struggle in nursing. Chapter three also draws on literature from nursing to draw parallels with cultural safety and to align the concept with nursing. The chapter includes a brief examination of postmodern concepts of culture and critical theories about social structure, identity and difference that have relevance for this research. Finally, the review draws on the aims of the research to identify gaps in the literature and to summarise the relevance that the reviewed literature has for this study.

Chapter four: Theoretical underpinnings, methodology and method

This chapter provides an overview of the key theoretical ideas used within the thesis, the methodology and rationale for choosing a narrative approach to explore the research question. Taking the complexities of a qualitative research project, involving stories of cultural safety, into account, I considered that a single analytical approach was insufficient to guide the collection of

data, the translation of data into text for analysis and the writing up of the findings of the research. To account for this complexity, I utilised narrative method to conduct the research interviews, an abductive research strategy (Blaikie, 2000, 2010), to guide analysis of texts complimented by aspects of narrative analysis from Frank (2002), Labov and Waletzky (1997) and Somers (1994). The work of Bourdieu (1972, 1984, 1990a, 1990b, 1988). Bourdieu and Wacquant (2005) provided the theoretical lens through which to interpret narratives of cultural safety within this thesis and Bourdieu's concepts of *habitus*, field, capital are identified to demonstrate how institutional relationships are shaped. Somers' work on narrativity and identity is used to explain contexts for relating and taking action. Methods used to gather data are outlined alongside ethical considerations related to the study.

Chapters five through seven:

These chapters constitute the substantive body of the research. Each chapter provides a cross section of how the people who contributed to this research apply cultural safety knowledge in their everyday nursing practice. In order to build the analysis of cultural safety provided in this thesis, themes at work within larger extracts from some of the people interviewed for this research will be fore-grounded, supported by a range of smaller extracts from the remaining informants. The selected narratives will link a number of aspects of education and practice to provide an account of how registered nurses apply cultural safety in their everyday nursing practice. These include: learning about cultural safety, meanings of cultural safety, cultural safety- a settings approach and cultural safety as a relational field. Drawing upon these substantive themes, the application of cultural safety knowledge and limitations associated with applying cultural safety knowledge in nursing practice will be identified and analysed.

Chapter five: Learning about cultural safety and personal constructions of meaning

This chapter situates cultural safety within an environment of change by exploring the way in which ideas about cultural safety transferred unevenly from educational into health care settings. The analysis will focus on how participants viewed and/or experienced this shift from either the perspective of a student or an already registered nurse. It is suggested that participants' attitudes towards learning about cultural safety were influenced by their experiences, personal views and the particular time period in which they were nursing students. Different meanings of cultural safety are identified in participants' talk about how they understand cultural safety as nursing concept. The talk of nurses interviewed for this project suggests that understandings of cultural safety are shaped by their identity, time in practice, values and beliefs about nursing and how

they engage with their environment as individuals and as nurses. Although there is no consensus about the meaning of cultural safety, these accounts illustrate a range of themes relating to cultural safety that are at work in the field of nursing practice.

Chapter six: Towards a settings approach, identity and settings in cultural safety

This chapter focuses on cultural safety by considering how practice settings shape the relational and narrative identities of participants. Extended narratives of four participants are used to illustrate how participants make sense of their actions, who they are as nurses and how they strive to practise in a culturally safe way in their work settings. It is argued that personal, professional, cultural and historical influences work to structure the way nurses apply cultural safety knowledge in their everyday nursing practice. This chapter addresses in detail the way the participants interact with their clients to support and maintain their own and their client's sense of self and cultural integrity within specific areas of practice. The accounts presented in this chapter illustrate how identity, setting, relationship and culture work to support and/or constrain culturally safe practice. The complex, multi-dimensional nature of practice is identified in this chapter through positioning the talk of participants within a matrix of cultural, institutional, material and symbolic practices and relationships of power that operate within the health care settings in which they work.

Chapter seven: Cultural safety as habitus, field and doxa

Issues of power embedded in material and symbolic practices identified in chapter six are also the focus of analysis in this chapter. The chapter will demonstrate how cultural safety might be understood through an analytical lens that employs Bourdieu's conceptual mechanisms of field, *habitus*, *doxa*, capital and interest in order to explore how the operation of the field works to constrain or allow culturally safe practice. *Doxa* (Bourdieu, 1972, 1984, 1990a, 1990b, 1998) may be thought of as the dominant social arrangements within a field which inform a person's actions and thoughts. I argue that within each field conflicts over the nature and possession of capital, combined with the presence of *doxic* practices that either constrain or enable a nurse's autonomy, influence her ability to determine how culturally safe care will be delivered. Incorporating the theories of Bourdieu into understandings about cultural safety draws attention to factors that impact upon care which are embedded within the personal and professional dispositions of the nurse as well as in the contexts within which she works.

Chapter eight: Discussion of findings and concluding thoughts

The discussion will provide an overview of cultural safety in nursing practice in the light of current knowledge and understandings of the concept. The chapter will discuss how the research aims have been met. The findings will draw on key theoretical concepts relating to narrativity, identity, *habitus*, practice, and field to argue for a reframing of health care relationships between the nurse and the person for whom she or he cares within networks of power relationships. Issues indicating directions for further research will be identified followed by possible methodological and practice implications of the study. Limitations will be addressed and the chapter will close with a reflection on the research process, concluding with a closing statement.

Chapter two: Cultural safety – The New Zealand context

Cultural safety is not about patients; it is about nurses, their behaviour and attitudes toward patients and their ability or otherwise to create trust. (Ramsden, 2002, p. 21)

2. Introduction

Chapter one positioned cultural safety in an historical context and identified influences shaping its development and introduction into nursing education. I defined cultural safety and justified my reason for undertaking this research. Chapter two examines New Zealand literature which has relevance for the research question. The review is presented in two chapters, focusing on four themes: national literature, international literature, cultural safety and nursing, and sociological underpinnings.

Within the New Zealand literature related to education and practice, Irihapeti Ramsden is considered a key driver in the development of cultural safety. Her work forms the substantive cultural safety literature in this country; therefore her contribution to the development of cultural safety is explored in depth. When cultural safety was first incorporated into mainstream nursing education it drew resistance and another kind of protest which differed from the protest by Māori, anti racist groups against the impact of colonial history on health care delivery to Māori. This new protest came from a mainly Pākehā community therefore a second theme examines nursing literature and media texts to illustrate the way this protest affected cultural safety in nursing and education. This is followed by literature exploring educational pedagogies aimed at providing a structure for cultural safety education. Attention is then turned to New Zealand based cultural safety research to explore links between education and practice.

2.1 Literature review search technique

I used multiple computer-assisted databases to carry out the literature reviews for chapters two and three. These included the Cumulative Index of Nursing and Allied Health Review (CINAHL), Educational Resources Information Centre (ERIC), PubMed, ProQuest, Science Direct and JSTOR. Articles were downloaded in full or abstract form from relevant databases. I complemented this process by perusing reference lists at the back of journal articles and books. These provided me with a visual pattern of authors and helped me identify how different authors were constructing cultural safety. This exercise also told me whose ideas were informing the author's thinking. For example several texts on culture in nursing did not mention Ramsden and

this indicated to me that cultural safety did not contribute to the author's thinking. The reference lists also extended my search by providing me with access to books and chapters in books I might not have known about. I used scholarly and professional nursing journals and books in Massey University library, and the Whitireia Community Polytechnic library. The bookshelves of friends and colleagues contained literature, some of which was rare and no longer in print, some I was not aware of or was not available on databases. Local libraries and bookshops were frequented to note latest publications relating to the research. I searched through my own archives of feminist texts and cultural safety and found original documents relating to early feminism and the early development of cultural safety such as the feminist magazine, Broadsheet archives, collections of writing, conference reports and minutes of meetings. I also reviewed unpublished theses about cultural safety to locate cultural safety research in a New Zealand nursing context.

Key words used to shape and refine my search included, cultural safety, Māori health, indigenous health, difference, Te Tiriti o Waitangi and health care, colonisation and health disparities. Other terms entered were *marginalisation*, *prejudice*, *racism in health care*, biculturalism, and multiculturalism. I also entered cultural congruence, bicultural, *cultural competence*, *transcultural care* and, *culture specific care*. I used these terms as they form part of a lexicon related to cultural aspects within nursing generally and are sometimes used interchangeably, or in lieu of cultural safety. My major focus in this review is on literature related to cultural safety, transcultural theory and nursing. However in chapter three I provide a brief review of literature relating to cultural competence and culture specific models of care. The introduction of the Health Practitioners Competence Assurance Act (2003) in New Zealand has meant that the differentiation between cultural safety and cultural competence has the potential to further confuse health care professionals as to what constitutes cultural safety and what constitutes cultural competence. Such confusion is understandable as both identify safety as essential in health care delivery. Nursing literature on cultural competence identifies differences in the interpretation of competency and safety (Campesino, 2008; Jirwe, Gerrish, Keeney & Emani, 2009), and this will also be further examined in chapter three of this review. I have mainly addressed nursing literature and recognise that while writers from other disciplines have also explored the concept from perspectives of youth social work, human geography and occupational therapy (Fulcher, 2002; Jungersen, 2002; Kearns, 1997; Kearns & Dyck, 1996), space does not permit full exploration of their ideas.

2.2 Positioning the review of the New Zealand literature

As outlined in chapter one, cultural safety in New Zealand nursing has its roots in the political activism and social change of the 1980's and 1990's which grew out of the national and international protests amid calls for social change in the 1960's and 1970's. The concept of cultural safety emerged in tandem with a call by Māori to honour Te Tiriti o Waitangi with the concept providing a framework for a critique of power in nursing and health care delivery. The positioning of cultural safety in New Zealand nursing opened up new ways for thinking about health care relationships within hegemonic nursing and health service structures.

The nursing landscape of the 1980s in New Zealand was underpinned by traditions of humanism and individualism and this grew out of a reaction to the 1940's international nursing education curricula which had seen a weighting toward a behavioural approach. From the 1950s through to the 1980s, the shape of nursing and nursing education underwent significant change. This was a time of nursing theory development which was instrumental in building a nursing discipline with its own body of knowledge and practice. Four North American nurse theorists influencing this change were nurse educators (Bevis, 1978; Bevis & Watson, 1989; Leininger, 1978; Peplau, 1952). Their work is discussed in the following chapter of the thesis. Similarly in New Zealand, nurse educators and administrators, for example, Salmon (1982), Chick and Kinross (2006) and Sherrad (1991), were exploring behavioural factors, relational changes and institutional influences in nursing and examining how these issues were shaping nursing within the New Zealand context. According to Williams (2000) the role of the registered nurse in New Zealand changed in the 1980s and 1990s to one of being primary care giver rather than a supervisor of student care giving as was the case in the 1960s and 1970s. Salmon (1982) and Chick and Rodgers (1997) capture key ideas emerging from these international and national discourses on the changing context of nursing by emphasising a shift away from medical frameworks to developing a research-based nursing discipline.

Since its introduction in 1990, cultural safety has given rise to tensions and conflict within nursing, with other health professionals and with the New Zealand public. These tensions revolve around its efficacy and relevance in everyday nursing practice and its application in a wider health care environment (Carrier, 1995a; Murchie & Spoonley, 1995; Papps & Ramsden, 1996; Ramsden, 1993b). Although originating in the early development of the concept, such tensions continue to influence its level of acceptance in health care delivery in the present. Tensions visible in the early development of cultural safety were played out in professional New

Zealand nursing journals (Bickley, 1988) and international nursing journals (Cooney, 1994; Coup, 1996; Leininger, 1996; Polaschek, 1988), the news media, (Dominion Post, 2003; The Dominion, 1997; The Press, 1997), Māori nursing and Māori nursing and student hui (Ramsden, 1990b) and within Pākehā cultural safety caucuses. Against this background I examine a range of literature focusing on the development of cultural safety and position it within nursing education, nursing, and the wider New Zealand community between the period 1987 and 2008.

New Zealand cultural safety literature falls into two broad categories. Between 1988 and 1998 cultural safety writing reflected the initial integration of the concept into nursing education and identified the dramatic impact the first published document *Kawa Whakaruruhau*¹⁷-*cultural safety in nursing education in Aotearoa* (Ramsden,1990) had on nursing education and practice. Both academic and media texts are used to document the contestable nature of cultural safety and the defence of its inclusion in the New Zealand nursing education curriculum (Carrier, 1995b; du Chateau, 1992; Frewin, 1993; Horton, 1998; Horton & Fitzsimons, 1996; Kearns & Dyck, 1996; Murchie & Spoonley, 1995). The concept also became a target for critique from international sources. Madeline Leininger, a North American transcultural-nursing theorist, challenged the scientific authenticity of cultural safety (Cooney, 1994; Coup, 1996; Leininger, 1996; Smith, 1996). This will be further discussed in chapter three.

From 1998 onwards, cultural safety literature shifted away from education and controversy to a growing focus on the application of the concept in education and practice settings (Benham, 2001; Bunker, 2001; Ellison-Loschman, 2001; Gibbs, 2005; Gully, 2000; Jeffs, 2001; Jones, 2001; Papps & Ramsden, 1996; Polaschek, 1998; Thompson, 2001). Several Masters and PhD studies provide a trajectory which demonstrates how New Zealand nurses have been working with, and creating, a unique lexicon and body of nursing knowledge addressing the complex aspects of cultural safety in nursing and nursing education (Clear, 2000; Fitzpatrick, 1997; Horton, 1998; Laracy, 2003; McEldowney, 2002; Pere, 1997; Ramsden, 2002; Richardson, 2000; Southwick, 2001 Spence, 1999; Wepa, 2001; Wilson, 2008). These authors are either nurses in practice or nurse educators in polytechnics or universities.

¹⁷ Kawa Whakaruruhau is a Māori term which in English conveys a sense of protection or shelter from harmful elements (Williams, 1990).

2.3 The contribution of Ramsden's work to the development of cultural safety

Irihapeti Ramsden, of Ngai Tahu¹⁸ and Rangitane¹⁹, nurse educator, nurse clinician and nurse activist, was a strong advocate for improving access for Māori to health care and for the recruitment and retention of Māori nurses. Ramsden is considered to be a key driver in bringing the concept of cultural safety from an environment of protest and challenge to create a framework of conceptual ideas guiding nursing practice. Her work forms the basis for the early development of cultural safety and the push for change in health care delivery to Māori primarily *and* to all people using health care services. A Google search for Ramsden (Irihapeti) revealed 532 references. A search on the ProQuest identified five references and on Google scholar, 181 references. This indicates Ramsden's influence on the development of cultural safety in New Zealand nursing and is reflected in the span of her writing (Ramsden, 1989, 1990a, 1990b, 1990c, 1990d, 1992, 1993a, 1993a, 1993b, 1994a, 1994b 1995a, 1995b, 1996, 2000a, 2001 2002). Her death from cancer in 2003 ended a long career of advocating for change in health services delivery for Māori, other marginalised groups and ultimately to all people at risk when using health care services.

Ramsden's groundbreaking works from 1987 to 2002 interrogated traditional ideas about what constitutes culture *and* safety in health care and in the process opened up a way for New Zealand nursing to radically reframe nursing and health care relationships. The work Ramsden, Māori nurse educators, Māori clinicians, Māori health care users, iwi and supportive Pākehā contributed to the development of the overall concept cannot be under estimated and an enduring quality of cultural safety is its perspective of the marginalised other in relationship with the dominant other and monocultural health care institutions. Cultural safety offers an opportunity for the nurse and other health care professionals to transcend taken-for-granted understandings of health care relationships incorporating notions of neutrality and equity by offering different perspectives on nurse-person relationships in the context of specific power interests at play in different settings and fields of health care delivery.

Ramsden's writing over 14 years recorded the development of her thinking from radical resistance to a sharpening of focus on a critique of health care relationships and power in health care delivery. During this time she did not waver in her assertion that cultural safety is a concept informed by critical theory which, by definition, provides a framework for critiquing processes and structures impeding or inhibiting access to health care. She considered that entering a health

¹⁸ Tribal affiliation

¹⁹ Tribal affiliation

service left a person vulnerable to cultural risk. In other words, to receive health care, a person may have to take action to protect their cultural identity or leave their culture at the door of the health care institution in order to receive the care they needed (1990a). Simply put, Ramsden's thesis of cultural safety is about maintaining vigilance to social justice and the proper use of power in the delivery of health care (2002) to Māori and to all people using health services. Ramsden's work captures not only the journey of cultural safety, but also tracks the socio-political changes and influences on the development of the concept. Ramsden's (2002) PhD thesis is a repository of the origins of cultural safety and knowledge development and shows how the concept has evolved over time.

Ramsden critiqued the historical colonising/colonised relationship between Māori and Pākehā to demonstrate how this relationship impacts health care of Māori in the present. Her compelling deconstruction of power and difference in health care relationships offers insight and clarity into the way power, attitudes and beliefs shape health care outcomes of the person using health care services (Ramsden, 2002). Overall, Ramsden's work makes the experience of the marginalised person receiving health care visible and provides for an in depth political analysis of difference in the context of inherently unequal nurse-person relationships. In this research, I will extend Ramsden's work through an examination of the way registered nurses make sense of and understand the concept in their practice as well as how they mediate and negotiate difference in nurse-person relationships and networks of relationships within contemporary health care settings and fields of practice.

2.4 From protest to mainstream: Breaking the mould

The 1990 report *Kawa Whakaruruhau: Cultural safety in nursing education in Aotearoa*, written by Irihapeti Ramsden in her capacity as Education Officer for the New Zealand Ministry of Education, was the defining document shaping cultural safety education and nursing practice in New Zealand (Ramsden, 1990a). The report drew together key findings and discussions from three hui called by Māori nurses and nurse educators to address spiralling negative Māori health statistics and Māori nursing student recruitment and retention in nursing education programmes. This ground-breaking report was a turning point for New Zealand nursing and initiated a dramatic shift from a nursing paradigm which contributed to a dualistic and inequitable health care environment. The report challenged nurses and health professionals to consider the experience of health care from the perspective of the recipient of care and address power imbalances inherent in health care relationships.

Ramsden's 1990 work unsettled accepted ideas that the world could be interpreted through a single or grand narrative of how life is or how a single narrative represented *the* truth of something (Williams, 1988), for example that the authentic experience of colonisation was *that* truth as interpreted through the experience of the dominant colonising group. By positioning cultural safety within a critical framework based on the works of Freire (1972) and Giroux (1983) Ramsden opened up an avenue for a critique of what was accepted as *truth* in nursing and health care practices. Ramsden (2002) held that cultural safety was a counter to a reductionist model of health care associated with the rise of the biomedical model in the 1930s. A model, she claims, as did Beavis and Watson (1989), heavily influenced the education of nurses up until the 1970's and 1980's.

The report *Kawa Whakaruruhau, Cultural safety in nursing education in Aotearoa* highlighted the need for nurses to work in partnership with Māori to deliver health care services in such a way that would protect from harm, ensure the right to self-determination and value participation by Māori in their own health care. While the initial focus was on Māori health, Ramsden maintained that an approach that promoted self-determination and participation was due to all people using health care services. Ramsden is explicit in her assertion that cultural safety should acknowledge a Māori perspective first, because health service delivery is biased toward the values and beliefs of the dominant Pākehā health service (2002).

2.5 Changing the landscape of nursing education

There are four key dimensions to cultural safety, which set the concept apart from the North American transcultural model first documented by Leininger in 1978. According to Cooney (1994), the four dimensions involve: the transfer of power from provider to the recipient of care; attitude change in the care provider; health care determined as safe by the recipient of care; the development of skill and knowledge to challenge and change institutional health care practices impacting negatively on health outcomes of people (Ramsden, 1990a, 1993a, 1995a; Ramsden & Spoonley, 1994; Wood & Schwass, 1993). These dimensions form the basis for the delivery of culturally safe care.

Leininger's transcultural care theory (1972), while recognising a cultural approach, fails to give nurses the knowledge and skills for challenging monocultural political structures in New Zealand which impact on Māori health in a local context. Cooney's (1994) interpretation asserts that a transcultural approach determines strategies that will provide culture specific care. Ramsden

(2001, 2002) on the other hand argues that the focus on care as *culture specific* can lead to a stereotypical view of culture and mask individual differences and expressions of identity. Leininger's use of the term culture specific differs from culture specific models of care as developed by different cultural communities. These will be further discussed in chapter three. Ramsden also asserts that such Leininger's approach may reinforce an assumption that culture is the key determinant shaping identity, whereas culture can be individually determined, is not a fixed or predictable concept and while an essential and core determinant of identity, is not the only one.

Cultural safety can be summed up thus; it is a partnership between a client and a nurse or other health professional and is characterised by a process of negotiated and equal partnership (Ramsden, 1990a, 1997). Ramsden explains cultural safety education as a four-stage process focusing on attitude change. Stage one involves the nurse examining the personal and professional attitudes that she or he holds about health, toward people using health services and their attitudes about nursing. Stage two requires the nurse to undertake an educational process to critically examine and deconstruct attitudes that may be incongruent with effective and safe nursing practice. The third stage requires a rebuilding of attitudes, which will reflect safe practice, and fourthly an outcome of this process is for the nurse to translate these changes into her or his everyday nursing actions through the development of a negotiated and equal partnership with the client or patient (Ramsden, 1997)

Throughout her writing, Ramsden challenges nurses to listen to ideas about how nursing behaviours impact on others, in particular, Māori clients. Ramsden argued that nursing services needed to be adjusted so that the nurse delivering the service could "move through the landscape of others" in such a way that the recipient of care experienced a sense of cultural safety (Ramsden, 1993a, p.5). She states, without reservation, that learning about cultural safety involves a process of change whereby awareness is raised, knowledge about the impact of power on care is increased and attitudes shift. With a shift in attitude it is assumed that there will be a behaviour change (Ramsden, 1993; Wood & Schwass, 1993). Ramsden (2003) is in no doubt that while attitude change is critical to the development of culturally safe care, cultural safety is about "understanding personal and institutional power and giving people choices" (p.7).

That it is the recipient of care who determines whether service delivery is culturally safe is contentious and is yet to be critically examined as to its full meaning (Carryer, 1995a). There is a tendency for recipients of care to indicate high levels of satisfaction with the quality of care

received and this may accurately reflect the situation or be an indication of a lack of understanding about what constitutes *good care* or awareness as to what other care is possible (National Health Committee, 1999). While Ramsden (1990a) sets the agenda for what constitutes culturally safe care, the term itself draws considerable attention as it is vulnerable to being interpreted as solely a race or ethnicity based concept.

2.6 Deconstructing the term cultural safety

Ramsden (1990) aligns cultural safety with the language used to measure other aspects assessing safety to practice. She explains the relevance of physical, ethical, legal and clinical practice - informed by an appropriate knowledge base - as indicators for safe practice and adds that Tāngata Whenua consider safe service delivery to be a requirement for safe practice, hence the term cultural safety. Ramsden (2002) interrogates the terminology of cultural safety further. She explains that attempts to change the term to a more acceptable definition, such as sensitivity or awareness, competence or appropriateness, “shifts the emphasis to a more easily managed term and plexus of ideas which has its roots in transculturalism or multiculturalism” (p.93). Murchie and Spoonley (1995), in their findings into the NCNZ Cultural Safety Inquiry, supported retention of the term as to replace it with any other term would detract from the intention of the approach. I interpret cultural safety as the mindful, conscious intention of the nurse or health professional to provide or create an environment of care and protection so that a person’s sense of identity and cultural integrity is maintained as a source of well being and recovery during times of illness, vulnerability or change.

The debate about changing the name is an ongoing concern and yet Ramsden’s analysis is clear; cultural safety is about the power of the nurse with the locus of control resting with the patient (Ramsden, 2002). She suggests that if the “locus of power shifts away from the patient to the nurse then the interaction ceases to be analytical and becomes descriptive” (p.94). This means that a focus on the patient rather than the nurse would offer an explanation of another cultural reframing or cultural construction of the person receiving care similar to transcultural care. This would result in the nurse describing how she would provide care to an *other* and not take into account the dynamic of the relationships of difference between the nurse and the patient. Contestation toward a perceived politicisation of the term brought cultural safety into the public arena and distracted nursing academics and practitioners from attending to the development of the concept in New Zealand nursing and what this might mean for nursing and the delivery of health care.

2.7 From protest to nursing

When cultural safety was first introduced officially into the nursing education curriculum, it quickly became a site of struggle for nursing, nursing education and the delivery of health care. The struggle revolved around what constituted nursing knowledge and who had the right to define what such knowledge was (Carryer, 1995a). While the concept had emerged from a struggle for recognition of marginalised indigenous knowledge, it became the site of another struggle within a dominant Pākehā discourse the origins of which lay in the colonial history of New Zealand. Cultural safety challenged traditional colonial discourses of power and knowledge which, though not necessarily visible to the dominant Pākehā health care providers, nevertheless shaped the delivery of health care, especially for Māori. Tension and conflict associated with its introduction found expression through popular weekly magazines, political commentary and daily newspapers. Different social and political agendas fuelled a sustained negative media campaign between 1990 and 1996 and resulted in a Parliamentary Inquiry into the appropriateness of cultural safety for nursing.

Cultural safety moved into the lexicon of nursing language and knowledge in an unplanned and uneven way and with an almost revolutionary energy. At its roots was an action response to the status of Māori health. Research evidence about Māori health confirmed the reality that health care services were not meeting the needs of Māori (Abbott, 1987; Manchester, 2002; Pōmareet al., 1995; Ramsden, 1992a, 2002). Cultural safety provided an opportunity for dominant monocultural health services to begin to address health inequities between Māori and Pākehā. With this opportunity came risk and, because it was a model arising out of a Māori worldview, it was resisted and rejected by the wider New Zealand public with the resistance driven largely by the Pākehā-owned news media (The Dominion, July 23rd 1997; Munro in The Christchurch Press, 13th July, 1993, Ramsden, The Listener, 1993 4th September).

Public anxiety about cultural safety grew as it became an issue to address in health care delivery. The issue within nursing was centred on the meaning of cultural safety for nursing and how it might be structured into the nursing education curriculum (Ritchie, 1993). Chapman (1993) noted that quality nursing included the recognition and acceptance of a person's culture, looked at from the perspective of the consumer. "If nurses are able to do this then nurses can work in any community that is different from their own" (p. 31). One way was that Māori nurses must have a sense of self worth as Māori, and two, Māori people must receive nursing care and treatment as Māori. Attention to difference within nursing education was noted by O'Connor (1993), editor

of Kai Tiaki-Nursing New Zealand, who reported on the beginning of a parallel comprehensive Māori nursing programme at Waikato Polytechnic which attempted to address the inequalities within the education system through meeting the cultural as well as the nursing education needs of Māori students.

Although cultural safety was contentious, following its introduction into the nursing education curriculum, the commitment of nurses in all spheres of nursing was such that the readiness and desire for action to address the untenable state of Māori health outweighed the desire for an orderly research and practice based investigation. What followed could not have been anticipated and the next section provides a detailed exploration of texts of nursing and popular media to illustrate the depth of feeling and racism that the term cultural safety ignited in the minds of the New Zealand public.

News media sources, key documents and professional nursing journals have been used to provide a detailed exploration of what became known as the *cultural safety debate*. Although most nurses in practice today are not familiar with this debate, its legacy continues to live on in the minds of many older nurses and health professionals and sections of the public. These memories continue to influence the integration of cultural safety into present day nursing practice and health care institutions and have relevance for how registered nurses apply cultural safety in their everyday nursing practice.

2.8 From protest to nursing to protest

When cultural safety was first introduced into the nursing education curriculum it quickly became problematic for nursing and nurse education. As previously mentioned, New Zealand was undergoing considerable social change. Cultural safety was part of that change and it coincided with the New Zealand Government's call for recognition of Te Tiriti o Waitangi. Criticism of cultural safety challenged the nursing profession's right to define, set and control its own programmes (Carrier, 1995a). Horton and Fitzsimmons (1996) suggest that critics of cultural safety were challenging the degree to which New Zealand nursing should determine its own knowledge development. In 1990, cultural safety questions were included as part of the State nursing exams. As a result, Du Chateau (1992) claimed that cultural safety had become a tool for social engineering rather than a contribution to more effective health care for people. This was followed in 1993 by the publication of a letter from a student nurse, Anna Penn, to the *Christchurch Press* critical of the teaching of cultural safety (Ansley, 1993). Du Chateau's

article and Penn's letter provided a fulcrum for a sustained attack on the relevancy of cultural safety education in nursing. An underlying premise was that cultural safety contributed to a politically driven curriculum (Brett, 1993).

An initial complaint by the student nurse, Penn, centred on her failing a cultural safety component of a nursing course on the basis of her attitude, her complaint eventually led to an inquiry into cultural safety in the nursing education curriculum. Her failure centred on a challenge she made to a Kaumātua or Māori elder who was facilitating a course on Māori health and marae protocol. Penn questioned the denial of her right as a woman to speak on a Marae, a situation where feminism meets indigenous knowledge and tikanga²⁰. While Penn's behaviour was presented as a matter of disrespect in the context of race and culture, closer examination suggests that other factors served to inflame the situation. Penn's challenge was also a personal challenge to what she perceived as a problem with the teaching of the nursing programme. Her behaviour brought into question her ability to meet the NCNZ requirement to be *fit and proper* to practise as a registered nurse (Christchurch Polytechnic, 1993). Her behaviour toward the Kaumātua was considered racist and disrespectful. Her actions served only to fuel a growing racist agenda against an emerging Māori assertiveness for their right to have control over who they were and their cultural way of being.

Penn's unacceptable behaviour as perceived by Polytechnic nursing faculty, members of Polytechnic governance structures and Māori commentators became a catalyst for deeper expressions of racism and prejudice by the mainly Pākehā population of New Zealand. Frewin (1993) in the *National Business Review* commented that "Anna Penn is an urban myth promoted by the media to satisfy a widely held prejudice" (p.35). Brett (1993) saw Penn's challenge as taking place within the context of an interpersonal relationship which became racialised. This relationship was conflicted not only by culture but also other characteristics. Penn's working class background, her sex, age and outspokenness crossed the boundaries not only of Māori protocol but also of nursing protocols in terms of what constituted *proper nurse behaviour*. All this contributed to interpersonal conflict and highlighted the subtleties and tensions in cross-cultural communication (Brett, 1993).

The cultural safety debate continued within popular literature with the news media expressing concern that nursing had moved away from its primary role and purpose. Du Chateau (1992) used cultural safety to decry a nursing move away from a sickness orientation to one of health.

²⁰ Custom or obligation or the right way (Ryan, 1995)

She saw nursing as abandoning the focus on rigorous and theoretical task-based nursing and including topics which were airy-fairy quasi psychological subjects (p. 98). Carryer (1995a) challenged the notion that there should be adherence to traditional authoritarian practices or truths which she described as “nurses knowing what was best for the client regardless of personal circumstances” (p12). Underlying much of the media criticism was the fact that nursing was asserting its right to determine its own parameters of professional nursing practice. It was stepping outside the boundaries of tradition and the norms of how people thought nursing *should* be. In so doing, it uncovered prejudices embedded in the historical relationship between the Crown and iwi, a relationship expressed in the everyday activities and social practices of Pākehā and Māori.

The extent of the opposition to cultural safety was such that a Parliamentary Select Committee of Inquiry into the teaching of cultural safety was set up. Parallel to this inquiry, a review into teaching was carried out by the NCNZ. This review recommended that attention be paid to curriculum development and teacher preparation (Murchie & Spoonley, 1995). On the strength of this the Parliamentary Select Committee did not continue and the control of cultural safety was back in the hands of the NCNZ. Following this investigation, the Council reviewed its 1992 Guidelines for Cultural Safety in Nursing and Midwifery Education (NCNZ, 1992) to send a message of inclusiveness and to placate the public perception that cultural safety privileged Māori. These guidelines have been reviewed over time to accommodate the shifting terrain of cultural safety and it is the 2005 guidelines that guide the cultural safety practice in New Zealand (NCNZ, 1992; 1996; 2005/2009).

2.9 Pedagogy and attitude change.

As the public debate unfolded, steps were being taken to develop an appropriate pedagogical approach which would guide the process of teaching for attitude change in student nurses. Ramsden (1990a) had already identified that the education sector was the platform through which cultural safety would be delivered. Ramsden (1993b) expressed concern that there was a need to develop theoretical frameworks for cultural safety education that would guide attitude change in student nurses. Central to Ramsden’s thesis for attitude change was that it needed to be facilitated in students for a very particular reason. She believed that, to change health care practices, nursing students needed to learn how to recognise racism in their own society, analyse its impact on Tāngata Whenua and others, and change their own behaviour (Ramsden, 1993b).

It is important to note that, at the time of the introduction of cultural safety, 1988-1990, the nursing workforce was still dominated by members of the European-Pākehā population who were either recent immigrants or descendants of the colonising communities of the late nineteenth and early twentieth century's. Ramsden was unequivocal in her claim that Pākehā society should change rather than Māori society changing "yet again" to accommodate the needs of the dominant group (p. 2). Wood and Schwass (1993) took up Ramsden's challenge to explore a theoretical framework for teaching cultural safety (Ramsden, 1993b). While the model was developed mainly with Pākehā students in mind, this model continues to form a basis for teaching attitude change related to cultural safety today and it is important to acknowledge that the cultures of nursing students today are considerably more diverse than they were in the early 1990s.

Apart from Ramsden, Wood and Schwass (1993) are the most frequently cited New Zealand authors in cultural safety education. Wood and Schwass' key work provides a beginning theoretical structure upon which to develop cultural safety teaching practice. Although educators had the Wood and Schwass framework within which to teach, Wepa's (2003) study found that educators lacked formal curriculum development and teaching method skills to teach the subject effectively. She identified an action-reflection knowledge base or action research as being a helpful approach when teaching a sensitive subject such as cultural safety (Wepa, 2003).

Wood and Schwass's (1993) model grew out of the central tenets of cultural safety. They identified cultural safety as being met through recognising, respecting and nurturing the uniqueness of Tāngata Whenua, and through safely meeting their needs, expectations and rights. Any deviation from this intent could result in culturally unsafe practice. Wood and Schwass presented a beginning framework for delivering culturally safe care. By identifying what constituted safe care, they described actions which could indicate 'unsafe' care. They framed safe practice as consisting of actions which promoted safe care; the "3 Rs", respect, recognition, and the protection of rights and the "3 Ds", any actions which diminished, demeaned or disempowered the cultural wellbeing of a person. They asserted that "although applicable to all cultures, these principles were to first be applied in the delivery of health care to Tāngata Whenua" (p. 4).

Wood and Schwass (1993) drew on the NCNZ's (1992) desire that through education, personal attitudes could be identified and changed if they had negative implications for the cultural safety of the person. This was revolutionary thinking for the nursing profession. With the work of North

American authors Bevis and Watson (1989) there had been a shift away from positivist thinking to a relational approach. Although Watson (1990) addresses the need to examine the impact of the nurse's attitude and interpersonal communication on health outcomes, the notion of actively and consciously setting out to change attitudes, such as in cultural safety, was an area that had not previously been addressed in nursing literature in such an audacious way.

Wood and Schwass (1993) consider that attitude change is "dependent on links between a person's attitude, their value system, their self-concept, the complexity of the attitude and how intensely the person holds it" (p. 7). They claim that the more strongly the attitude is linked with a person's value system, self concept and intensity of feeling, the more difficult it is to change. On the basis of their research they evolved a model for teaching attitude change, in the context of cultural safety, based on the Māori concept of poutama which conveys an idea of a weaved staircase pattern. The model is made up of three steps, with each step shaping and evolving a shift in attitude from one of sensitivity to one of safety. The staircase model clarified notions of sensitivity, awareness and safety and made each concept a feature of attitude change. For Wood and Schwass, cultural safety is a process which begins with *sensitivity*, where the student comes with existing knowledge and personal experience and uses these to understand their own cultural background. They go on to develop an *awareness* of racism through a process of Te Tiriti o Waitangi education and by identifying strategies for institutional change. The third stage is where they position themselves as being safe clinicians. Being safe involves developing a greater awareness and valuing of cultural difference, thus enabling students to demonstrate culturally safe nursing practice. From this position it is expected that the nurse will "move from the personal realm to the institutional, actively seeking change ways to change the health system, redressing issues of powerlessness, and facilitating the emergence of institutional cultural safety"(Wood & Schwass, 1993, p. 7).

Drawing on Perry's (1984) model of ethical and cognitive development and stages of thinking, Wood and Schwass (1993) align educational pedagogy to help guide students through each stage of attitude change. In stage one, *dualism*, the learner sees the world in absolutes and relies on authority for knowledge. At the same time, the learner's own attitudes are held strongly and a challenge to their opinion is an attack on themselves. Stage two, *relativism* allows the student to recognise there are different ways of viewing the world. They can accept that their opinion may be right for them but not so for somebody else. At this stage a person can defend a position without being defensive. Accompanying this stage is a state of being *value free* in which the learner is neutral or objective and insists that any other point of view is "just that person's

opinion”(pp. 9-10). Stage three of Wood and Schwass’ model identifies an evolving commitment where the student can recognise a number of positions in relation to any issue, where they can consider them all and choose to commit to act in a particular way. An underlying assumption of this way of being is that students can learn to provide considered reasons for their view and be able to enact their view, intelligently and reflectively. This is an approach that is not necessarily confined to a nursing education framework but is relevant to a nursing practice environment as well.

Woods and Schwass’ (1993) model is represented as a linear process and they suggest that a person moves to the next stage when they feel dissatisfied with their present one. They observe that moving on means that the student is leaving old and familiar attitudes and taking on new ones that have been untried. This process may be accompanied by loss and grief and this needs to be acknowledged by the educator to promote movement toward change. As established, central to cultural safety is attitude change and the skill of facilitating such change is in balancing support and challenge according to where the student is in their development. The Wood and Schwass model has guided the development of cultural safety education curricula since 1993. However other authors argue that while attitude change is possible, it is not clear to what degree it can be assessed. Horton (1998) doubts whether a student could be failed because of attitude. Nevertheless, as has been discussed, a nursing student did fail cultural safety because she demonstrated an unwillingness to change her attitude and this resulted in her exiting the programme. Her failure triggered unprecedented scrutiny of nursing by the New Zealand media and public which makes any decision to fail a student on attitude complex and not one to be taken lightly. Horton (1998) claims that students are required to change their attitude and behaviour but they are unable to critique the rationale against which behaviour change is measured or prove what they have learned. She suggests that it is not so much the failure but rather the processes and procedures used to fail the student that matters.

Richardson’s (2004) (not this researcher), view is that there is little evidence to support any measurable change in health care practice as the result of cultural safety education. She states that informal studies and anecdotal evidence suggest that nurses are providing safe care but that there is no corresponding validation from the recipient of that care. Richardson notes that while reflective practice and practice exemplars are the main source for demonstrating the efficacy of cultural safety, this action relies on the nurse’s ability to accurately analyse the situation. Richardson concludes that to date there is no concrete evidence to suggest that cultural safety has changed health care delivery. Hughes and Farrow (2006) raise questions about how culturally

safe practice can be assessed. They make the point that the New Zealand Nurses Organisation and the NCNZ codes and scope of practice standards have required registered nurses to demonstrate cultural safety practice and yet there is little concrete evidence or structure about how this is to be achieved. The use of practice exemplars is the most commonly used format to assess but Ramsden (2002) cautions that although “nurses own estimation of their practice is accepted as valid commentary it is a dubious form of evaluation” (p. 171).

Educationalist Jeffs (2001) acknowledges the early work of Wood and Schwass and positions her teaching approach to attitude change in cultural safety as an attempt by nursing to “transform the historic power relationship between nurses, nursing and those they serve” (p. 41). Jeffs takes a broader view than that of Woods and Schwass and takes into account the nurse and the client within the context of the institution. According to Jeffs, the process of evaluation of the nurse’s service by clients uncovers the power of the nurse as a health professional and culturally constructed being. Jeffs maintains that cultural safety identifies the unsafe nature of health institutions for those who do not share, or have access to, the culturally constructed power of the nurse. Like other authors (Fitzpatrick, 1997; Horton, 1997; McEldowney, 2002; Papps, 2002; Pere, 1997; Ramsden, 1993b, 1995a, 2002; Richardson, 2000; Spence, 1999; Wepa, 2003), Jeffs claims that cultural safety is aimed at working with nursing students to help them understand their own culture, through a theory of power relations, and apply their understanding in a way that is safe for the recipient of care. Jeffs states that the cultural safety educator has a difficult task because of the limited social and collegial mandate the educator has. Cultural safety is a difficult subject to teach and Jeffs maintains that this difficulty is not so much to do with the expertise of the teacher but rather with the lack of faculty and institutional support for the teaching of the subject.

Jeffs’ (2001) focus is on the recipient of care as being the judge of what constitutes culturally safe care for them. She notes that clients are supported when nursing and nurses empower clients by the “liberating experience of being the assessors of the nurse’s practice” (p. 42). The author notes that this should be a positive experience for the client as well as the nurse. However when a nurse or a health professional is asked to relinquish power it must be acknowledged that any person who has control is not going to cede that power to the less powerful merely as a goodwill gesture (Jeffs, 2001; Ramsden, 1994a). Whilst in an educational setting a nursing student may find it easier to take risks with relinquishing power, when it comes to practice, nurses are “constrained by a longstanding hierarchical traditions and by institutional factors and demands” (p. 43). They are also constrained by the values and philosophies guiding health care practices.

Jeffs (2001) argues that emancipatory education is required to produce registered nurses who can practise in a culturally safe way. The author provides a model, which, she suggests, represents a “safe, stable, interesting and democratic classroom” (p. 43). Firstly the educator recognises that education is political. Secondly there is recognition that nurse educators have a professional mandate from the NCNZ to teach cultural safety, together with a moral mandate based on health inequities between Māori and Pākehā. A third step is the establishment of a culturally safe classroom. Fourthly, the educator has to give up the need to be liked and it is at the fifth step where the focus is on assisting the student to experience attitude change.

Informed by the work of bell hooks (1981), Jeffs observes that giving up power involves a degree of pain as new learning challenges, and eventually replaces, old ways of thinking and knowing. While not specifically concerned with cultural safety, Boler and Zembylas (2003) note that in a context of critical inquiry, students are asked to “radically reevaluate their worldviews” (p.111). This process can surface feelings of anger, grief and disappointment. It can also offer “opportunities for viewing the world through new eyes and [developing] a capacity for critical inquiry”(p. 111). Jeffs suggests that recognising the pain and including it in the curriculum is an important aspect of teaching. There are several ways by which students will show the pain of attitude change and it may include, anger, withdrawal, blaming or absenteeism (Jeffs, 2001; Wood & Schwass, 1993).

While it resonates with Wood and Schwass model, Jeffs’ model for emancipatory education attends to the more affective aspect of attitude change and is represented by zones of fear, challenge and reflection, zones in which student and teacher must work and take responsibility for learning. Jeffs asserts that attitude change will occur more readily when the student has frequent but relatively short times in the challenge zone along with time spent in the zone of reflection. She says that prolonged time in the challenge zone may move the student to the fear zone. On the other hand too much time in the comfort/consolidation zone could result in boredom or loss of interest.

Jeffs (2001) notes that cultural safety education has to occur within an acceptable social mandate. Such a mandate, she suggests, is not present in the teaching of cultural safety. She points out that, if there is no social mandate to support cultural safety teaching, then her emancipatory model may assist students in taking responsibility and in being clear about their role as they are learning about cultural safety. At the same time, students are reassured that they will not need to face challenges beyond their capacity to cope. An emancipatory model, as described by Jeffs (2001)

has implications for this research. Just as cultural safety teaching does not always enjoy a social mandate within education, the same social mandate for the implementation of cultural safety in practice enjoys varying degrees of acceptance. Jeffs claims that while cultural safety may not be valued within an institutional setting, nursing students can be supported in taking responsibility for their nursing actions as individuals. Woods and Schwass (1993) and Jeffs provide two models of teaching cultural safety. Neither model has been evaluated as to its effectiveness in changing attitudes and both have been used in guiding and supporting teaching for attitude change in cultural safety. It is not known how an exposure to these models is translated into everyday nursing practice. Continuing with the research theme, the next section explores local New Zealand nursing research which aims to explicate cultural safety in practice and education.

2.10 Cultural safety research: The New Zealand context

This section explores New Zealand based theses and examines the complexity of thinking and interpretation of culture and cultural safety in nursing. I have grouped the research accordingly; clinicians (Clear, 2001; Fitzpatrick, 1994; McEvoy, 2000; Spence, 1999; Pere, 1997) and nurse educators (Giddings, 2005; Horton, 1998; Laracy, 2003; McEldowney, 2002; Ramsden, 2002; Richardson, 2000; Wepa, 2000).

Clinicians:

In 1996, following on from the Parliamentary Select Committee of Inquiry into cultural safety, the NCNZ amended its original definition of cultural safety to demonstrate to the New Zealand public that Māori were not being privileged over any other group or individual. Cultural safety was always intended to be inclusive of all people who were at risk of being marginalised by monocultural, heterosexual health care institutions. It was the Māori reality and experience of health services that required input and resources to help reduce health inequality between Māori and other groups. Clear (2001) and, Clear and Carryer (2001), describe the findings of a research study exploring a wider context of difference in cultural safety, sexuality (Clear & Carryer, 2001). They observed that little health-related research has been conducted with lesbian women. Clear's (2001) research explored lesbian issues in the context of cultural safety and is an example of the broader interpretation of cultural safety. Clear's argument is that research that has been done with lesbians has tended to see lesbian identity as one component of the whole person. The aim of Clear's critical social and feminist research was to investigate what factors hinder or facilitate lesbian women accessing healthcare. The research identified a number of factors that

have relevance for cultural safety and identified factors which can result in a person's cultural safety being compromised.

Clear and Carryer (2001) identify aspects of care relevant to nurses who care or work with lesbian women in health care services. These include themes of *speaking for themselves*, *invisibility* and *invoking the closet hanger*, by not disclosing sexual orientation. The authors suggest it is these factors that influence whether a lesbian will disclose her lesbian identity. The lesbian woman manages this by monitoring responses and adopting a guarded position as the health care unfolds. This enables her to choose to disclose if it becomes necessary. This means that the lesbian woman has to manage this on top of dealing with the presenting health issue. The authors suggest that whilst the participants did not use the term *safety*, the complexity of their decision-making about disclosure of their sexuality does inevitably place them at risk of receiving compromised care. This extra decision-making thus disadvantages them from levels of safety implicit in the care of heterosexual women, where heterosexual women are more likely to share the culture of the health care environment. The research highlights a key factor in determining disclosure of sexuality. This is the perception of negativity from health care professionals. Clear and Carryer (2001) hold that while the neglect of issues of diversity in cultural identity and sexual expression within education continues then nurses are in no position to claim that the attributes of culturally competent care, partnership, advocacy caring or the uniqueness of the individual are inherent in nursing practice.

In March 2000, The New Zealand Nursing Journal, Kai-Tiaki Nursing New Zealand published an article by McEvoy, a registered nurse researching lesbian health for her Masters degree. Her thesis was that women who identify as lesbian struggle to get safe and appropriate health care, due to a lack of awareness and knowledge about lesbian health needs and to prejudice. The publication of this article drew strong responses from nurses in the following April issue of Kai-Tiaki Nursing New Zealand, in letters to the editor, and these proved the very point that McEvoy was making. While there was some support for McEvoy's view, her detractors were very open in their negative attitudes toward health care for lesbians. One respondent suggested that McEvoy should get a life and the article had the respondent and her colleagues falling about laughing. Another respondent was unaware that lesbian patients needed treating with any more dignity and respect than anyone else, inferring that lesbians were asking for a different kind of care rather than to be treated with respect in their health care needs as lesbian. The writer notes that for her, all patients have a right to privacy and appropriate treatment, but fails to relate this to a need for difference to be acknowledged. Clear (2001) and McEvoy (2000) both give expression to a

broader positioning of cultural safety and show the need for the principles to be applied in the same way as for anybody else receiving health care.

In addition to Clear and McEvoy's research there are only two New Zealand nursing practice based studies (Fitzpatrick, 1997; Pere, 1997). Both studies were undertaken within a similar time frame (1992-1997) when cultural safety was under intense public scrutiny through the media (Ansley, 1993; du Chateau, 1992; Frewin, 1993). Methodologically Pere (1997), a Māori registered nurse of Kahungunu, Rangitane and Ngai Tahu descent takes a broad sweep evaluative approach around the interface between education and practice, while Fitzpatrick (1997) uses a deeper narrative approach focusing on the experiences of Pākehā nurses in practice.

Pere (1997) interviewed Māori and non-Māori clinicians who had recently graduated as registered nurses. Her aim was to investigate the effect of Kawa Whakaruruhau/cultural safety on nursing practice. Her findings produced insight into the way Māori and non-Māori nurses felt toward the presence of cultural safety in nursing practice. While there was agreement that the concept was an essential aspect of nursing education, there was distortion about the meaning as it was sometimes confused with, or interpreted as, Tikanga or Taha Māori education, both of which preceded cultural safety education. Pere also found that cultural safety had greater meaning for Māori nurses than non-Māori. Māori could apply their own knowledge of being Māori in advocating culturally safe care for Māori clients. Non-Māori questioned its validity and did not perceive their culturally safe practice as being enhanced by education but rather by life experiences and personal philosophy. This research was undertaken 13 years ago and many of the thoughts, feelings and attitudes expressed by participants in this study are still being expressed today. Cultural safety has become more accepted to some extent; however, the application of cultural safety nursing knowledge within mainstream health services is either understood but unevenly applied, or not well understood and ignored.

Fitzpatrick (1997) used a narrative methodology to explore cultural safety in nursing practice from a Pākehā /Tauīwi²¹ perspective. Fitzpatrick's work examined in depth stories where participants described their cultural safety practice. Her study was undertaken in a health service providing care and treatment to a high Māori population where the imperative to acknowledge cultural safety as an approach to health care could be seen to be greater than in areas with a smaller Māori population. This small study identified significant findings suggesting that cultural safety in practice is a complex but necessary component of nursing education. Fitzpatrick found that the strength of cultural safety lay in the determination of the individual

²¹ With capitals, non-Māori or, those who came after the original people, that is Māori.

nurse to persevere with cultural safety in their practice. Cultural safety is interpreted in the context of the nurse's personal philosophy and professional practice beliefs. Cultural safety parallels nursing in that it is a personal process. Fitzpatrick's work identified that the nurses in her study had to manage negative and disruptive actions and responses from colleagues toward their commitment to cultural safety practice. Like Pere, Fitzpatrick found that the term was not well understood in practice and easily misinterpreted. She concluded that more attention be given to the teaching of skills which could be used in practice to work with cultural safety, that the concept be discussed more within a multi disciplinary forum and that there be ongoing support from the institution for nurses in practice who are implementing cultural safety.

Educationalists:

Spence (1999) a Pākehā cultural safety educator used a hermeneutic approach to expand understanding of everyday nursing practices in a context of difference. Spence explored nurses' experience of nursing people from cultures other than their own and set the study up to look at micro differences in the context of ethnicity and everyday interaction. She interviewed 17 nurses of different ethnicities and cultures with the dominant number being Pākehā, then Māori and Māori/European, Samoan, Eurasian and English born. She concludes that notions of prejudice, paradox, and possibility describe the experience of nursing a person from another culture. While Spence's study leans toward a transcultural turn rather than cultural safety, she situates it within a cultural safety framework. Spence's work identifies the complexity of using a transcultural approach within nursing and highlights tensions experienced by nurses when working with people from a culture different from that of the nurse. Spence's work provided her with a new way of working with nursing students in practice in that, rather than focusing on drawing out the influence of negative prejudices on nursing action, she is more likely to explore with students their assumptions that contribute positively to cross-cultural understandings.

Horton (1998) identifies cultural safety in health care as being situated within Te Tiriti o Waitangi. Her focus is on the educational environment within which teaching takes place. Horton (1998) argues that cultural safety pedagogy is flawed in that it does not meet criteria for a science of teaching or pedagogy. She suggests that the politics of pedagogy includes not only what is taught but also, who teaches it, how teaching is done and the rights of those being taught. Horton claims that socio-economic differentiation on the basis of discrimination is the antithesis of respect for human rights within the political democracy of New Zealand and this has to be balanced with protecting individuals as well as group rights in a democracy. In other words there

is a dilemma for minority groups when they strive to maintain their cultural difference and at the same time contribute to the overall functioning of the nation state and share the overall political and economic power. Another claim Horton (1998) makes is that, “while people may be born into a social group and inherit its culture, their socio economic rewards are realised through meritocracy and adapting to the dominant culture” (p.68). Within a cultural safety context, this means that the rewards of good care are experienced when a patient successfully adapts to the nurses expectations and routines and the institutional culture of the hospital. Horton identifies that while cultural safety was originally intended to address inequitable Māori health status, and while education institutions were best suited to this, it could not be known at the time that situating a marginalised discourse into a structure privileging the dominant colonising group would become problematic.

Early strategies for teaching cultural safety were centred on consciousness raising processes, which were aligned with the social protest movements and more specifically the feminist movement (Hanisch, 1969). These strategies were not only incompatible with the expectations of student learning, they were also incompatible with the values of the institution within which cultural safety education took place. Bourdieu (1974) proposes that educational cultures reflect the values of middle class elites and as such disadvantage students from groups other than those whose *habitus* or, way of doing things, is aligned to the dominant group. Laracy (2003) examines her experience of being a Pākehā nurse educator teaching cultural safety. She investigates what being Pākehā means for her in her cultural safety teaching. Laracy used heuristic self-narrative and claims the term Pākehā as a political statement in the context of New Zealand. Her identity informs her actions and being in an ongoing way, everyday and in everything that she does. She believes that cultural safety requires that the nurse engage consciously with matters of power, justice, and equity within the context of their practice on a day-to-day basis.

Southwick’s (2001) study diverges from the commonly perceived dualistic and dichotomous relationship between Māori and Pākehā by examining the experiences of Pacific women as they negotiate their lives as nurses within New Zealand. Her study realises Bourdieu’s (1998) claim that educational structures, by privileging the dominant elite, disadvantage those whose *habitus* does not conform to the elite values. Southwick speaks from her experience as a Pacific woman and nurse educator. Her study centred on gaining an understanding of the meanings her participants constructed around their experience of becoming a nurse, in order to identify forms of dissonance between their cultural worlds as Pacific women and the world of nursing. She

maintains that “taken for granted and hegemonic values are embedded within nursing and that as a result, nurses from ethnic minorities are marginalised within nursing” (p.24). She challenges the rhetoric surrounding the profession’s espoused goal of culturally safe nursing through documenting the unexamined and often unintentional consequences of hidden hegemonic values within nursing which position the discipline itself as an agency of oppression.

Southwick’s (2001) work provides a strong contrast with Spence’s (1999) research which suggests that culturally safe nursing is happening in practice. Southwick would suggest otherwise. She acknowledges that both the promotion of transcultural nursing theory (Leininger, 1970, 1978, 1991) and cultural safety (Ramsden, 1992; NCNZ, 1996, Papps and Ramsden, 1996) are examples of how the nursing discipline is working to address the challenge of reaching out to diverse communities and to meet the health care needs of marginalised people. She argues however, that neither challenge the hegemonic taken-for-granted assumptions of nursing itself. Southwick suggests that both cultural safety and transcultural care theory paradoxically act to reinforce the assumption that nursing is a profession undertaken exclusively by members of the dominant group of society, thereby reinforcing the marginalised position of minority groups in the society as ‘exotic’ other. Southwick (2001) challenges the nursing profession to address the way hegemonic and taken-for-granted values and beliefs are embedded in the nursing profession producing and reproducing conditions of oppression. Oppression, she claims, arises out of unexamined, ethnocentric assumptions that knowledge, values and beliefs of dominant Pākehā culture are deemed to be a necessary and sufficient standard for what counts as knowledge for all cultures in the New Zealand context.

Southwick’s identification of the way her participants shifted between discontinuous boundaries moved her study beyond mere description of the participant’s experience. Rather she says the stories direct attention to the boundaries themselves and invite the asking of more questions such as “what happens when boundaries are created - who has the power to create boundaries and what is the nature of that power – whose voices are privileged and whose are silenced when boundaries create dichotomous divisions within a society?” (p. 120).

Richardson (2000) a Pākehā and Wepa (2001), iwi affiliation Kahungunu, carried out their research over a similar timeframe as Fitzpatrick (1997) and Pere (1997) but from an education perspective. Both Richardson and Wepa interviewed nursing lecturers who taught cultural safety. They used different methodologies and their own cultural lens and this shaped their approach to the research. Richardson used a thematic analysis, Wepa, an action research approach. Both

worked with Māori and Pākehā participants and both drew similar conclusions but from different perspectives. Richardson found that cultural safety teaching is balanced by a number of issues; these include personal, political and professional factors which shape what happens in the classroom. Richardson's participants had developed a level of skill in teaching a controversial subject but were often not supported in their teaching. The research showed that, while there were times of stress, there were also times of satisfaction when educators felt they were contributing to change. Wepa (2001) found that teachers coped with everyday stress while they were developing strategies for teaching the subject. Māori lecturers experienced a greater degree of stress because of iwi obligations and the need to build a Māori nursing workforce. Both authors concluded there was a need for more support of all teachers of cultural safety - and more so for Māori teachers - as well as institutional support for teaching. It is interesting to read Pere's (1997) thesis alongside Richardson (2000) and Wepa (2001) as the juxtaposition of the works illuminates the relationships between lecturers and students and the teaching of cultural safety during a controversial stage of development. These together with the work of Wood and Schwass (1993) and Jeffs (2001) demonstrate the complexity and challenge of teaching for attitude change within a mainstream educational structure.

2.11 Making links between educational pedagogy and nursing discourses in practice

Research by McEldowney (2002) and Giddings (2005) both Pākehā educators review theories for teaching and both focus on teaching and social change. McEldowney approaches her study from an education perspective while Giddings situates her research with nurse clinicians.

McEldowney's (2002) thesis and subsequent work provides an examination of the complexities of teaching cultural safety. McEldowney used a narrative life story methodology to explore the philosophical, theoretical and pedagogical positions of six Pākehā/Tauīwi women who teach cultural safety. She positioned her study as a political act by raising and critiquing issues of power, social justice, agency, resistance, and praxis in nursing education. She asserts that her use of life-story narrative is also a political act by investigating the what, why and how of teaching for social change in a political context.

McEldowney concludes that teaching cultural safety is a different enterprise to teaching other nursing subjects. Her findings identify a connectedness and integrity between the participants' lives and the moral imperative motivating them to teach for difference. She identifies cultural

safety educators as change agents and maintains that cultural safety teachers undergo significant *shape shifting* experiences in their lives. These experiences impact how they view and act in their world and are translated into their teaching practice to bring about change in a complex system of social and political structures.

McEldowney (2002) provides a mosaic of what constitutes a teacher who teaches for social change. She found that the awareness of teaching for social change is tacitly embedded in the day-to-day practice of the people who contributed to the research and that they do not think consciously about it. There was a view expressed by participants that they often did not know the impact of their teaching on students. The exploration of teaching and the experience of teaching cultural safety might have parallels in the practice of culturally safe nursing. A cultural safety perspective requires a nurse to consider the political dimensions of her or his nursing practice in the assessment of health care delivery in a complex socio-political environment and in an environment where they encounter multiple differences in relationships and settings. For nurses experienced in the practice of cultural safety, this may be done unconsciously and with little feedback about the impact of their practice on patients. It is interesting to note that when some Pākehā researchers talk about teaching as a political act (McEldowney, 2002; Richardson, 2000) they often refer to teaching cultural safety or teaching for social change, in contrast to Māori researchers who speak from a position of being connected with their community and experiences of marginalisation as Māori (Pere, 1997; Wepa, 2002).

Giddings (2005) draws similar conclusions to those of McEldowney. Giddings based her research on her view that nurses are concerned with issues of social consciousness. She notes that the underlying causes of widening gaps in health status worldwide are complex and diverse and argues that the “institutionalisation of discriminatory health care policies and practices” (p. 224) contribute to and sustain these disparities. Giddings notes that nurses’ experiences are a “microcosm for other health professions and the larger social structures and systems – all of which constitute a social and political reality of disparity” (p. 224).

Giddings’ work presents a theoretical model of social consciousness adapted from the work of Gadaw (1995). Gadaw’s ‘*3-position dialectical framework of acquired, awakened and expanded consciousness- makes visible the way people respond to social injustice in the lives and the lives of others*’ (Giddings, 2005, p. 224). Her work arises out of transcultural and cultural safety, the two most influential approaches to cross cultural issues in health care, and a feminist critique of oppression and power in relation to nursing and health care. Giddings interviewed 26 female

nurses from New Zealand and the United States of America. The participants claimed various racial, cultural and sexual identities and they worked in a variety of speciality backgrounds. Giddings notes that a person's location influences the opportunity for social action and this has consequences for personal identity and professional practice. These consequences were explored through the experiences of the nurses in her study. Giddings considers that "a person who is socially marginalised and operates within a position of acquired social consciousness may accentuate characteristics not in conflict with the dominant cultural ideal" (p. 233). The nurses in this study acted to become more like the "constructed ideal of the white good nurse" (p. 233), in this case nurturing and kind, in keeping with being female in a white Anglo culture. Walking between two worlds was a feature of the experience of nurses who were marginalised and this meant self monitoring and being vigilant in interpreting the actions and behaviours of others. A person in this position, suggests Giddings, is not available to take action and perpetuates the status quo.

A second element of Giddings' work centres on an awakened social consciousness. This occurs when a person, who becomes aware of social injustice in the context of a particular marginalised issue, experiences a change in attitude which results in transforming action. Rather than trying to fit in with the status quo, some of the nurses in Giddings' study "stopped obeying the rules" (p. 234) but experienced negative consequences when they stood up for themselves, or made social injustices visible. Nurses who were not marginalised by culture or sexual orientation were isolated and labelled as outsiders especially when they did not take part in criticising or labelling colleagues or clients, or questioning a policy. According to Giddings nurses in this position may challenge the status quo for a while but will give up and "withdraw from the dominant culture and work outside the mainstream where they are unavailable for leading mainstream change" (p. 234).

A third position within the dialectical framework developed by Giddings is that of expanded consciousness. Giddings asserts that a person coming to a situation with an increased consciousness of conditions around them, becomes aware of contradictions within oppressive relationships, structures and professions and will expand possibilities for taking action. In this category, Giddings notes that language is a powerful driver in the construction of social reality. Nurses in the study who were marginalised by behaviour and not identity saw how social constructions had a positive effect on their reality as they occupied a social position of being a "white good nurse" (p. 234). This was strengthened if they were white, heterosexual and educated. They became marginalised when they transgressed the powerful assumptions of the

mythical Nightingale nurse. An expanded consciousness was activated when they came to understand “the anger of a marginalised group toward a dominant culture, toward them. It was at this point that they recognised ‘their position was on the backs of others’” (p. 234). By recognising this shift the nurses they felt able to act. Rather than blaming themselves or others, they were free to critique oppressive processes and deconstruct their own actions, the actions of others and power relations within nursing hierarchies. They were knowingly able to make choices, resist hierarchies, take action on their own and other’s behalf and challenge social injustice within their practice settings.

Giddings (2005) set out to explore social consciousness in nursing in relation to widening gaps in the health status of differing populations. One conclusion she draws from her study in relation to health disparities offers a reminder as to how marginalisation and health disparity pervades mainstream thinking. She argues that by focusing on disparities, and not on the privileging and marginalising processes within social structures and systems, there is a risk of inadvertently reinforcing stereotypes, attitudes and prejudices toward groups identified as marginalised. She further argues that this points to the perpetuation of a disparity model as a basis for social action which situates and constructs people at a deficit end of the continuum. “Social issues and health needs therefore become the target of mainstream interest and action which reinforces the discriminatory processes of othering” (p.237). Secondly Giddings (2005) notes that by dividing social realities into subcategories of health, education and justice, attention is drawn away from an interconnectedness underpinning all economic and political systems that institutionalise privilege and oppression.

The works of McEldowney (2002), Giddings (2005), Jeffs (2001) and Wood and Schwass (1993) offer insights into attempts of theorise cultural safety from the perspectives of education and nursing practice. The authors have positioned the subject within educational pedagogies and discourses of social justice and provide templates for further theoretical development. Part one of this review has identified that there is a site of struggle between education and practice and within a wider social context. The literature reviewed in this section has also identified a blurring and slippage between cultural safety and transcultural care.

2.12 Summary

The literature in this chapter positioned cultural safety within an New Zealand context and reviewed a range of available literature from 1988 – 2008. The work of Irihapeti Ramsden

provided arguments for cultural safety being introduced into the nursing education curriculum. Tensions and resistance to the concept were explored and early research relating to pedagogical approaches considered. This was followed by a review of theses undertaken by clinicians and educationalists in New Zealand which attempted to articulate the translation of cultural safety into nursing education and practice.

While my research focuses on how registered nurses learn about and apply cultural safety knowledge, the literature examined so far suggests that attention to cultural safety on its own is inadequate in providing a context to inform the study. While cultural safety was intended to provide a framework for delivering health care services in a way which made the presence of difference in relationship legitimate, the literature suggests that there are tensions between what constitutes ethnicity-based care and what constitutes cultural safety. Chapter three examines national literature in dialogue with international literature to identify constructions of cultural safety from different academic and practice perspectives. It considers both cultural safety and nursing work as relational and political endeavours, before positioning this study in relation to postmodern concepts of culture and critical theories of difference.

Chapter three: Cultural safety – In dialogue with the international literature

3. Introduction

Ramsden (2002) noted that it was frustrating to see cultural safety being redefined by others. This frustration was in response to what she saw as trend toward interpreting cultural safety as ethnicity, a multicultural endeavour, cultural competency or as transcultural care rather than as a concept for guiding an analysis of power in every relationship of difference. This chapter identifies and explores tensions inherent in positioning cultural safety alongside broader concepts of culture in nursing. It is not possible to provide an in-depth critique of all the available international literature and consequently this thesis does not purport to consider the overall use of cultural safety internationally. The first section provides a background to the evolution of nursing theory and culture in nursing. Following this a selection of literature, from 1994 to 1997, which significantly engaged New Zealand authors in dialogue with Madeleine Leininger (1991) is critiqued. Leininger is sometimes referred to the architect of culture care theory, more commonly referred to as transcultural care therefore this dialogue was instrumental in making tensions related to cultural approaches transparent.

It makes sense that cultural safety is interpreted against local backgrounds, experiences and political contexts and while this is a given, the challenge is how cultural safety is interpreted while at the same time a critical positioning is maintained. The international literature selected in this chapter is by way of providing an examination contrasting international interpretations with New Zealand literature demonstrating how tensions play out in multi cultural, bicultural, culture specific and competency contexts. Two articles are examined in depth to provide this contrasting argument, Canadian authors Anderson et al. (2003) and Australian authors Johnstone and Kanitsaki (2007). These works were selected because the authors are frequent commentators regarding cultural safety and have made important contributions to the development of the concept by positioning cultural safety within different theoretical paradigms within multicultural fields of practice. De Souza's (2008) work clarifies differences between cultural safety, transcultural care and cultural competency, and identifies concerns related to incorporating cultural competency into legislation regulating the work of health practitioners in New Zealand. Drawing on relativistic ideas, Canadian ethicist Kikuchi (2005) raises concerns about culture specific models of care. Tensions between culture-specific models of care and concepts of

wholistic²² and holistic nursing are discussed to highlight further complexity in interpreting cultural concepts. Research by Māori nurse academic Wilson (2008) identifies the strengths Māori women draw on to maintain their own health and well being and that of their whānau. Finally, literature that considers cultural safety and nursing work as relational and political is positioned in relation to postmodern concepts of culture and critical theories of difference.

3.1 Competing paradigms

Chapter two provided a brief review of literature explaining the use of culture in the context of cultural safety to differentiate it from its representation in transcultural care. Ideas about cultural care in nursing had their origins in anthropology. Lipson and De Santis (2009) note that as early as the 1930s anthropologist, Esther Lucille Brown, wanted nurses to attend to a patient's cultural background and the effect of environment on a person's well being. They note that after World War II there was a growing need to address cultural care in nursing education. This desire was in part driven by the return, following World War II of North American military nurses who brought with them a broader understanding of cultural differences and in part, by a growing demand from nursing structures to include social science and behavioural content in nursing education curricula.

In the early 50s, Peplau (1952), a psychiatric nurse, formulated her theory of nursing as an interpersonal process developed in the context of relationship. Initially her contribution was toward articulating a theory of psychiatric nursing. However, as relational aspects of care became more central to general nursing the usefulness of her theory was realised in broader nursing contexts. Peplau's focus is on interpersonal processes and therapeutic relationships that develop between the nurses and the client. Central to her thesis was the need for the nurse to understand her [sic] own behaviour and to work in partnership to assist the client in overcoming their problems.

From the 1950's to the present day the development of nursing theory and the production of nursing knowledge has undergone a steady change. Trends in nursing scholarship have tended to parallel scholarship within philosophy, feminism, education and social sciences (Andrist, Nicholas & Wolf, 2006; Cody, 2006; Daly, Speedy & Jackson, 2006). Over time nursing

²² I have used wholistic to convey the idea that health care is whole and greater than the sum of its parts as in a systems model. It includes holistic but encompasses more than the physical/spiritual and social/emotional and focuses on environment, relationships and cultural knowledge.

theorists have gradually identified and articulated new directions for nursing as a discipline by developing theories and conceptual models which can inform thinking and explain nursing actions in diverse contexts of health care. Henderson (1966), for example, sought to name contexts and the content of nursing work. Levine (2005) was concerned with conservation aspects of nursing by exploring the relationship between health and energy and the nurses' role in conserving patient energy (Schaefer, 2006). Roy (1988) utilised four modes of adaptation to explain an interrelationship between the physical, self-concept, roles and interdependence as a way of organising nursing assessment and intervention. Leininger (1978) drew on her anthropological background to develop nursing theory in the context of transcultural care. Benner (1984) utilised humanist principles to identify the development of the nurse from a novice to an expert clinician while Newman (1980) considered the nature of nursing by exploring the concept of health as expanding consciousness in practice.

North American nurse academics Bevis and Watson (1989) summed up the shift of nursing from a landscape of objective measurement to one based in humanism. They urged a rethinking of nursing and called for a curriculum change by challenging the behaviourist approach in vogue in 1970s nursing. Bevis and Watson (1989) proposed an approach to the development of nursing knowledge more representative of humanist qualities associated with care and ethical behaviour. The behaviourist curriculum, and the assumption that learning may be measured through empirically observable objectives, was no longer a useful way by which to frame the changing reality of nursing and they wanted to transform nursing into a caring and relational endeavour. They considered that a caring and ethically based curriculum would be characteristic of all nursing and would influence the humanistic, compassionate treatment of patients and change the quality of nursing care. In proposing a curriculum change they also wanted to move nursing thinking away from a reliance on a medical model of care to a more relational framework. They claimed that this would align education with clinical practice and declared that caring theory could be applied in education and then be translated from this pedagogical practice into the clinical world.

The early work of another North American nurse theorist, Leininger (1978, 1991, 1995), explored the concept of care in nursing and linked this with notions of culture. Leininger's theoretical premise was knowledge of what care means to a person both attitudinally and behaviourally, combined with basic knowledge about cultural values and beliefs, would enable nurses to provide culturally competent care (Andrews, Boyle & Carr, 1995). Leininger was a key motivator in shifting the shape of nursing in the 1970s and 1980s with her culture care theory of

diversity and universality (1978, 1991). Leininger's (1991) work directed nurses to discover, and document, the cultural world of the client in order to use their interpretations of cultural knowledge and practices to develop cultural constructs of care which were applied within a transcultural care framework. Accordingly her original culture care theory provides a basis for making culturally congruent professional care actions and decisions. While Leininger's theory established the importance of culture in explaining a person's health behaviour, her work overlooked the complexity of multifaceted health care relationships and health care environments and how these influence patient care and health care outcomes. Since Leininger's early work there has been an evolving critique of transcultural or culture care theory and there is a growing awareness that a single focus on ethnicity and cultural rituals and practices risks overlooking influences and practices shaping health care, for example (Cummings, Estabrooks, Midodzi, Wallin & Hayduk, 2007; Dreher & MacNaughton, 2002; Patterson, Osbourne & Gregory, 2004).

The theoretical propositions of Peplau (1952), Bevis and Watson (1989) and Leininger (1978, 1991) provided an impetus for changes in approaches to nursing knowledge and the construction of concepts of care in nursing. However the events and thinking leading to the development of cultural safety suggest that North American nursing theories and concepts, on their own, did not always ensure the provision of safe care in a New Zealand context. Early contributions of New Zealand nurse academics confirmed that while New Zealand nursing was part of a wider international nursing community, there was a need to develop a body of knowledge that reflected the needs of local populations (Chick & Rodgers, 1997; Salmon, 1982).

3.2 Aotearoa New Zealand authors debate transcultural care theory.

Between 1994 and 1997 New Zealand nurses and nurse educators discussed their views about cultural safety, contrasting it with the North American model as espoused by Leininger's (1978) culture care theory (Cooney, 1994; Coup, 1996; Smith, 1996). Cooney (1994) began the debate by considering the similarities and differences between transcultural nursing and cultural safety. Whereas Southwick (2001) asserts that transcultural theory and cultural safety both reinforce the marginalisation of minority groups in New Zealand, Cooney explicates the difference between the two. Whilst Cooney recognises Leininger's contribution toward drawing nursing's attention to the need to address culture in the context of nursing, she is also critical of Leininger's assumptions about cultural care. Cooney maintains that Leininger positions culture care theory within a positivist scientific paradigm that sets it apart from cultural safety. A positivist paradigm, suggests Cooney, perpetuates inherent power imbalances between the nurse and the

recipient of care. The assumption is that nurses need to know about the health practices of different cultures to which they can respond to therapeutically in ways which can be measured. In contrast, Cooney identifies the goal of cultural safety as nursing actions which recognise, respect and nurture the unique cultural identity of Tāngata Whenua, and all New Zealanders in order to safely meet their needs and expectations and ensure they can maintain their rights within the New Zealand health care system. Cooney (1994) further examines differences between Leininger's culture care theory and Ramsden's concept of cultural safety. Whilst both require an understanding of culture and an awareness of self, Cooney claims Leininger develops her model from a Euro-centric, positivist perspective where the subject of observation is the client rather than the nurse.

Leininger's (1978) theory of culture care means that the nurse has to have an understanding of difference and be able to identify specific cultural patterns that occur for people. Cooney (1994) contrasts this view with cultural safety which sees the person surrounded by activities, values and life experiences that are normal for that individual. She maintains that people evaluate others according to their own values and experiences, that is, their own norms. If one group asserts their norms on the other, a state of imbalance exists. This imbalance then threatens the identity of the dominated group. This says Cooney is cultural imposition, and may be identified as such when the nurse labels behaviour of the client as uncooperative or noncompliant. The dominant group can feel threatened when the imposition of their professional culture is pointed out to them. Thus cultural safety requires that the nurse understand the impact of her or his own culture on that of the client.

Culture care theory, or, transcultural care, (Leininger, 1978, 1991) needs to be viewed within a North American multicultural context. Cultural safety sits within a bicultural context unique to Aotearoa New Zealand, politically²³ and relationally. Ramsden (2002) identified a relational bicultural relationship as any encounter between a nurse and a patient or client. This is not to be confused with the political bicultural context which recognises Māori as the indigenous people of Aotearoa New Zealand in partnership with the Crown or the Government of Aotearoa New Zealand. Te Tiriti o Waitangi acknowledges this primary political relationship between Māori

²³ The political meaning of bicultural encompasses Māori and Western values systems and is guided by Te Tiriti o Waitangi. The political bicultural relationship helps define national identity. It is inclusive of all cultural groupings in New Zealand while acknowledging two primary groups originating from Te Tiriti o Waitangi, Māori and the British Crown. A bicultural positioning affirms the rights and responsibilities of Māori and all people who arrived after Māori. "It must be remembered that of all minority groups the Māori alone is party to a solemn treaty made with the Crown. None of the other migrant groups who have come to live in this country in recent years can claim the rights that were given to the Māori people by the Treaty of Waitangi. Because of the Treaty Māori New Zealanders stand on a special footing reinforcing, if reinforcement be needed, their historical position as the original inhabitants, the tāngata whenua of New Zealand" (Waitangi Tribunal, 1986, p.37)

and the Crown which underpins all health relationships (Cooney, 1994). Ramsden (1993b, 1995f, 2003b) states that the person receiving the care determines culturally safe care, whereas the evaluation of transcultural care comes primarily from the perspective of the nurse (Leininger, 1978). Cooney (1994) positions transcultural care in a mono-cultural framework and claims that cultural safety actively recognises institutional racism and the effect this can have on health. Cooney's claim is supported by recent literature providing evidence that there is a relationship between institutional racism and health inequalities (Harris et al., 2006) 2006). Cooney asserts that a mono-cultural dimension ignores issues such as race, racism, politics and poverty cycles, and does not give nurses strategies for challenging these factors at a policy, institutional or political level.

Coup (1996) covers similar ground to that of Cooney (1994) and adds that cultural safety refutes the Nightingale ethos of nursing people *regardless* of difference and demands that people are nursed with *regard* to their difference. Coup places transcultural care within a local context by reflecting on what would happen if Leininger's culture care theory were adopted in Aotearoa New Zealand. Coup concludes that culture care theory, or transcultural care, would constitute an extension of a colonial relationship with its inherent power inequity and thus perpetuate cultural imposition and unequal health care relationships.

Following the critique of culture care theory by Cooney (1994) and Coup (1996), Leininger (1996) responded by suggesting that the New Zealand authors misinterpreted her ideas and others lacked knowledge of scientific method. This, she suggested, limited the ability of Coup and Cooney to conduct a comprehensive scholarly analysis of her work. In another article Smith (1996), like Cooney (1994) and Coup (1996), acknowledged the contribution Leininger's theory made to the development of nursing knowledge in relation to culture. However she challenged Leininger's assertion that her theory did take account of power issues. Smith (1996) argued that Leininger's awareness of domination and ethnocentrism in relation to indigenous people is token. Smith (1996) observed that any programme purporting to reduce unsafe practice can only be driven by those who define the element of risk from their own perspective, that is from their experience of the care that they receive. Smith (1996) and Bruni (1995, 1997) articulate a view that transcultural, or culture care theory may in fact reinforce the very problem of the paternalistic and ethnocentric care it seeks to address.

3.3 Reading cultural safety: International contexts

This section draws on two international studies to identify the tensions and complexities involved in transferring cultural safety from the indigenous bicultural context of New Zealand to international multicultural nursing contexts. I have focused on one Canadian study (Anderson et al., 2003) and two Australian authors (Johnstone & Kanitsaki, 2007). Other authors in Andersen et al. have provided a suite of articles contributing to theorising cultural safety in a multicultural context (Brown & Varcoe, 2006, 2009; Brown & Smye, 2002). Unfortunately due to space restrictions it is not possible to permit a broad critique of this body of literature.

The study by Anderson et al. (2003) offers a perspective on incorporating cultural safety into a Canadian context. Framed by a postcolonial feminist discourse and the concept of cultural safety, these authors undertook two feminist ethnographic studies, one hospital-based and one home-based. The goal was to extend understanding of how patients and registered nurses from linguistically and culturally different backgrounds negotiated decision-making during health care. The second study investigated the way patients managed health care in the home on discharge from hospital. Key to their investigation was identifying the extent to which cultural safety could be used to explain their interpretations of their findings. Their participants were representative of people from diverse social and cultural backgrounds and included new migrants, South Asian and Chinese, and non-migrant Canadians of European descent.

Anderson et al. (2003) identified complexity in interpreting processes underpinning cultural safety in their research to such an extent that the process of undertaking the research engendered feelings of cultural unsafety in research participants. They commented that the act of categorizing people as being from specific ethnic groups essentialised people, suggesting that they were other than Canadian. They observed that some of their participants saw themselves as Canadian first. The researchers concluded that the act of categorising had the potential to marginalise people. A tension associated with transferring cultural safety into practice is highlighted by this study. It draws attention to the difficulty of responding to a person as an individual in the context of their culture, while at the same time resisting a cultural or racial discourse. Similarly, Giddings (2005) claims that focusing on health disparities risks marginalising people further.

Anderson et al. (2003) used the concept of cultural safety as an interpretive tool to make connections between cultural safety concepts and the person's experience. For example in one category, communication, patients who did not speak English reported that their safety depended

on their ability to communicate with health care providers rather than on feelings of being diminished or demeaned due to any lack of ability to speak or understand English. The authors note that not being able to communicate may result in feelings of disempowerment and question if this could also be read as being demeaned. Another finding centred on the experiences of English-speaking Canadians of European ancestry who had experienced difficulty negotiating the health care system. Anderson et al. commented that such people could be overlooked as needing culturally safe care and consequently written out of a cultural safety discourse. They consider that cultural safety should be able to account for power for all of their research participants. This study made visible complexities inherent when working cultural concepts in nursing. The researchers grappled with taken-for-granted cultural aspects such as ethnicity and race and at the same time made visible tensions associated with interpreting cultural safety in a multicultural setting and keeping a focus on the health provider as a key shaper of health care.

In this thesis I have focused on not so much who is doing the interpreting but rather what is being interpreted and, more importantly, the cultural lens through which cultural safety is being examined. Suffice to say that cultural safety consciousness is a requirement in all nurse-patient encounters and while not subscribing to an essentialist position it needs to be recognised that essentialist notions of ethnicity, gender and age for example can be brought more to the fore when differences between the nurse and patient are perceived to be greater than differences between a nurse and a patient who share apparently similar identifying characteristics such as ethnicity, colour, gender or language.

Anderson et al. (2003) concluded that in a multicultural context a rewriting of cultural safety was necessary. They suggested that a postcolonial, feminist perspective would provide a more useful theoretical lens through which to examine colonisation and neo-colonialism, thereby revealing “the varied intersecting social relations of people’s lives” (p. 211). This study raises some important issues in the transferring of the concept from a national setting to an international setting. Anderson et al. capture the complexity in recognising cultural safety in research data when they say that “cultural safety did not announce itself in the transcripts-it was not a thing to be found” (p. 206). They found that *finding cultural safety* depended very much on their interpretation. This resonates with the application of cultural safety in a New Zealand context in that ‘finding cultural safety’ in everyday health encounters is not always immediately apparent.

Australian authors, Johnstone and Kanitsaki (2007) used a naturalistic inquiry approach to data collection, interviewing 145 participants in focus groups or in one-to-one interviews. The

research questions asked what health care providers and consumers of diverse cultural backgrounds know and understand about the notion of cultural safety. Other questions asked about the perceptions and experiences of cultural safety as a process in multicultural Australia, and to what extent the construct can be interpreted and advocated for as a cultural risk management strategy in a multicultural context. A key finding in this study is that, although cultural safety has been talked about by Aboriginal proponents, it is poorly understood and does not have currency within mainstream, multicultural health care contexts in Australia. The authors also found that there was an idea that cultural safety meant that “things were done safely” and that people from diverse backgrounds “got safe care and did not receive less than adequate care because of poor communication or staff lack of cultural knowledge” (p. 251).

Johnstone and Kanitsaki (2007) conclude that within multicultural Australia there is a lack of understanding of the concept and how it is applied in practice. For Johnstone and Kanitsaki cultural safety fails to provide a practice framework for the delivery of culturally appropriate and responsive care to people from diverse backgrounds. One other finding worthy of mention are the risks associated with upholding user definitions of cultural safety. By this the authors mean that cares and treatments may be preferred by an end user but that these treatments may be harmful to them. This implies that nurses or other health professionals are for some reason unable to use their clinical judgement when working with these situations, or that the recipient of care is unable to engage in a dialogue with the health professional concerning their health needs.

In early cultural safety practice it was considered that cultural safety involved a transfer of power from the provider to the recipient of care (Ramsden, 1990a). In hindsight it is clear that this framing is somewhat simplistic, although not intended as such. When a person seeks health care, they do so because they believe that the health professional has the power, that is knowledge to treat their illness or condition and to make them well. Ramsden’s concept of transfer of power in practice means that the nurse maintains an environment where the person is involved fully in their care, their identity is maintained and they feel able to comment on their care. The transfer of power does not mean that perceived harmful cultural practices are accepted uncritically. A transfer of power can mean that the person should have the right to comment on health care practices that they perceive as harmful to them. This could include an attitude, a belief or an intervention. Johnstone and Kanitsaki’s final conclusion is that in multicultural Australia cultural safety is problematic. They comment that if cultural safety is to function as a meaningful framework for guiding delivery of culturally and linguistically appropriate and responsible health care outside of Aotearoa New Zealand, its processes need to be better informed by, and

incorporated into, a cultural competence framework. Johnstone and Kanitsaki (2007) suggestion that cultural safety be incorporated into a cultural competency framework outside of Aotearoa New Zealand only serves to create tensions between cultural safety and transcultural care and detracts from the intent of cultural safety as providing a framework for a practical workplace analysis of power.

Anderson et al.(2003) and Johnstone and Kanitsaki (2007) rework cultural safety so that it makes sense to their health care settings and this is understandable. I argue that the political landscape, in this case, multiculturalism, shapes the way cultural safety is interpreted hence any approach to cultural safety can only be interpreted within specific broader national and social contexts. Given that influential Western nations, such as North America, Canada, England and Australia function socially and politically in a multicultural context where a transcultural paradigm dominates, there are implications in how cultural safety is interpreted in such contexts. Anderson et al.'s (2003) work could be seen as a reframing of cultural safety conform transcultural concepts in a multicultural society. If this is so then there is a risk that cultural safety becomes reinterpreted within a narrow focus of cultural ethnicity. Any focus on culture alone invokes the presence of binary or dualistic relationships which may unconsciously guide a person's actions. Fletcher (2006) observes that a binary approach, by definition, constructs relationships of right or wrong, creating conditions of conflicting power. This she suggests can "close us down" (p.54) and can lead to the development of "habitual tactics" with which to defend ourselves from threat. This means that "we are reluctant to abandon old ways of behaving because they serve a purpose" (p.54). Binary constructions are by definition unequal as both partners are defined in relation to each other in a hierarchal way, in this case where one is identified as having power and the other as not. Anderson et al. (2003) do go some way toward teasing out their interpretation of cultural safety by separating out and identifying the different paradigms informing cultural safety and transcultural nursing, thus highlighting complexity in applying cultural safety in a clinical context.

Anderson et al. (2003) and Johnstone and Kanitsaki (2007) share with Aotearoa New Zealand a similar colonising history where indigenous populations have been excluded from decision-making, informed by their own worldviews, in mainstream health services. All the authors seem to have missed the point that cultural safety is about the nurse or health care provider *and* institutional power which is relevant in any care setting even if this is interpreted according to local conditions. Fletcher (2006) observes that behaviour is determined by the organisational structure rather than solely by intrinsic character. The researchers started from the premise of

transcultural care in a multicultural environment and these discourses shaped the findings which led them to their conclusions that cultural safety was not an appropriate or suitable model for their communities. It is recognised that, within an Aotearoa New Zealand context, the implementation of cultural safety may be problematic (Ellison- Loschman 2001; Ramsden, 2002; Richardson, 2000). The problem is not only with misreadings of cultural safety as ethnicity and transcultural care but also with the support for it in practice, the focus on power, attitudes and the quality of the relationship between the nurse, the health care provider and the recipient of care.

The above literature identifies that transcultural care holds a dominant position within international health care. Other North American authors have offered critiques of transcultural care (Culley, 2006; Gray & Thomas, 2006; Gustafson, 2005; Mulholland, 1995), all of whom support a move away from essentialising concepts of culture, however, only Culley refers to cultural safety as a way forward. Culley like other international researchers review, positions cultural safety within health inequities experienced by indigenous peoples. She identifies health risks when ethno-cultural-racial identity is demeaned, suggesting that cultural risk is related to social disparities in postcolonial societies. Culley is accurate in her assessment of what cultural safety is but limits her thinking to aspects of cultural safety that link ethnicity and inequity. She argues for a non-essentialist approach to cultural difference “to unmask the assumptions of transculturalism and develop possibilities of practice which do not solely represent the particular habitus of dominant ethnic groups” (p.150). Culley raises an important point when she posits how ethnicity is to be taken seriously in a way that does not fix cultures in set of fixed cultural properties. She then goes on to suggest that there are no conceptual tools to address this. While Cully draws on cultural safety to inform her thinking, she does not consider that cultural safety could be one such conceptual tool. While addressing the need to shift away from transcultural care, she narrowly positions cultural safety as ethnic safety rather than safety for all in relation to all nurse-patient relationships.

Gustafson (2005) like Cully, critiques transcultural care as being essentialist, suggesting that transcultural nursing theory “centres culture as a way of understanding individuals and their response to health care”(p.3). Using a critical cultural perspective, Gustafson sets out to deconstruct transcultural nursing theory as a framework for thinking through, talking about, valuing and engaging with human and social differences. She makes the claim that transcultural theory texts “legitimizes whiteness as a politically neutral identity position from which to interpret race difference”(p.9). A critical cultural perspective for Gustafson means that thinking differently about diversity requires challenging categories of difference which may be held up as

distinct, bounded and static biological facts or essentialist categories of human identity. Extrapolating this theme she then turns her attention to problematising culture. She recognises that nursing texts generally do not problematise race or other discourses of difference and therefore continue to use racial categories as a tool for classifying people (Jacob, Holmes & Buus, 2008).

Cooney (1994), Coup (1996) and Smith (1996) and Gustafson (2005) consider that while transcultural theory opened up spaces and possibilities for discussing difference, and the politics of difference, the concept is flawed. She claims that it will not “transform the social practices and relations that institutionalise the dominant approach to social and human differences” (p.14). However, in advocating for a critical cultural perspective, she fails to draw on cultural safety literature to support her argument for a different approach.

This section explored literature identifying different representations of cultural safety internationally. Another area of contention is that of cultural competency and culture specific models of care. The following section touches briefly on cultural competency as it is gaining traction in nursing but to date has not been investigated as an appropriate framework for measuring cultural care.

3.4 Cultural competency and cultural safety

Cultural competency is a term contributing to confusion about the constitution of cultural safety (Wepa, 2008). This serves to further complicate and create misunderstandings and tensions between cultural safety and cultural competency. Durie (2001) describes cultural competence as being similar to cultural safety but deriving from different paradigms and different starting points. Both focus on the relationship between the health carer and the patient or client. Cultural safety, however, attends to the experience of the recipient of care, whereas cultural competence addresses the capacity of the health carer to improve a person’s health status by integrating culture into a clinical context. Cultural competence has been a feature of nursing and health care for at least twenty years and is only now moving centre stage as an evaluative tool for cultural care, as embodied in the New Zealand Health Practitioners Competence Assurance Act 2003 (HPCA Act, 2003). Definitions of competency are open to interpretation but in nursing have usually evolved from traditional concepts of culture and ethnic diversity associated with transcultural nursing. Campinha Bachote (2006) and Leininger (1999) describe cultural competence as referring to the multicultural knowledge base that nurses need, combined with the

ability to apply such knowledge in practice. Jirwe, Gerrish, Keeney and Emami (2009) and Gerrish and Papadopoulous (1999) claim that culturally competent nurses are sensitive to cultural differences and base their care on this. Gustafson (2005) describes cultural competence as representing “a quantifiable set of individual attitudes and communication and practice skills that enables a nurse to work effectively within the cultural context of individuals and families from diverse backgrounds” (p.2). Gustafson’s definition suggests that, rather than a single focus on ethnicity, the skills of cultural competence, attitudes, communication and practice by definition need to be applied in every nursing or health encounter since all people using health services come from diverse cultural backgrounds in the context of their relationship with a nurse or health care provider. Ramsden (2002) calls this the bicultural relationship.

De Souza (2008) offers a view of cultural competence which differs from North American notions of competence. She positions cultural safety and cultural competence as two discreet entities and examines them within a New Zealand context. De Souza identifies cultural safety as an indigenous nursing approach developed from inequalities in Māori health, while she sees cultural competence as having been imported from transcultural care which was developed within a multicultural context. She provides demographic information for different cultures (Māori, Pacific and Asian) within Aotearoa New Zealand and states clearly that cultural safety goes beyond describing the cultural practices of these or any other group; this she says can essentialise group members. She emphasises that cultural safety focuses on self-understanding and the values and attitudes the nurse brings to her or his practice.

De Souza’s (2008) interest is in cultural diversity and cultural competence. She argues that, when responding to cultural diversity in Aotearoa New Zealand, there are two considerations - safety and competence - both of which reflect points of complementarity and tension. She further maintains that there are tensions between cultural competency and cultural safety and provides a succinct table of difference. Cultural competence emphasises learning about the culture of the patient and incorporating this as a dimension of practise while cultural safety focuses on the recognition by the health professional that he or she is the bearer of personal and professional culture bringing a political dimension to health care. Cultural competence is not concerned with social transformation whereas cultural safety is concerned with shifting institutional power through an analysis of power inequalities in society. Cultural competence is also a mechanism enabling external and political control over professions in the name of health and safety of the public, by assessing a health professional’s competence to practise. One international interpretation of competence by Leonard and Plotnikoff (2000) alludes to cultural

safety concepts by noting that cultural competence is a mechanism for providing care to patients, compatible with their values and traditions. Competence involves an awareness of one's own values and those of the health system. De Souza's commentary is timely as there continues to be considerable uncertainty as to what constitutes cultural safety and cultural competence. Her article provides a beginning point for some clarification of these concepts. At the same time her work identifies an area of potential risk for the ongoing development of cultural safety.

De Souza (2008) observes that the significance of cultural competence in Aotearoa New Zealand has grown with the introduction of the Health Practitioners Health Competence Assurance Act (2003). In interpreting the use of competency in relation to culture within the Act, De Souza draws on Betancourt, Alexander, Green and Camillo (2002) definition of cultural competence as "the ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients' social, cultural and linguistic needs" (Betancourt, Alexander, Green, Emilio Camillo, 2002 p.1). De Souza argues that the 2003 Act risks marginalising cultural safety which focuses on all people using health care services, while cultural competency becomes the guiding framework for delivering health care to culturally diverse populations. This will only serve to perpetuate the very health care practices that cultural safety is designed to address, as well as to reinforce practices and policies which benefit the dominant group and assign those who do not have membership to the margins of health care. In a world of fluidity and complexity this is a retrograde step. Instead, an understanding of cultural safety by health care professionals could offer a way of developing new and appropriate ways of engaging with all people who use health care services. De Souza then proposes a set of operational strategies for increasing responsiveness to diverse groups using a cultural competence framework of clinical competence, organisational competence and systemic cultural competence.

It could be argued that the interpretation of competence, cultural safety and transcultural care is shaped by the standpoint of the speaker. This is important, as the view will shape the practice. From a cultural safety perspective *all* patients the nurse cares for come with diverse values, beliefs and behaviour and social and cultural linguistic needs. Interconnected social and political networks will shape a person's cultural expressions of identity. Therefore health care is not a one size fits all arrangement. Rather it means that the nurse requires knowledge and skills to communicate, assess, interpret and mediate differences between herself and the client, including her own differences and the client's differences. In other words nurses need to be able to negotiate a bicultural relationship with another person. Although it may not be intended, a single focus on a transcultural perspective or culture specific approach risks singling out people with

diverse values, beliefs and behaviours and may privilege difference from the perspective of the dominant group. The use of the term *diverse peoples* infers that the dominant group is relatively homogenous with little diversity in values or social needs. This is a normative view because anyone who differs from the dominant group is constructed as different. De Souza's work goes some way to delineating between cultural competency and cultural safety by focusing on institutions and systems as well as individual competence. The follow section considers culture specific theories of care.

3.5 Culture specific models of care.

To date the selection of literature presented in this review has highlighted tensions in the positioning of cultural safety in an international arena and a competency discourse. Another tension worthy of note is that of cultural safety in relation to ethno or culturally specific health care models. Ramsden (2002) was concerned that transcultural care theory privileged an ethnicity approach to cultural care and did not always address issues of power and attitude of the health care provider toward the recipient of care. A random search of nursing textbooks for reference to cultural safety identified one which drew on the concept to introduce a relational context to nursing (Crisp & Taylor, 2008). These authors also made distinctions between cultural safety and transcultural care and drew on the New Zealand experience to inform their view. Other texts tended to position concepts of culturally specific care within the following categories; ethnicity, race, transcultural care, cultural values and beliefs, cultural competence (Berman, Snyder & Jackson, 2009; Christenson & Kockrow, 2005; De Laune & Ladner, 2006; White, Duncan & Baumle, 2010). The next section interrogates the positioning of culturally specific care models within the broader concept of cultural safety.

Kikuchi (2005) and Cody (2006) critique a growing trend toward the development culture specific theories of nursing based on the beliefs and values of the culture within which they are to be used. Kikuchi's critique is in response to a North American trend to replace existing models of nursing with culture specific models. Parker (Fawcett, 2003) comments, for example, that while Thai students studying in the West used Western conceptual models, they found that when they returned to their country the models were not adaptable to nursing practice in their home situations. Parker commented that initially she thought the Western models were universally and globally useful and the Thai students thought otherwise. Parker then recognised that Western nursing theories focus on the individual even though there is an assertion that family, community and populations are addressed. Parker's conclusion was that "the best hope for successful

development and use of nursing theory resides in theory that reflects the culture” (Fawcett, 2003, p.134). Cody (2006) disagrees with Parker’s arguments for cultural models of care that are developed by, and for, particular ethnic groups, asserting that “to care for all people, a nurse must have a philosophical and theoretical grounding for human diversity that will support their work in caring for those unfamiliar and different from themselves” (p.197). Kikuchi’s (2005) critique of culture specific theories draws upon Dolhenty’s (2003) philosophical critique of relativism. She suggests that:

There are no fixed values, only fluctuating human valuations, or that ethical truths are relative and that right action depends on the attitude taken towards by an individual or group and therefore may vary from individual to individual, or from group to group. (Kikuchi, 2005 p.303)

Kikuchi’s claim that treating all values as taste or preference, that is as subjective, means that there can be no judgement of right or wrong because to do so would imply the existence of a unified, fixed moral standard. For Kikuchi cultural relativism is problematic as it suggests that nurses have no moral basis for intervening when they encounter cultural practices that they know are injurious to human health. In proclaiming the moral risks for nurses when working with culture-specific models of care Kikuchi omits to turn the lens of risk on the nursing or health professions and their potential to violate or endanger a person’s health by imposing their own cultural values on to someone who does not share those values.

Kikuchi’s (2005) sphere of concern is with cultural practices such as the stoning, burning or limiting of the education of women. While these practices cannot be ignored, her proposal to subsume such models into transcultural care does not provide the answer. This would effectively enable the dominant culture to retain control over the knowledge development of other groups and continue to construct difference as exotic, or outside what is considered normal, thus keeping alternative or culture specific models at the margins of mainstream health care. By placing nurses within theories of moral relativism Kikuchi raises a question about how nurses can develop theories of nursing which will allow for the expression of cultural values without simultaneously opening the door for abuse and the charge of colonialism or Western hegemony. Kikuchi’s work is worthy of mention because her suggestion that a focus on cultural practices which are culturally and politically fraught means that a nurse may unconditionally accept cultural practices as being appropriate, non negotiable and therefore fixed rather than dynamic within a contemporary health environment. Of greater importance however is the need for nurses to deliver care and services in ways that meet the health care needs of the person receiving care,

and in the context of their cultural and everyday experience of living, and that this care is assessed as safe by the recipient of that care. Kikuchi does however raise some important issues for culturally safe health care in Aotearoa New Zealand and the positioning of culture specific models of health care within mainstream health care systems.

In Aotearoa New Zealand, within the context of cultural safety and Te Tiriti o Waitangi, there is a growing momentum from ethnic and social groups to evolve their own models of health care by drawing on their insider, wholistic cultural worldviews, positioning and health care knowledge. Many of these models arise from within the landscape, geography and cultural histories of specific communities. For example, Te Whare Tapa Wha (the four sided house) model is based on the foundations and cornerstones of the whare (house) (Durie, 1994). Samuel's (2009) Cook Island mental health recovery model derives from the landscape of the Cook Islands, while Vakaola Tokolauen (Kupa, 2009) draws on the geographic characteristics and objects (for example the canoe) used on a daily basis in Tokolau. The Niu Tupu or coconut model is influenced by the natural resources and characteristics of Niue to inform an approach to health care and the development of health relationships (Mailigi Hetutu, personal communication, October 12, 2009).

While *wholistic* culturally specific models parallel Western *holistic* models of health, they differ in a number of ways. Both have their genesis in a General Systems Theory approach (Bertalanffy, 1968), with holistic care being more associated with a Biomedical orientation. General systems theory draws on a mechanical metaphor to construct a science of wholeness and integrated functioning. Any imbalance in one part of the machine gives rise to imbalance in other parts. The theory has been adapted by medicine and nursing to describe a health care approach emphasising integration of physical, social, emotional, spiritual and socio-cultural aspects of being. For nursing, holistic health care is that which takes into consideration all aspects of a person's health needs. Such care also draws on Eastern philosophies of wholeness, balance and healing and an interconnectedness with natural environments (Montgomery-Dossey & Keegan, 2009). While both *holistic* and *wholistic* cultural models of health care share a goal of harmony and balance in human functioning, *wholistic* culture specific models are grounded in cultural world-views, historical and contemporary cultural relationships and are informed by eco-spiritual foundations. A Western holistic approach tends to focus on the therapeutic intervention, specific treatments and a connection between the nurse and the patient, thus care is individual and does not always take into account the holistic nature of health in wider sociocultural and familial relationships.

Culture specific models of care tend to remain intact and functioning within a community setting. When a client is admitted to an inpatient facility, more specifically a mental health facility, tensions can arise at the intersection of the more dominant holistic Western and wholistic cultural world-views regarding health care delivery. One way of managing these tensions can be for mainstream systems to unconsciously equate culture specific models of care with a more holistic model of care (Mika Perez, personal communication, August 14th 2010). This can mean that health care providers may attempt to integrate or overlay holistic models of care over culture specific models and view them as similar or interchangeable. This has the effect of devaluing the culture specific models and privileging the Western holistic approach, thus marginalising culture specific care models by claiming sameness. The danger of perceiving them as the same risks perpetuating the status quo where cultural models, already subsumed by a dominant medical model now becomes misinterpreted as holistic approach and not wholistic. Western concepts of holistic care will subsequently influence and shape the way care is delivered and experienced by the patient.

3.6 Cultural safety and the health of Tāngata Whenua

Wilson's (2008) grounded theory research examined the way Māori women draw on their day-to-day strengths to maintain their health and well being and that of their whānau. Wilson argues that these strengths can sometimes go undetected and yet they are vital to improving health. She observes that:

A culturally appropriate health service is contingent on the inclusion of a client's cultural beliefs and practices into intervention plans... not establishing key cultural beliefs and practices risks providing a health service that lacks relevance and compromises its efficacy for its recipients.(p.173)

In other words, health care providers do not always provide culturally safe care because of the absence of an environment of safety for a person.

Wilson asserts that the ability to provide culturally appropriate and acceptable health services is a requirement for gaining the client's trust and this extends beyond the establishment of relationships to respecting the person's world-views and cultural preferences. She notes that when outcomes are not achieved for the health of the client then it is not unusual for the client to be blamed or labelled non-compliant. According to The Nursing Council of New Zealand (2008), competency is "the combination of skills, knowledge, values and abilities that underpin

effective performance as a nurse”. Wilson points out that Competency 1.5 of the NCNZ (2005/2009) requires nurses to practise nursing in a manner that the client determines as culturally safe. This means the recipient of care needs to experience a level of trust where her needs and wants can be conveyed to the nurse in a way which will keep her safe. It also means that the nurse needs to have the knowledge, ability and resources to listen, assess and interpret communication and actions which may indicate compromised safety. Although the experience of the recipient is a key tenet of cultural safety, in some nursing encounters, the recipient of care is sometimes the least able to comment on care. Often they do not challenge at the time of an encounter but as Wilson (2008) found, a recipient of care may act on poor quality of care by discontinuing use of a service or ‘walking away’ rather than speaking up about the service. Wilson’s research identifies that a recipient’s experiences of health care are, however, given voice in other venues such as group discussions and research settings.

Wilson’s (2008) research explored Māori women’s understandings of health and their interactions with mainstream health services. A Māori-centred approach informed by the work of Durie (1997) was used to ensure a research process reflecting Māori values and processes from the beginning of consultation to the dissemination of the findings. A Glaserian grounded theory approach (Glaser, 1998), was used in conjunction with Durie’s model (2001), to analyse data using a constant comparative analysis to generate codes, emerging concepts and categories. Wilson’s findings briefly were as follows. Nga Kairaranga Oranga – weavers of health and well-being was the substantive grounded theory finding that explains the health and well-being of Māori women and provides a framework for Māori women’s insights into their interactions with mainstream health care services. This overarching theory was further explained as Mana Wāhine²⁴, the important components for health and well-being such as whānau, spirituality, traditional and contemporary knowledge and self care behaviours. Mana Wāhine explains the barriers to experiencing positive health outcomes for Māori women. Challenges and barriers include a strong socialisation to put others first, fear of past experiences of health care and negative encounters with health care providers. Engaging with health services was a key ingredient of safe care expressed in the need to develop positive relationships with health care providers. The way relationships are woven together determines the nature of engagement a Māori woman has with a health service. The Māori women that Wilson worked with found that health services were problem-focused, that the services compartmentalised health issues or problems and this resulted in their overall needs not being recognised and interventions being inappropriate - in short a biomedical approach was the usual approach experienced.

²⁴ Wāhine is the Māori term for women, plural. Wahine is singular.

Wilson's (2008) findings raise the concern that, although nurses have been educationally prepared in cultural safety since the 1990s, this training may not translate easily into practice. Wilson notes the need for nurses to maintain a reflective stance to their practice through examining their personal cultural beliefs and values in order to consider how these might impact on the care they deliver. Moreover, nurses need to recognise and value the beliefs and practices of health consumers and integrate these in care planning. All these factors are dimensions of cultural safety. Wilson notes that The New Zealand Nursing Council competency reviews of culturally safe practice are somewhat problematic as there is nothing in the assessment structure which caters for feedback from the recipient of care. Even if there was, there is the vulnerability factor on the part of the client who may feel unable to comment. Her research identified that, while Māori women knew what they wanted from a health service and health care providers, knowing what they wanted contrasted with their experience. Participants reported that at times health providers did not listen when something was wrong, or were unable to respond in a way that indicated they knew what to do to correct a situation. Wilson draws on Durie's (2001) work and offers another approach, drawing on a cultural competency framework based in the nurse's ability to articulate and demonstrate care where the client feels safe. The nurse does this by articulating an understanding of links between knowledge, beliefs, attitudes and power and demonstrates this by situating their actions within this framework in order to explain how they improved a person's health status and to demonstrate how they integrated the person's culture into clinical practice. Contingent on this process is the health professional's willingness to address issues of power and to acknowledge how the interplay of values and attitudes affects the health care relationship.

While cultural safety is part of the same lexicon of nursing, the literature identifies that there are tensions between cultural safety and other conceptualisations of culture in health care. Nursing knowledge has evolved over time and has been largely informed by dominant discourses of humanism and positivism. The following sections consider nursing work as a political project and begin to outline how postmodern ideas about culture and critical theories of difference, which underpin this research, may contribute to new developments in cultural safety in the twenty-first century.

3.7 Theorising nursing work as a relational and political endeavour

As established in chapter one, the appearance of cultural safety in nursing was in part driven by the intense radical change occurring in the latter half of the twentieth century. This was a time

where the values and assumptions, entrenched knowledge paradigms and regimes of truth underwent critical interrogation (McHoul & Grace, 1995). Kincheloe and McLaren (2005) observe that a critical analysis centering on notions of self and social structures informed by postmodernist, feminist and postcolonial discourses called for new understandings about technologies of power, the production of knowledge and the nature of social relationships in the social sciences, art and literature. Such interrogations touched the personal and public lives and relationships of people, becoming the focus of research, dialogue, and investigation in the social sciences, arts, literature, politics, and education (see for example Butler, 1987; Daly, 1978; Derrida, 1976; Foucault, 1980; Giroux, 1983; Heidegger, 1962; hooks, 1981, Lourde, 1984; Merlau-Ponty, 1983; Morgan, 1978; Sawicki, 1994, 1991; Warhol, 1962). Nursing was not immune to these shifts in thinking and, as in other health disciplines, the profession was challenged to examine its own assumptions and ideas about the practice and discipline of nursing. In Aotearoa New Zealand cultural safety became a vehicle for a radical rethinking of nursing, signifying a shift away from the more traditional humanistic frameworks of nursing knowledge development to a more critical stance, opening up ways for previously marginalised voices to contribute to the development of nursing ideas in this country.

Over the last 50 years, the discipline of nursing has utilised different philosophical underpinnings to develop coherent sets of ideas through which to guide the construction of nursing knowledge, research and practice. Campesino (2008) identifies three sets of ideas based in positivism, humanism and critical theory. Firstly, a positivist perspective attends to the assessment of health through objective measurement. This view alone, suggests Campesino, overlooks social and cultural differences, which influence professional relationships. Secondly she asserts that a humanist perspective focuses on “notions of equality and individual freedom, and operates on an assumption of sameness among people” (p. 299). One problem with this approach, she observes, is that when differences arise within nurse and client interactions, these differences are explained away as variations of cultural norms and values rather than as social categories that produce power differences. A humanist-based caring ethic, informed by a value of commonality among people, assumes that every person will be treated the same. Thirdly, Campesino identifies a critical lens as one that has the potential to transform nursing’s approach to cultural education *and practice* [my italics]. Such an approach provides a way to interrogate, deconstruct and reconstruct assumptions about power and privilege to improve the delivery of health care. Gustafson (2005) asserts that critical theory can explain how social privilege operates to perpetuate power inequities in health care relationships and, a critical approach involves an assessment of pedagogical practices identifying how curriculum design and textbook discourse

reflect a dominant white middle class perspective. This she claims may silence or marginalise the experience of non-dominant populations. Gustafson argues that by not problematising race or other discourses of difference, racial categories will continue to be used as a tool for classifying people.

The shifting philosophies and competing paradigms identified in this chapter suggest that there are multiple interpretations and definitions of nursing and nursing work. In this next section I will consider a range of different interpretations by presenting the ideas of a selection of key authors. Current privileged explanations of nursing tend to focus on the caring qualities of nursing (see for example, Benner & Wrubel, 1989; Leininger, 1978; Noddings, 1984; Watson, 1990). Thorne and Hayes (1997) acknowledge the work of the above care theorists and credit them with making important dimensions of caring explicit, for example the moral idea of protection and enhancement of human dignity and moral principles inherent in caring relationships. They also argue that there is a problem with these theories as they are not able to accommodate all the dimensions of nursing. Thorne and Hayes consider that caring is shaped by the social structures of the institutions of care and cannot be viewed independently from these structures.

New Zealand nursing theorist Christensen (1990) was one of the first nurse theorists to articulate the stages of an illness trajectory by a person undergoing surgery. She identified this as the nursed passage and through using a grounded theory approach which named the work that the nurse and the client engaged in from admission to discharge. Her research positioned the nurse-person relationship as active and interactive with the nurse and the person for whom they provided care working through independent and interdependent processes. Nursing knowledge continues to develop over time and cultural safety is an original indigenous contribution to this development which emerges from the experience of the recipient of care.

Diers (2004) and Reed (2006) offer descriptions of nursing that have relevance for this research. Diers explains the work of nursing as being in touch with another human being, by being invited into the “inner spaces of other people’s existence without even asking” (p. 143). Within this space where there is “suffering, loneliness, the tolerable pain or cure of the solitary pain of permanent change, there is the need for the kind of human service we call nursing” (p.143). According to Diers the tradition of nursing is embedded in an explicit value of helping others do what they would “do for themselves if they had the skill, energy, or will, or when recovery is not possible, to assist in the act of dying and dignifying the person with their personal history,

idiosyncrasies, needs, values and desires” (p. 143). Reed (2006) on the other hand, proposes a definition of nursing which centres on nursing processes of well-being, that is where nursing involves a process that is developmental, progressive and sustaining and by which well-being occurs. This process is characterised by complexity and integration in human systems and it is not how nurses facilitate well-being but, rather “how nursing processes function in human systems to facilitate well being” (p. 127). Other theorists, such as Hatrick-Doane and Varcoe (2005), Peplau (1952) and Travelbee (1972), frame nursing within a relational framework.

Aotearoa New Zealand authors, Ryan, Carryer and Patterson (2003) note that while nursing work is focused on bodily issues experienced by a person, this experience is mediated by the psychosocial, cultural and political context of the person (p.53). They identify that an illness experience and identity are closely connected and the *way* in which illness is experienced transforms one's sense of self in the contexts of social meanings of sickness *and health* [my italics] (p.66). Diers (2004), Reed (2006) and Ryan, Carryer and Patterson (2003) provide constructions of nursing which integrate sociological, critical and humanist concepts as being the focus of nursing. Collectively they position nursing as a dynamic, relational endeavour requiring not only attention to the person but also to the socio-political contexts in which nursing takes place. The claiming of the relational as a core defining concept of nursing shifts nursing away from the more traditional humanistic frameworks of nursing knowledge development to a more critical stance because it takes into account the world view of the recipient of care. This shift opens up the way for previously marginalised voices to contribute to the development of nursing ideas in an Aotearoa New Zealand context and introduces a new praxis dimension to nursing in Aotearoa New Zealand, one which focuses as much on the provider of care as on the recipient of care (Ramsden, 1990). Kincheloe and McLaren (2007) observe that any theory of praxis needs to be purposeful and guided by critical reflection and a commitment to revolutionary practice. They assert that this commitment involves a rejection of the historical and cultural logics and narratives that exclude those who have been previously marginalised. The work of Campesino (2008), Kincheloe and McLaren (2007), Ramsden (2002) and Ryan, Carryer and Patterson (2003) collectively position nursing as both a politicised discipline and endeavour.

3.8 Cultural safety as a social movement

Stories of cultural safety in Aotearoa New Zealand are constituted through discourses of colonisation and historical events that bring contemporary interpretations of unequal power relations between Māori and Pākehā into sharp relief. Health inequities between Māori and

Pākehā are an enduring feature of these historically unequal power relations (Reid & Robson, 2007). Emerging from these cultural concerns related to inequity come a deeper set of concerns or interests centering on the influence of unequal power relationships on health outcomes for Māori. Actions taken to address these concerns have not come through the traditional orthodoxies of nursing, medical or health care interventions but through a call for a radical re-orienting of the relational dynamics between nurses and Māori using health services (Harris et al, 2007). As a social movement *and* a nursing subject, cultural safety brought cultural processes, identities and interests in from the margins of society to mainstream structures. This repositioning from protest to mainstream disrupted and unsettled established ideas about the culture and constitution of nursing, health and the person using health services in the context of institutions and health care settings.

In providing a narrative analysis of social movements, Polletta (2006) uses culture as a way to theorise about the purpose and function of social movements. She considers that people use culture practically and creatively to pursue their interests in all settings and it is culture that defines what counts as practical and what counts as an interest and these are conveyed through stories. Polletta claims that familiar stories can make courses of action seem reasonable and possible and make other courses of action seem ineffectual, ill considered or impossible. She further claims that familiar stories may shape the interests and identities from which people initially take such strategic action. Such stories cannot be seen in isolation but must be viewed in relation to culture, power and practical action beyond social movements. Over time, stories articulating different dimensions of cultural safety have done exactly that, they have made some actions possible, some ill considered and others impossible. Ramsden (2002) gives meaning to Polletta's theorising when she suggests that the interests of a colonising discourse have major health and disease outcomes for Māori. Deprivation of economy, resources, land and identity and the impact of these on health outcomes have, according to Ramsden, remained largely unrecognised and under-analysed in nursing and midwifery education until challenged by cultural safety.

Although the historical cultural relationship between Māori and Pākehā was the crucible for analysing health structures in contemporary New Zealand, it was the interests arising from this analysis that brought a call for action; that is the interests of relationship and structural inequalities. The action needed was to challenge these interests and move toward developing a health service for Māori to be able to access health care which was appropriate, affordable and acceptable to them as individuals and as whānau. Polletta (2006) notes that it is a "mix of

structural and cultural processes that produce new identities and interests and it is these that are thrown into the spotlight in any social movement” (p. 5).

3.9 Critical theory and postmodern concepts of culture

As has already been established, a tension within cultural safety is that of associating the term *cultural* with a narrow anthropological/ethno concept, whereas Ramsden’s conceptualisation of culture is more within a relational realm. According to Ramsden (2002), anthropologically informed ideas of culture produce an observational approach in which care stays focused on the cultural activities of the patient. There is a risk that a stereotype of culture is promoted which can lead to a view of culture as fixed and unchanging. Such a view risks masking broader dimensions of behaviour and experience in any given situation. Both Atkinson (1999) and Allan (1989) argue for a reorienting of culture away from an anthropological positioning to a more relational and subjective framework. Atkinson, in the context of language learning teaching English for speakers of other languages (TESOL) appropriately suggests that standard notions of culture are being replaced by “alternative or non standard views of culture” (p.626). A received view in this context refers to a perception of cultures as being located geographically and forming distinct identities with relatively unchanging and homogenous, all-encompassing systems of rules that substantially determine human behaviour. A non-standard concept of culture for Atkinson considers postmodernist concepts arising from a critique of a more traditional view of culture. He cites common postmodern interpretations, for example, as identity, essentialism, power, difference, discourse, resistance, and contestation. These are not exclusively postmodern concepts as they can also be interpreted within constructivist and symbolic interactionist frameworks of culture and identity.

Atkinson (1999) examines concepts and categories of culture in a postmodern context. Allan (1989) provides a critique of postmodern notions and the structure of culture. He acknowledges that structures of culture are important and uses the term to emphasise culture as a “symbolic reference system whereby humans manufacture and reproduce a meaningful real world in action and interaction” (p.4). He asserts that this definition “stresses human agency in the creation of meaning” (p.4). According to Allan, structural aspects of culture, which include signs and symbols such as language ideas, topics, norms, values, beliefs and art are cultural artefacts, do not on their own produce meaning. Rather “humans produce meaning in concert with the cultural system” (p.4). Allan identifies the structure of culture as a resource and a constraint for social action in that it stabilises meaning, delivers social encounters which are repeatable and

predictable across time and space. Cultural safety provides a framework to aid understanding of meaning a person makes of their experiences of health care and in the context of their culture.

Allan (1998) claims that focusing on cultural structures alone does not take account of the affect meaning function of culture which constructs cultural reality. There are two key elements to Allan's assertions. One is that human reality derives from a cultural reality and that the reality must be felt to be real. Secondly, worlds are subjectively ordered and experienced by an individual through culture and in context. This means that any sense meaning aspect of culture is not necessarily created through language but through social processes that emerge from repeated interactions. In short Allan's proposition regarding the function of culture is to socially render experience subjectively meaningful to create sense and meaning. In this context culture is positioned subjectively as well as structurally, with the subjectivist structure being more sociological and dynamic than the structural tool. In cultural safety both the structural and the sense-meaning functions of culture work in concert and it is important therefore that this study takes both into account. Cultural safety involves working within specific macro-cultural structures, as defined by Allan, as well as working with the micro elements of culture whereby meaning is produced in interaction with others.

The introduction of culture into a humanist structure of nursing created cultural safety as a site of struggle. Jacob, Holmes and Buus (2008) in discussing humanism in the context of forensic care argue that while offering a sense of hope and optimism in the delivery of care, nevertheless fails to acknowledge power relationships between the nurse and the day-to-day reality of the client in a forensic setting. They note that while nursing is informed by other discourses such as critical theory, the humanist discourse dominates. Perron, Fluet and Holmes (2005) observe that a critical perspective can be a threat to humanism because of its focus on deconstructing major concepts that have guided nursing practice and literature. Plummer (2001) offers a middle ground between humanism and critical theory by arguing for a critical humanist approach to research and life story methodology. He proposes a path through which key elements of both can be rendered into a new paradigm for thinking and action. This new approach may also offer a way forward to guide a rethinking of cultural safety. In building a case for a critical humanist approach to research and life story methodology, Plummer provides a critical analysis of the rejection of humanism by postmodernist, post structural and critical theorists, for example, Giroux (1983) and Foucault (1980). Instead, Plummer positions human beings as embodied, emotional, interactive beings striving for meaning in a wider historically specific social world. He rejects notions of the humanist subject as being the solitary unencumbered self and a simple

self-actualising individual. For Plummer, a critical humanism embraces both critical and humanist elements of being by interrogating notions of *self*, *person*, *agent*, *subject* and *personhood*. Plummer suggests that while post modernism provides a critique of traditional notions of what it means to be human, he rejects Foucault's (1980) notion that human subjectivities are constituted through discourses of power/knowledge. This he says excludes wider interpretations of humanism and is a narrow interpretation of the individual agent as a "powerful, actualising and autonomous force in the world" (p. 57).

Plummer (2001) suggests that to be understood, human beings cannot be taken out of context of the time and space of which they are always a part. He asserts that the human being is "stuffed full of culture" as well as being part of their historical moments. This history and culture are always in process and always changing. Human beings "nest in a universe of contexts" and it is these qualities which diminish the power of the concept of "the universal man" (p. 262). He calls for a critical humanism which provides a relational or middle way to ameliorate the excesses of the narrow concept of humanism and the extremes of postmodernist thought. This means an approach to sociology which accommodates different voices and different models in response to people and their different needs in different contexts. Similarly cultural safety calls for a new way to accommodate different voices in response to different needs in diverse contexts.

3.10 Power and difference in cultural safety

Central to the notion of cultural safety is the way power and difference are played out in the context of the nurse-person relationship. While there are many interpretations of power and difference, this research draws on ideas of power as described by Pierre Bourdieu (1972, 1984, 1990a, 1990b, 1998) and Bourdieu and Wacqaunt (2005) and difference in the context of identity using Somers' (1994) conceptualisations of identity and narrativity. These theorists will be more fully explained in chapter four. Prior to cultural safety, power in nursing was more or less invisible in considering how aspects of social identity, skin colour, ethnicity, sexuality, gender, class or any differentiating social characteristic influenced health care. If power in nursing was made visible it was mostly in relation to professional power differentials between nurse and doctors (linked to gender) and not so much between the nurse and the person receiving care. Kenny (2004) suggests that social and cultural aspects of difference are screened away from political and moral consideration by liberal arguments built on individualist and universality premises. Kenny argues that being in a group whose culture is reviled and devalued is to be prone to a kind of moral harm. To make effective repairs to damaged identities requires that the

internal self-dislocation generated by maligning intersubjective relations be overcome. The despised group must be revalued and publicly acknowledged as a legitimate presence within the body politic.

Bourdieu's concept of power resonates with cultural safety as his notion of power is made more explicit in the context of relation, the individual and institutional structures. Bourdieu's analysis of power is articulated through his concepts of field, *habitus*, and capital. Bourdieu's concept of field can be defined as a network of objective relations between positions. These objective relations are acted out in a cultural field. Drawing on Bourdieu's ideas Webb, Schirato and Danaher (2002) suggest that within this field:

power operates as a meta field or macro-concept to describe the way individuals and institutions in dominant fields relate to one another and the whole social field. The field of power operates as a configuration of economic, cultural and symbolic capital that shapes relations and practices in the field. (p. 12)

The work of Bourdieu is of particular relevance for this research as his ideas about power were influenced by his experiences of working with marginalised populations in Algeria in the 1960s.

Within nursing education, an understanding of power and difference, that draws upon critical theory, aims to ensure that graduates will be able to provide care and health services which the recipient of that care or service identifies as culturally safe (Wood & Schwass, 1993). In its present form, cultural safety includes all people, but has special significance for people who have the potential to be marginalised by the health care system on the basis of their culture, ethnicity, sexuality, gender or ability (Nursing Council of New Zealand, 2005/2009).

The literature demonstrates that nursing is shaped and defined through different philosophical lenses and that one lens on its own is inadequate for explaining the purpose and function of nursing or describing cultural safety. Cultural safety represents a platform for rethinking and defining nursing and offers new ways for nursing to find new stories about working with difference.

3.11 Evaluation of the literature

The literature in chapters two and three was organised into two main categories: debates among local Aotearoa New Zealand scholars were considered in the previous chapter, and a small

selection of international literature was evaluated in this chapter. Together these chapters demonstrate problems associated with incorporating a framework originating from an indigenous, bicultural worldview into international multicultural research and practice contexts. Overall, the local literature conveyed the view that cultural safety was concerned with difference, power and attitudes of the nurse. Historical understandings of cultural safety within Aotearoa New Zealand have been mirrored by international interpretations of cultural safety which have tended to over-emphasise its origins within arguments about nursing across ethnic difference. This has meant that cultural safety has tended to be viewed, and dismissed, as a uniquely Aotearoa New Zealand version of cultural competency that has little relevance elsewhere. In a body of literature dominated by North American nursing theorists, proponents of cultural safety in this country have struggled to articulate a crucial point of difference - that cultural safety education is fundamentally about developing in nursing students a critical analysis of the way in which power operates within all nurse-patient relationships. A stated outcome of culturally safe care is that the recipient of care determines safety. However, I could not find any literature which addresses this specifically apart from examples used in unpublished graduate research reports.

The use of cultural competencies as an evaluative tool for delivering culturally appropriate care is gaining ground within health care disciplines internationally and is being written into codes of practice within this country. This trend serves only to further complicate an already confused landscape of cultural safety. It is apparent from this review that cultural safety is still not clearly understood and that it is open to being interpreted within ethnic and racial contexts, even though it is acknowledged as not being about ethnicity or race but about power. I conclude that as long as cultural safety continues to be interpreted, misinterpreted, reinterpreted and aligned with concepts of ethnicity, race and culture, it risks being disregarded and/or becoming an apolitical concept. With the emphasis on cultural competencies in Aotearoa New Zealand health legislation, cultural safety risks being viewed as a *cultural endeavour* rather than as a relational endeavour. This is because, for the dominant group, the focus on ethnicity is less problematic as it does not require self-examination, especially in relation to power and attitude. If the political intent of cultural safety is lost then nurses risk perpetuating the values, attitudes, stereotypes, marginalizing behaviours and power relationships that cultural safety is designed to critique and disestablish.

Cultural safety has the potential to open up new possibilities for the delivery of health care to all people without overlooking the priority for improving health care for Māori. The meanings of cultural safety need to be made explicit in the context of its defined purpose and new ways of

reframing cultural safety within a pragmatic network of relationships established. The relevance of this review to the research question is that it has set out the terrain of cultural safety literature over the past two decades. It provides a backdrop for exploring issues relating to the application and delivery of culturally safe care in everyday nursing practice. This narrative study of how nurses learn about and apply cultural safety knowledge in everyday practice will help to articulate dimensions of culturally safe nursing practice within an Aotearoa New Zealand context that move beyond a narrow race and ethnicity-based interpretation of cultural safety. In order to do this the research will explore cultural safety in the context of the social milieu of the nurse and in relation to the wider structural fields in which health care takes place.

Chapter four: Theoretical underpinnings, methodology and method

4. Introduction

This chapter examines the philosophical and methodological underpinnings of the study, the methodological approach and methods selected to carry out the research. The chapter begins by linking a culture of storytelling within nursing to a justification of the decision to use narrative methodology within the thesis. Following this I outline the aims of the research and consider epistemological dimensions guiding the abductive approach to the gathering and analysis of interview material for this project. The theories of Bourdieu (1972, 1984, 1990a, 1990b, 1998) and Bourdieu and Wacquant (2005) on *habitus*, capital and field, and Somers' (1994) work on relational narrativity, are outlined in order to draw out the theoretical relevance of these authors for this research project. The chapter then provides an overview of the method and design of the study, explaining how narrative approaches to research guide data collection, the identification of themes and analysis of interview material within the substantive chapters of the thesis. The chapter discusses ethical concerns associated with this research and concludes with a discussion about the credibility of the study.

4.1 Situating the methodology: Nursing and narrative research

I chose a narrative approach as an appropriate methodology because nursing tends to have a storytelling culture. This way of doing research was reinforced by one of the participants who commented that the need for nurses to “catch and carry people’s stories” was an important part of nursing work. Storytelling is inherent within any nursing situation and stories about nursing practice are shared by nurses in their everyday conversations. Frank (2006), a health researcher, suggests that new stories about health are always calling for new and revised practices. He asserts that people know themselves and each other by and through their practices and they know their practices through stories. As health needs new stories so too does cultural safety need new stories which will advance understanding of the concept in the twenty-first century. One of the ways knowledge is anchored and internalised as nursing knowledge is through repeating the familiar and telling new stories. Rashette (2005) notes that stories may remind us of the power of presence and support in times of grief, or draw attention to the need to challenge an unjust or unfair system.

The process of relating stories in nursing contributes to the production of many narratives of nursing practice and this process makes nursing visible and meaningful, not only to the teller but also to the listener of the story. Frank (1995) notes that storytelling is as much for an *other* as it is for oneself. Nurses use stories to find meaning at times when interaction has been particularly difficult, or where identities are called into question, where telling a story may help explain and understand difficulties and achievements over time. Le Guin (1989) suggests a story is “a means, a way of living, it asserts, affirms, participates in directional time, time experienced and time as meaningful” (p. 39). Narrative, Le Guin claims, is the language used to connect events in time which moves a story through time. Therefore, a narrative methodology has been selected as appropriate in this study because the qualities and characteristics of narrative resonate with the way nurses experience the reality of everyday nursing and bring these experiences to the attention of another person. In this research, narrative provides a way for bringing stories to text for analysis and offers the storyteller a space in which to find meaning or understanding in their experience, and for the researcher to hear about the experience of the narrator.

Holloway and Freshwater (2007) refer to narrative inquiry as being concerned with people’s lives. It examines the ways in *which* “individuals and cultural members construct their world. It is person centred and linked to autobiography, subjectivity, reflexivity and power” (p. 15). Cultural safety can also be linked to notions of subjectivity, reflexivity and power, therefore I believe there is a right or natural fit between a narrative methodology and cultural safety as both use stories as a way of making sense of the social world and what is happening in it. There is never only one kind of story of cultural safety; this research will present different stories in order to provide further understanding about how cultural safety is communicated within nursing practice in a range of health care settings.

4.2 Aims of the research

The aims of this research were to:

- Enable participants to reflect on how their personal background and positioning influenced their initial responses to cultural safety education;
- Explore how participants experienced and interpreted cultural safety education;
- Explore how the practice environment reinforced, reframed or modified what participants learnt and how they practiced as a result;

- Understand how cultural safety currently informs participants' personal and professional identities.

By researching how registered nurses apply cultural safety knowledge in their nursing practice, I wanted to provide an analytical explanation of how cultural safety knowledge is transferred from education into practice. The thesis provides an exploration of how registered nurses experience the application of cultural safety within their current health care settings and the ways in which cultural safety informs the construction of personal and professional identities. An understanding of how settings and identities impact on practice will provide new insights from which an analytic reading of cultural safety in nursing practice can be made. I argue it is time for a rethinking of cultural safety within the context of present day nursing education and practice as discussed in chapter one. To deliver culturally safe health care there needs to be a fuller appreciation of the meanings nurses attach to the concept as well a more nuanced understanding of the contexts within which culturally safe nursing happens. This research will contribute to expanding this knowledge base by identifying the issues raised when participants translate their personal understanding of cultural safety into practice settings which differ remarkably in the degree to which they value such practices.

As discussed in chapter two, nursing knowledge has traditionally been structured in relation to nurse, health/illness, person, environment and relationship and this has been used to characterise the discipline. Cultural safety adds the dimension of power, identity and critical reflection to the New Zealand vocabulary of nursing. Since the positioning of cultural safety in nursing education, the boundaries between education and practice have been blurred. Very little is known about the application of cultural safety knowledge in everyday nursing practice and, as already established, the concept is open to multiple interpretations depending on the position of the interpreter. The setting within which health care takes place also determines the way cultural safety is enacted in the context of traditional knowledge structures within nursing. To find out more about how registered nurses applied the concept in practice, I wanted a method of gathering data which would give me first person interpretations and which was in keeping with the experience of the participants, therefore a qualitative approach was chosen. In selecting narrative methodology for this research there needed to be a consistency of ideas between the nature of nursing, the nature of cultural safety within nursing and the structure of the research process; these synergies are outlined in the following section of the chapter.

4.3 Narrative inquiry

In this thesis I wanted to expand the ontological, public and cultural narratives of cultural safety by providing the opportunity for registered nurses to tell stories about their experience of learning and applying cultural safety in their own practice. The use of a narrative approach in this study provides a way for repositioning conventionally received notions of cultural safety from a single terrain, based upon the structural positions relating to sex or ethnicity that actors happen to occupy, to one that addresses the positioning of the nurse in the context of identity and in relationship with a patient or client within different practice fields. The next section of this thesis explains the genealogy of narrative, and the theoretical ideas that inform my approach to narrative methodology.

A common theme in narrative literature is that there is no consensus about what narrative is, or how narrative research might be undertaken. Narrative provides an alternative to the study of human action by observation and measurement through utilising an interpretive approach involving storytelling methodology. In narrative, the story becomes the object of the study, focusing on how people make sense of their lives (Cortazzi, 2001; Mitchell & Egudo, 2003; Polkinghorne, 1988; Riessman, 1993). Riessman (1993) notes that narrative does not fit into any clear-cut boundaries of a single scholarly field. Elliott (2006) and Polkinghorne (1998) consider that narratives are basic and universal modes of human experience, while Labov and Waletzky (1997) view narratives as oral versions of personal experience. Somers (1994) argues that people's lives are storied and it is through stories that actions are guided and communities of interest are created. Somers asserts that experience is constituted through narrative as people make sense of events by attempting to integrate action within one or more narratives. She claims that experience is constituted through narrative. Somers' arguments about relational narrativity provide for a shift away from largely representational forms of identity as laid out in identity politics to an ontological narrativity (Somers, 1994) which focuses on action and identity in relation to time, selves and settings (Phibbs, 2007). Somers' ideas will be further discussed later in this chapter.

Narrative inquiry, as research methodology, arises from the interdisciplinary work of qualitative researchers (Bruner, 1990; Clanindin & Connelly, 2000; Polkinghorne, 1988; Ricoeur, 1981, Riessman, 1993). The importance of narratives/storying is gaining recognition in nursing as a way for patients to make meaning of their illness, or for nurses to illuminate the experience of

nursing practice (Fitzpatrick, 1997; McCance, McKenna & Boore, 2001). Denzin and Lincoln (2005) provide a very straightforward description of the characteristics of narrative:

A narrative is a story that tells a sequence of events that are significant for the narrator and his or her audience. A narrative as a story has a plot, a beginning and an end. It has an internal logic that makes sense to the narrator. Every narrative describes a sequence of events that have happened. (p. 37)

An important point to note is that some theorists use story and narrative interchangeably. Polkinghorne (1988) makes no distinction between the two, while Scholes (1981) views narration as involving a sequence of events which have a degree of continuity of subject matter which supports a process of being told. Cortazzi (2001) and Polkinghorne (1988) consider narrative to be the primary form from which human experience is made meaningful. Drawing on the works of Robinson and Hawpe (1986) and Riessman (1993), Rice and Ezzy (2004) note that a narrative is a story with a series of logical and chronologically related events that are caused or experienced by actors. Narrative interviewing draws out data over which a research framework may be laid (Holloway & Freshwater, 2007). Mishler (1986) and Riessman (1993) note that through the process of narrating stories, people attempt to make sense of the world and of themselves. Riessman further observes that for the interpretive researcher, the historical truth of an individual's account of an event is not what counts but rather the researcher recognising that the storyteller selects the component of the stories they tell and then reconstructs them in order to convey the meaning they intend the listener to take from the story.

Freedman and Coombs (1996) note that the way people construct their political and social realities manifests through interaction with other people and institutions. Somers (1994) claims that people are guided to act in certain ways and not others based on the projections, expectations and memories derived from multiple, but ultimately limited, repertoires of available public and cultural narratives. Somers' (1994) work struck a note with me in relation to my study because currently there are limited repertoires or narratives of cultural safety in everyday nursing practice. There is still a tendency toward framing the concept within ethnicity or race-based theories of difference and fixed categories of culture and identity, rather than multiple, unstable concepts of culture, difference and identity and the spaces within which care happens. This study attempts to increase repertoires of culturally safe practice from which registered nurses might draw to inform their own practice.

4.4 Abductive research strategy

An abductive approach, which is specific to the social sciences (Blaikie, 2000, 2010), was selected as being a suitable means of investigating cultural safety in nursing education and practice and it may be usefully connected with narrative inquiry through its focus on ontology, action, language and meaning. Blaikie (2000, 2010) identifies abductive research as interpretive, providing “accounts of social life by drawing on the concepts and meanings people use to explain the activities that they are engaged in” (p. 115). Abductive methodology focuses on how individuals interpret, and describe in their own terms, the conditions in which they find and/or locate themselves. In any given situation the subjective interpretations of individual actors are located in common understandings of social life which are negotiated during, and maintained through, ongoing interaction. Blaikie argues that these “meanings and interpretations both facilitate and structure social relationships” (p. 116). Abductive research acknowledges multiple and changing social realities that are constructed through the processes in which actors collectively negotiate meaning and shape action within the context of cultural and institutional constraints. Much of this mutually constructed knowledge is taken-for-granted, becoming salient when social life is disrupted and actors are forced to consciously renegotiate the shared meanings and interpretations that are given to individual actions and/or situations (Blaikie, 2000, 2010).

Abductive research eschews a focus on identifying general themes that cut across the transcripts provided by participants in favour of exploring the specificities of language, meaning and context within individual stories. Unique stories are not treated as outliers, or exceptions; instead the focus is on understanding the world through “*the meanings and interpretations given by the social actors to their actions, other peoples actions, social situations, and natural and humanly created object*” (Blaikie, 2000, p. 115). In an abductive approach to research the researcher attempts to encourage participants to reflect on the processes through which social life becomes predictable, or knowable, by drawing attention to the ways in which different meanings and interpretations are negotiated through ongoing social interaction. The progression from lay descriptions of social life provided by participants to technical descriptions of social life developed by the researcher forms the process of analysis within an abductive methodological approach (Blaikie, 2000). An example of the abductive approach to research and analysis within this thesis is provided in chapter eight where I asked one of the participants to reflect on a time when she felt that she had provided culturally safe care. The lay description provided by the participant, of challenging the use of a large communal pot of tea within a community residential facility which did not take into account individual preferences and needs, was then turned into a

technical description of social life through the application of Bourdieu's theoretical ideas about *doxa* and field.

4.5 Social constructivism

Abductive research regards social reality as constructed through the processes in which meanings and actions are negotiated by actors. This thesis is based on social constructivism as described by Guba and Lincoln (1989). A constructivist paradigm rests on its claims that there is not one single truth but rather socially constructed realities. Philosophically, social constructivism or naturalistic inquiry draws on a basic belief system or worldview which guides the investigator, not only in choices of method but in also in ontologically and epistemologically fundamental ways (Guba & Lincoln, 1989). A constructivist approach implies that research is not value free and that knowledge is constructed by the interaction between the researcher and the researched.

Crotty (2004) asserts that in research data there is a connection between the text and the reader. This connection provides a basis for the interpretation that the researcher will make of the text. Crotty notes that "texts are not just antique or foreign curiosities. They are means of transmitting meaning – experience, beliefs values-from one person, or community to another" (p. 50). This research relies on texts to analyse the way registered nurses apply cultural safety in nursing practice. The following sections explain the underpinning theoretical ideas in the study.

4.6 Theoretical orientations

Key organising discourses of cultural safety derive from ideas about power, relationship, identity, difference and reflexivity. These discourses define the mechanics of cultural safety and explain how it works. The ideas of Bourdieu (1972, 1984, 1990a, 1990b, 1998) and Somers (1994) which focus on relational identities, power and reflexivity, resonate with the key organising themes within cultural safety discourses, and together their theories have structured my research field and the process of data gathering and analysis. Other theorists have also been used strategically throughout the thesis to address specific aspects of data analysis, for example, Davies and Rom Harré (1990) in chapter six, Frank (2004, 2006) in chapter five, as well as key nursing theorists and nurse researchers (see chapters two and three).

The ideas of Somers and Bourdieu were attractive as a framework for analysis in this study as both attempt to collapse boundaries between subject and object or actor and agency by

considering the way social reality operates within relationships. Both Bourdieu and Somers make key contributions to social theory in this regard. Bourdieu offers a reconfiguration of sociological thought through attention to the way networks of relations operate within different organisational fields. Central to Somers' thesis is her linking of narrative and identity in order to eschew essentialism and bridge sociological boundaries between agency, structure and experience (1994). The theories of Bourdieu and Somers are outlined in the following sections of the thesis.

4.7 Bourdieu, habitus and field

Wacquant notes that Bourdieu's concepts of *habitus* and field allows Bourdieu to separate an analyses of the individual or microanalysis and structure or macroanalysis. (Bourdieu & Wacquant, 2005, p. 23). Bourdieu also rejects concepts of submission and resistance which he claims have traditionally been used to structure the shape of dominated cultures; this, suggests Bourdieu, prevents us from adequately understanding practice and situations that are defined by an "intrinsically double skewed nature" (p. 23). Bourdieu asks, for example, that if a person is to resist and can only make a claim of resistance by claiming the characteristics that mark them as dominated, such as colour and culture, is this resistance? If however a person "works to efface everything that is likely to reveal their origins, or help a person advance a social position, should that then speak of submission" (Bourdieu & Wacquant, 2005, p. 23). Similarly in cultural safety, if a nurse asserts the need to provide culturally safe care, and the field in which she works does not support the concept, she risks alienation from the group for resisting or challenging the rules of the field. If on the other hand, she remains silent or is constrained from acting, she risks personal or professional discomfort related to not being able to nurse in a culturally safe way. Being positioned as either resisting or submitting to the dominant discourses at work in the field makes her either complicit in perpetuating culturally unsafe practices or as resisting the dominant practices operating within the field of health care. Instead Bourdieu suggests that dynamics related to submission and resistance have the potential to constantly shift and change depending upon the resources that are available to actors and the relational practices that operate within a particular field. In nursing work modifications in the dynamics of the field may occur rapidly through changes of shift, staff or patients.

Bourdieu rejects the idea that there is an over-arching concept called society and instead replaces it with concepts of field and social space (Bourdieu & Wacquant, 2005). Field and social space

(*habitus*) are two methodological devices used by Bourdieu to collapse boundaries between subject and object by designating them as *bundles of relations*:

A field consists of a set of objective, historical relations between positions anchored in certain forms of power, or capital. *Habitus* consists of a set of historical relations deposited within individual bodies in the form of mental and corporeal schemata of perception, appreciation, action. (p.16)

According to Bourdieu *habitus* and field are relational in that they function only in relation to one another. Bourdieu argues that a field represents a space of play which exists only to the extent that players who enter into it, and who believe in it, actively pursue the prizes it offers (Bourdieu & Wacquant, 2005). Bourdieu and Wacquant claim therefore that a theory of field requires a theory of social agents and vice versa, a theory of *habitus* is incomplete without a consideration of social structure.

Capital is a mechanism operating within fields of practice consisting of assets which can be available for the production of wealth (Harker, 1990) or, in this research, the production of discourses and health care practices. Capital may be cultural, social, economic or symbolic; the first three forms may be identified respectively as competencies and skills, interpersonal networks and material assets. Symbolic capital refers to honour, prestige and power and includes the meanings, values and types of social recognition attached to each form of capital within a particular field. When a person comes into contact with a field, struggles over the forms of capital that operate within that field may occur, intensifying when the value associated with one form of capital is questioned and in circumstances where the established equilibrium or structure responsible for the reproduction of power is threatened (Bourdieu, 1998). *Habitus* works in conjunction with capital and field to create relational practice. *Habitus* may be referred to as the socially made body (Phibbs, 2007) and is a system of dispositions, or lasting acquired schemas of perception, thought and action which operate within individuals. Dispositions are developed in response to the objective conditions encountered within the field and it is the *inculcation* of objective structures into the subjective experience of a person that blurs boundaries between structure and agency (Bourdieu & Wacquant, 2005).

Bourdieu argues that a field prescribes its own particular value, holding its own regulative principles or values. The principles define and regulate socially structured spaces where people struggle, depending on the position they occupy in that space, either to change or to preserve its boundaries or form (Bourdieu & Wacquant, 2005). A field is simultaneously a space of conflict

and competition in which participants compete to establish monopoly over the different kinds of capital at work in the field (Bourdieu & Wacquant, 2005). For example medicine holds greater cultural capital than does nursing, with health administrators generally holding a greater economic capital than medicine and with patients have varying degrees of capital which can be used depending on the kind of health service they are using.

In health care the *habitus* of a nurse, a patient and other health professionals disposes such participants to disciplinary and social activities and perspectives which inform the cultural and historic values of their respective fields, or, in the case of the patient, the cultural, social, individual and historic values shaping their identities. The *habitus* of each actor expresses how they become who they are, how they position themselves and are positioned by others within fields of power relations. Such a conceptualisation of fields of power and *habitus* shifts a focus away from an individualist/structuralist division and opens up new possibilities for relating and examining the way cultural safety works in nursing practice. The next section focuses on the work of Margaret Somers.

4.8 Somers and relational narrativity

Cultural safety is a complex subject for nurses to understand and encompass in their work. While they may begin their nursing practice with a theoretical knowledge of the concept, applying this knowledge is mediated by a number of organisational and institutional relationships which support or constrain actions when delivering culturally safe care. By utilising the notion of relational narrativity, as described by Somers (1994), I am provided with an analytical tool to explore the way registered nurses integrate cultural safety into their nursing practice.

Somers (1994) suggests that studies of identity formation have made major contributions to an understanding of social agency but also identifies some notions of identity formation, for example essentialist categories of identity, as problematic. This she says “tends to conflate identities with what can often slide into fixed essentialist, pre-political, singular categories such as race, gender, sex” (p. 606). She acknowledges that essentialist notions of identity are useful in restoring the identities of previously marginalised others but observes that a single category of identity may be only one of a number of narratives that people use to define or locate themselves. Somers argues that *rigidifying* aspects of identity risks the creation of misleading identity categories, arguing instead for incorporating into the core conception of identity the destabilising dimensions of time, space and relationality. This she suggests can be realised by bringing to the

study of identity formation the epistemological and ontological challenges of a relational narrative analysis.

Somers (1994) asserts that experience is constituted through narrative, helping people make sense of their lives by attempting to integrate what is happening within one or more narratives. According to Somers “people are guided to act in certain ways, and not others, on the basis of projections, expectations and memories derived from a multiplicity but ultimately limited repertoire of available social, public and social narratives” (p. 614).

This study seeks to elicit narratives which make concepts of cultural safety available for analysis, identifying the ways in which participants negotiate and mediate the influence of social and public narratives in their personal lives and professional culturally safe nursing practice. Somers argues that narrativity is not simply epistemological, a way of knowing the world, but also an ontological condition of social life; a way of being in the world. The next section will examine these epistemological dimensions of the research.

Somers (1994) holds that identity formation can be reconfigured through narrative. She asserts that narrative identity is concerned with epistemology and social ontology as it is through narrative and narrativity that we constitute our social identity. She says that, “all of us come to be who we are by locating ourselves and being located in social narratives rarely of our own making” (p. 606). Central to Somers’ notion of narrative identity is her thesis that “narrativity and relationality are conditions of social being, social consciousness, social action, institutions, structures and society” (1994, p. 621). She claims that:

The self and the purposes of self are constructed and reconstructed in the context of internal and external relations of time, space and power that are constantly in flux. That social identities are constituted through narrativity, social action is guided by narrativity, and social processes and interactions, both institutional and interpersonal- are narratively mediated provides a way of understanding the recursive presence of particular identities that are nonetheless not universal (p.621).

Somers (1994) claims four dimensions of a reframed narrativity and these dimensions - ontological, public, meta and conceptual - contributed to the analysis of the transcripts within the thesis. Ontological narratives are the stories that actors use to make sense of, and to act within, their lives. Drawing upon Somers’ (1994) concept of ontological narrativity, Phibbs (2007) argues that:

The ontological dimensions of narrativity bring certain people into being, they shape identities and selves; narrative identities structure choices and activities. Story-actions in turn produce new narratives and hence new identities, politics and communities...Identities are crafted, modified and abandoned, and particular courses of action followed, according to how people are located by and locate themselves, however temporarily, in a range of given narratives. Narrative identities are never complete; they are always in the process of being formed. In this sense they embed identities in an ever unfolding flow of temporally and spatially specific social relationships. (Phibbs, p. 48)

This positions narrative and ontology in relationship as both follow a process that is mutually constitutive. A narrative location provides social actors with identities. At this level narratives are social and interpersonal.

Personal narratives are defined in relation to the broader public narratives that circulate in certain contexts (Phibbs, 2007). Public narratives are the shared social narratives, or cultural stereotypes, that are embedded in collective understandings of the social world. Public narratives are attached to institutional formations that are larger than the individual and may include narratives of family, workplace or government. Public narratives are not neutral; some narratives carry more weight than others implicitly shaping understandings of the world through prioritising one meaning over another. Public narratives, as shared social scripts, are legitimated through the ahistorical and decontextualised field of meta-narrativity (Phibbs, 2007; Somers, 1994).

Meta-narratives are narratives that embed contemporary social actors in “history and social science” (Somers, 1994, p.661). These narratives include theories and concepts that are encoded within master narratives and may be epic as in capitalism versus communism, individual versus society or, in this research, competing paradigms of thought, humanism versus critical theory.

Conceptual narrativity is recognised as those concepts and explanations that are constructed by the social researcher. In this study important concepts relevant to the notion of conceptual narrativity include, cultural safety, identity, power, *habitus*, field, relationships and settings. Somers (1994) claims that within a conceptual narrativity lies the challenge to create a vocabulary that can be used to construct and plot over time and space, ontological narratives and relationships of historical actors, the public and cultural narratives that inform their lives, as well as the crucial intersection of these narratives with other relevant social forces.

Somers’ work helped me guide the structure and flow of the interview process. The interview brought forth stories positioning the participant with a specific time period and identified their

relationship to cultural safety through stories of learning about cultural safety and the meanings that cultural safety had for them. Public narratives were identified when they shared stories of how they applied cultural safety in everyday nursing practice. These stories illustrated how their relationships with clients, themselves and the institution were played out in everyday encounters.

Finally a conceptual narrativity approach provided a structure for me to construct a new understanding of cultural safety, moving the concept beyond historical binary relationships and fixed notions of identity, to a formulation of cultural safety embedded within nursing relationships built on narrative co-construction of identity and *habitus* within fields of power, influence and interests. Narrative methodology, like cultural safety, focuses on aspects of self in relationship. The interview method used for data collection is explained and ethical considerations arising from this process identified. The process of analysis will be described and issues arising addressed.

4.9 Research design

This thesis is informed by a constructivist/interpretive ontology which assumes that it is impossible to separate the inquirer from the inquired (Guba & Lincoln, 1989) and that the researcher and the participant are interlocked in an interactive process in which one influences the other (Mertens,1998). Based on this understanding, the goal of the research design was to collect rich data about how registered nurses apply cultural safety knowledge in their everyday nursing practice. The research focuses on narrative constructions of identity to provide a structure by which sense can be made of the way cultural safety knowledge is applied in everyday nursing practice.

4.10 Interview as method

Prior to undertaking this study I considered an action research approach which focused upon changing practice. However as my reading of the literature deepened, I concluded this approach was premature. I needed to know more about the individual experience of the nurse in applying cultural safety in nursing practice before a focus on groups and change could be attempted.

From my experience as a teacher of cultural safety I was aware of the potential for students to repeat what can be seen as the rhetoric of cultural safety; *treat each person with respect regardless of difference* or *culturally safe care is determined by the recipient of care*. These statements can

sometime be espoused with very little practical understanding of what this may mean. I wanted to hear stories about cultural safety from different perspectives and interpretations. I decided that the best method for achieving these goals would be a semi-structured, face-to-face interview. Drawing on Ricoeur's (1981) concepts of actor agency I constructed an interview schedule loosely based on the 'what', 'why', 'who', 'how', 'with whom' and 'against whom' to provide a framework which would focus attention on the participant in interaction with their environment. The structure of the interview provided an element of control and order for the participant as well as the flexibility that enabled them to develop their own stories without interruption from the interviewer (appendix 2).

Mishler (1986), a classic theorist in interview theory, observes that the interview is jointly constructed between the interviewer and respondent and that the aim of the interviewer should be "to stimulate the interviewee's interpretive capacity" and the "role of the researcher is to activate narrative production" (p. 54). Thus within the interviewing process the dual roles of stimulator and activator are required to gather information. Mishler cautions researchers not to act on their potential to train "storytellers to suppress data generation or storytelling by limiting answers to short statements or by interrupting narratives as they occur" (p.54) as this distorts or inhibits the flow of the story development. As the researcher I needed to be mindful of three things. Firstly, I needed to be an interviewer who would create a space for the person to want to respond to questions. Secondly, I needed to resist premature narrative interpretation by offering my interpretation of what the participant might be meaning since interpreting is different from reflecting back understanding. Thirdly, I needed to be reflexive and alert to any action or intervention interrupting the participant's flow of telling.

Another factor I had to consider when choosing a semi-structured interview was the nature of the power relationship inherent in the research relationship between the participant and myself. Clanindin and Connelly (2000), Elliott (2006) and, Holloway and Freshwater (2007) address power imbalances with the narrative inquiry process. Power is an issue because the researcher has control over the questions, the beginnings and endings of the interview. The narrative interview is most productive when, according to Holloway and Freshwater (2007), the interviewer suppresses her desire to speak. By doing this the storyteller can deepen their story and have ownership of the story by creating a space where the storyteller can hear herself tell the story. In this way, the power imbalance may be lessened.

In narrative research the way questions are asked, as well as under what conditions the interview takes place, shapes the interview and influences the way a person responds (Clanindin & Connelly, 2000). Holloway and Freshwater (2007) note that narrative researchers cannot simply go into the research situation and say “tell me a story about...”. The researcher has to establish a rapport and address any concerns arising about the research prior to the interview beginning. They state that the “data collection method for stories and narrative interviewing is well planned, well prepared, and is flexible enough to focus on multiple issues as they arise” (2007, p. 76).

In this research, I wanted to provide a space where voice could be given to stories of learning about cultural safety and applying it within everyday nursing work. I wanted to elicit episodic stories as well as longitudinal stories about cultural safety in nursing practice. In telling stories of cultural safety, the participants were also telling me stories of their personal lives and their own disposition toward culture safety and toward the actors in their stories.

4.11 Ethical considerations arising from the research

One criterion for inclusion in this research was that participants had undertaken a cultural safety education programme within a technical institute or university. Following the placement of an advertisement in the Kai Tiaki Nursing New Zealand I received a reply from one nurse who had not been through a programme but was keen to take part. I discussed this with my supervisor, and as it was not considered a case for major alteration to the original ethics proposal, I went ahead and interviewed her. One other participant fitted this profile and I interviewed her using the same rationale as the previous participant. Interviewing these participants added an unforeseen dimension to the study as they brought another perspective which illustrated the experience of cultural safety outside a formal educational process.

Another ethical issue was returning original transcripts to the participants (appendix 3). I returned the transcripts after completion of the data analysis with my interpretations and original transcripts so that participants could consider my interpreted story in the context of their transcripts if they so wished. The transcripts were not returned at the point following transcription because I wanted them to have the transcripts with them when they read my interpretations of their stories. Had I returned them earlier, the original transcripts may not have been readily available for the participants to refer to when reading my interpretations of their stories.

4.12 The process of ethics approval and participant selection

The research proposal was submitted to the Massey University Ethics Committee in 2003 (appendix 4). My intention was to enrol participants from different agencies to elicit a range of views about cultural safety practice. This would include agencies where cultural safety was an integral part of everyday practice and related to Te Tiriti o Waitangi. I speculated that this would be more likely in areas where there was a high Māori population. I also wanted to draw in participants from agencies where cultural safety was incorporated into the policies of the organisation but might not be supported in everyday practice.

The process of informing people about the research, and subsequent participant recruitment, became lengthy and drawn out. Each District Health Board had to review the proposal and the Regional Ethics Committee had to collate each District Health Board's findings, passing them onto me for alterations or additional information. This took several months. Although the regional national guidelines for gaining ethical approval had been modified to make it more efficient, in reality each District Health Board had its local regional committee who wanted to review my proposal. Even though I had received approval from the Central Ethics Health Committee, when I came to send out information to the Directors of Nursing, some local ethics committees had changed their membership and requested that my proposal be submitted to them again. I chose not to continue with this process with one District Health Board as too much time had passed and to repeat the process again was too onerous and time consuming.

Of those District Health Boards who did accept my proposal, a letter was sent to the Directors of Nursing outlining the purpose of the study (appendix 5). It was accompanied by several flyers advertising that I was seeking participants (appendix 6). The Directors of Nursing were asked to distribute them in places where registered nurses would have access to them. I emphasised the need for anonymity because of the sensitivity associated with cultural safety.

I received three responses from District Health Boards; two accepted my proposal and one declined. A colleague working at a hospital known to me undertook to distribute advertisements in her work place. I was careful to explain that she was to distribute them and she could talk about the research but could not enlist participants. She distributed this advertisement to a number of wards as well as wards at a hospital within the same area. From this I received nine expressions of interest. My original goal was to talk with nurses across a number of geographical areas and interview a number of nurses who would give me a range of experiences until I reached

saturation point. Although I had no set number, I estimated that I would talk with about 18 nurses in an initial interview with the possibility of a follow-up interview to clarify any areas that needed further explanation. Having recruited nine participants from one geographical area, I reviewed my recruitment process. I was in two minds as to which way to go. One way meant that I could work with the participants I had and do a follow up interview with each one to elicit further narrative experiences based upon responses to themes identified within the transcripts of the first interviews. Alternatively, I could advertise in Kai-Tiaki Nursing New Zealand to cover a greater area to fulfil my objective of obtaining diversity across geographical areas and practice settings. Following consultation with my supervisor I advertised in Kai-Tiaki Nursing New Zealand and I received three expressions of interest from this (appendix 7). In addition I recruited four participants by word of mouth. Friends and colleagues heard about my research and passed the information on to people that they knew. In total I interviewed 16 participants. I made a decision following the first interview not to pursue a second interview because the first interview contained rich data.

4.13 Participant selection

Expressions of interest from registered nurses were received by email or phone. I spoke briefly to each person to see if they met the criteria for participating; that is, being a registered nurse who had undertaken a cultural safety education programme within a Polytechnic or University School of Nursing and who was currently in practice. They also had to be able to communicate in English. Two participants had not undergone a formal cultural safety education programme, however, further discussion with them meant that they would be suitable as participants as they had developed their own understanding of cultural safety gained over years of practice and through working with nursing students. Having been deemed to meet the criteria, all prospective participants were sent an information sheet outlining the details of the research (appendix 8). They were asked to sign a consent form and return it to me if they agreed to participate (see appendix 9). If they chose to have a whānau or support person present, this person was asked to sign a declaration stating that they were there as a support person and agreed to maintaining confidentiality (appendix 10). I then arranged to meet them at a place that was suitable to them for the interview.

4.14 The participants

Sixteen registered nurses, all women, responded to the advertisement. I will refer to the participants sometimes as participants and sometimes as the women who participated in the research. The participants reflected a range of backgrounds related to class, ethnicity and sexuality. They were employed in the following areas: two in general medical/surgical units, one in mainstream Māori community mental health, two in iwi providers of community health services, one in an oncology unit, one in specialised surgical unit, one diabetes nurse educator, one acute crisis mental health service, two aged care, one community mental health service, one youth health service, one forensic rehabilitation service, one practice nurse and one manager. Their ages ranged from mid 20s to 60s and they reported their time in nursing practice as being from one year to 30 years.

In this section the 16 women participants are introduced. Collectively their entry into nursing reflects particular stages in the development of cultural safety in nursing education and its arrival within nursing practice environments. This historical positioning has been a factor in shaping the meaning of cultural safety for each woman and influences how she applies cultural safety knowledge in practice. The narratives identified that nurses who had been in practice for some years and had not been through a cultural safety programme, came to learn about cultural safety through their everyday nursing practice and the accumulation of nursing experiences where they had to learn how to negotiate and mediate difference in an unconscious way. The more recently graduated participants came to nursing practice knowing about cultural safety and with a more conscious and reflective awareness of power and the effect of this on client care.

Janis graduated as nurse in the 1950s long before cultural and notions of difference were considered a factor in the delivery of nursing care. She was of the school where you *nursed people regardless of their culture*, at a time when there was little or no awareness of the relationship between culture, beliefs and attitude of the nurse on the care of the client, and even less on the impact of eighteenth, nineteenth and twentieth century colonising philosophies on the health care of Māori. Elizabeth and Polly underwent hospital-based nursing education programmes in the early 1970s and before the beginning of the transfer of nursing education to tertiary education institutions. Elizabeth had no formal education in cultural safety but had many years of experience working in various hospitals and community health care agencies in New Zealand and other countries. This means that her many years of practice and working with different people enabled her to recognise concepts of cultural safety when she came in contact

with it in the late 1980s early 1990s. In the 1980s, Polly began work as a registered nurse in an emergency department. During this time, she studied toward gaining a Bachelor of Arts degree at University. Exposure to key Māori academics and ideas about power, along with the emerging data about social and health inequalities between Māori and Pākehā, made her more aware of issues of power and difference in levels of health care access. These factors, together with her involvement in the anti racism education, the organised protests against the 1981 South African Springbok rugby tour and her being lesbian, position her as an outsider and therefore different within her nursing community. In the late 1980s she went into teaching nursing and cultural safety.

June underwent a hospital-based general nursing education running parallel to technical institute nursing education in the mid 1970s. She later went on to do her psychiatric nursing registration and Bachelor of Nursing. For her there was little teaching about concepts of difference and she came to her understanding of power and inequality from teaching in a nursing programme in a polytechnic where the curriculum was based on Te Tiriti o Waitangi and values of difference in relationship. These values were embedded within the structure of the organisation as well as in the nursing curriculum. Joy graduated in the mid 1970s, and was an early recipient of nursing education in a polytechnic. Cultural elements in relation to health care were just starting to be brought into the public domain through the political activism of young Māori and Māori academics and she was part of the first group of students who visited a Marae to learn about Māori health in an attempt to enable Pākehā nurses gain an understanding of Māori culture. In the 1980s Joy became a lecturer in nursing and specialised in teaching cultural safety and had recently returned to nursing practice.

Both Sally and Mary graduated in the late 1980s from Polytechnics. This was a time when bicultural concepts were being introduced into nursing education programmes and cultural safety was starting to be talked about. Sally was on the shoulder of bicultural nursing and cultural safety and her early grounding was in bicultural relating in Aotearoa New Zealand. As a new graduate she experienced the full impact of the public, political and social controversy surrounding cultural safety. The cultural content of her nursing programme exposed her to transcultural concepts of caring which preceded biculturalism in Aotearoa New Zealand context, therefore her point of reference is transcultural care and this has shaped her ideas and practice about the concept of culture in nursing. Jill and Kate's formative experience of learning about culture was when they were required to visit a Marae as part of their cultural education. The

purpose of this was to assist students to engage with Māori and to learn about Māori tikanga in the hope that this would help them to provide appropriate care when caring for Māori clients.

By the time Rose graduated in the mid 1990s cultural safety education was firmly situated within a critical theory framework within nursing education and focused on analytical deconstructions of institutional and personal power. The earlier transcultural approaches had been superseded by cultural safety which was now part of the formal curriculum. However the tensions between learning about bicultural practices were often blurred with concepts of transcultural nursing, the North American model. Cultural safety became the driver for education relating to nursing across difference and continues to be so today. As a student Rose, like Sally and Amanda, was exposed to the intense public controversy and animosity toward cultural safety.

Chris and Barbara are older women who graduated in 2003. By now concepts of difference in a broader context were embedded within the curriculum and these concepts became more visible alongside the institutional and personal critiques of power. The ages of Christina, Debbie, Jill, Louise, Patricia, and Ruby range between 30 and 55, and they graduated as registered nurses in 2005. The approach to teaching cultural safety varied across technical institutes and polytechnics. For some of these institutions there was a focus on cultural safety as applying to Māori populations, while for others cultural safety was incorporated into caring and communication aspects of nursing. The controversy of the late 1990s, as explained in chapter two, was not part of the experiences of these women; nevertheless, they are sometimes exposed to the legacy of this historical controversy in their practice as registered nurses. This sometimes put them in conflict with what they were taught about cultural safety and what they experienced in practice in relation to cultural safety in their work setting. Even though they had the consciousness and knowledge about power and its impact on health outcomes, they were, and are, not always in a position to act on their knowledge.

4.15 The interview

Before the interview I sent each participant an outline of the guiding questions, which were designed to be used as prompts to stimulate discussion and conversation. I found that after my first two interviews my style changed. As I became more comfortable with the interview format I made minimal use of the interview guide. I found that when I first met with participants there was a desire to start talking before I had turned on the tape recorder. They were ready and prepared and once preliminary greetings were complete they easily engaged in conversation.

After this had happened twice I decided to set the recording equipment up and, before turning on the tape, begin a conversation about mundane matters such as what was happening in the workplace right now, how were things going generally. I explained to participants what I would do and found that, before long, cultural safety would come into the conversation. It was at this point that I turned on the tape recorder and the conversation evolved from there. The interviews took place over 15 months during which time I travelled to five different locations to interview participants and three came to my home.

When I first started to interview participants I asked them to share stories about their cultural safety education as a way to begin the conversation and as a warm-up to identifying experiences of applying cultural safety in practice. It was during this process that I became aware that these early experiences were intertwined with present practice and continued to influence their attitudes and experiences, either directly, “I learned that from cultural safety” (Ruby) or indirectly, “they, colleagues, say cultural safety was a load of mumbo jumbo” (Debbie). It was at this point I realised that my original aim of focusing on the nurse in practice would need to be revised to include experiences of cultural safety education.

4.16 Anonymity

One important principle of research is that anonymity in relation to the identity of the participants is maintained in subsequent publications arising from this research. The New Zealand health care environment is small with considerable mobility between health care agencies. Likewise, the nursing community is small and interconnected. My own extensive experience within the health and education system meant that I knew a considerable number of nurses in many different practice environments. To address anonymity I offered the women an opportunity to provide a pseudonym. Some chose not to at the interview stage. When I returned my interpretation of their stories much later on in the research, I suggested that they did provide a pseudonym as they could be easily identified by their name or place of work (appendix 12). However, pseudonyms do not necessarily guarantee anonymity. One participant was potentially identifiable because of her appearance and how she positioned herself within her workplace. As a result I was careful to keep descriptions as general as possible. Where a participant worked in an area in which few nurses practiced I used general, rather than specific, identifying information.

4.17 Data analysis

Elliott (2006) and Riessman (1993) note that there are two aspects to narrative method. One method involves gathering data from the field, the other involves analysing texts. Frank (2002) notes that while people tell stories, the narrative of the story comes from the analysis of those stories, thus stories come from the field and the narrative comes from an analysis of story text. He argues that the researcher's role is to interpret stories in order to analyse underlying narratives that the storyteller may not be able to give voice to. This section explains how I went about turning the stories from the field into texts for analysis.

4.18 From oral story to written text

Once I had gathered the interview material I then had to transfer this data into written text in preparation for analysis. Silverman (2006) suggests that researcher transcribing of tapes is part of the research activity, the argument being that through repeated listening to tapes, the researcher will become more familiar with the material - the subtle nuances, tones, and the general way that participants present their stories. After I had taken eight hours to transcribe one, one-hour tape I elected to have the tapes professionally transcribed. Tilly (2003) notes that consideration be given to who transcribes as "the transcriber's interpretive/analytical lens shapes the construction of the final texts and has the potential to influence the researcher's analysis of the data" (p. 750). I was fortunate to engage the services of a transcriber who at the time was working for a nursing organisation and was familiar with the concept of cultural safety and nursing language. This meant that she was more engaged in the process of transcribing than she might otherwise have been. Before transcribing she signed a confidentiality agreement (appendix 11).

As mentioned previously in this chapter, I drew on Blaikie's (2000) abductive research strategy to guide selection and analysis of texts by identifying stories used to explain what cultural safety meant to participants and how these stories captured meaning. In Blaikie's work analysis is twofold. Firstly I had to move stories from the telling to technical description and narrative, that is, from data to text to narrative elements identifying concepts and ideas used to describe cultural safety in everyday practice. Stage one described activities and meaning and stage two of the analysis drew out categories and concepts that formed a basis for understanding, and answering, the research question.

Earlier in this chapter I briefly identified other authors whose narrative analytical frameworks were selected to guide analysis. Here I outline how I drew on each one when working with the transcribed participant texts. I employed Frank's (2002) narrative analysis framework as I read the text several times, with the taped interview running or the transcripts on their own, to familiarise myself with the style, tone, language and rhythm of the words. Although the narrative structure employed by Labov and Waletzky (1997) is not used in the analytical chapters of the thesis, I found their ideas about abstract, orientation, complicating action, resolution and coda useful for assisting me in noting how the narrator marked the beginning and the end of the narrative as well as how it was constructed. I selected stories that would address the question of how registered nurses apply cultural safety knowledge in nursing practice. I looked for stories that contained an abstract, or a summary of the narrative, complicating action, or what happened, evaluation or meaning and significance of the action, resolution, or what finally happened and coda, or how the participant returned their perspective to the present.

With Frank's (2002) analysis in mind I noted how the narrator responded to the questions I asked and in what manner. I also noted how the participant sought to affect me, as the listener, with her story and what change the narrator may have wanted to bring about in me. For example, one participant was relating a story about an interaction with a client who was seemingly resisting the participant's encouragement to pursue a particular course of action. For me as the listener, the storyline seemed to be moving away from the original idea being expressed. The way in which the participant was expressing what she was saying conveyed a particular kind of energy which kept me engaged and listening even though I was tempted to interrupt. I remained silent, continuing to listen and let her know I was listening and as the story unfolded it transpired that the story was not actually about the content of the story but was about a significant moment in her nursing practice which had a profound effect on the way she saw herself as a registered nurse. Had I projected my own agenda onto this story, the outcome might have been very different. Drawing on the work of Somers (1994), I reflected on the way the narrators positioned themselves in the story and identified public and social narratives embedded in the specific stories. This was more transparent in stories involving participants explaining the way in which their culture and identity had influenced their understanding of cultural safety. For example participants would refer to themselves as Pākehā or Māori when relating a story where they were engaging with a person from a culture that was different to their own.

Considerable time was spent exploring the transcripts, identifying, the *what, why how, when with whom* or *against whom* of the stories. This involved teasing out the stories, noting interactions

between the participants and me and identifying elements of narrativity, identity, power, relationship, context and time within the texts. Reading the transcripts from different perspectives helped me identify a range of actors in the stories and how different story actions interacted with one another.

Following this lengthy process I then identified an idea or a group of ideas for each group of sentences from each participant transcript relating to the question, and highlighted these. I then cut and pasted these groupings onto a single page to examine them for consistency between different transcripts. From this data I went through a fourth cycle and identified stories which had a beginning, a complicating action and some kind of resolution. A final cycle of analysis identified and grouped the stories into themes. The themes were arrived at as result of repetition across participant narratives. It appeared that no matter the structure or uniqueness of the individual stories that were shared, there emerged a coherent order of experience represented in this study as stories of early experiences of coming in contact with cultural safety and meanings attached to the concept; the influence of the practice setting on the construction of identity in nursing relationships; and the way power works and influences the enabling or constraint of cultural safety in different fields of practice.

4.19 Establishing and maintaining trustworthiness

In qualitative research Sandelowski (1993) notes that validity should be not linked to claims of truth as in positivist research, but to trustworthiness. Trustworthiness is established when the researcher makes research practices visible and “therefore auditable as a way of tracking and verifying the research process” (p.2). The next section identifies reflective processes and actions undertaken to verify the trustworthiness of the research process. Central to this process is reflexivity, my positioning as the researcher, credibility, establishing a relationship, connectedness with the research community and rigour and validity through feedback.

4.20 Reflexivity

Holloway and Freshwater (2007) emphasise the importance of reflexivity in qualitative inquiry as a means for establishing the trustworthiness of the study. They regard thoughtfulness and reflection as essential qualities which should be present in the research relationship and which need to be considered in terms of the researcher’s relationship with her participants, her own reactions toward the participants as well as the researcher’s own positioning, stance and feelings. To be considered trustworthy the researcher needs to make her own interests and background

transparent in terms of how these factors influence the research (Holloway and Freshwater, 2007). The focus of this research was an area in which I have been involved for many years, so I was mindful that I came to the study with a particular mindset about cultural safety and needed to pay particular attention to reflexivity in conducting the research. I had to ensure that as I worked with the participants, heard their stories and analysed their texts, that I was not overlaying my own bias, prejudices or assumptions onto their stories. Elliott (2006) notes that reflexivity in research methodologies indicates an awareness by the researcher of their own identity, or self, in the research process, including the data gathering process and the writing up of the research. She also claims that, rather than researchers providing detailed accounts of their experience of research, they need to provide an analytic discussion of how their own theoretical and biographical perspective impacts their relationships with research subjects, their interpretation of research evidence and the form the research takes.

Mauthner and Doucet (2008) claim that reflexivity involves recognising that the researcher, the method and the data are interconnected and interdependent and this is consistent with a constructivist paradigm of inquiry. They explain that, as well as a reflexivity in relation to difference, the researcher also needs to consider the interplay between “multiple social locations and how these intersect with the particularities of our personal biographies” (p. 401) which need to be made explicit when analysing data in order to understand what is influencing the production of knowledge and how this production is occurring.

4.21 Reflexivity in narrative research

There are two key elements in Holloway and Freshwater’s (2007) approach to reflexivity. Firstly, the researcher is open about the process and her responses to it and secondly, that transcripts are read in a reflexive manner. Holloway and Jefferson (2000) identify prompts to guide a reflective process, which I applied to my own research. These prompts included; what I noticed in the reading, why I noticed it, how was I interpreting what I noticed? And how did I know if my interpretation was the right one?

Applying Holloway and Jefferson’s (2000) prompts to my own reflexive process was useful for monitoring my own positioning and assumptions when reading transcripts. There were times in the reading, when the boundaries between subjectivity and objectivity became blurred, that I vacillated between believing that by bringing a reflexive knowing to the reading of texts I was fulfilling the academic research requirement of objectivity and experiencing a sense that indeed

this felt like false reassurance. Reflection did help me monitor my thoughts feelings and actions but it also helped me think I was being objective in my observations, thoughts and interpretations as per research expectations.

Different readings of Bourdieu's epistemic reflexivity helped guide my thinking about my processes. Wacquant, in Bourdieu and Wacquant (2005) observes that a commitment to reflexivity is an important feature of Bourdieu's social theory. Previously in this chapter I discussed Bourdieu's concepts of *habitus* and field and found these ideas useful for examining reflexivity in this study. Kenway and McLeod (2004) suggest that field and *habitus* can be considered in relation to reflexivity. They observe that "each action is relationally positioned in the field and this position determines a situated viewpoint of the activities within the field" (p. 526). These actions and positioning can be applied in explaining reflexivity in this research. Kenway and McLeod note that "in feminist and poststructural research, reflexivity is an imperative or a *doxa*, a taken-for-granted belief and "that the researcher situates themselves, their own investments, their own constructions in the research in the production and meaning of partial truths" (p.527). This *taken for grantedness* is apparent when the researcher as autobiographer reflects on the effect of their presence and conduct on the interpretation of the research (Kenway & McLeod, 2004).

Bourdieu's concepts of reflexivity goes further than noticing the autobiography of the researcher and acknowledges the partiality and bias of perspective in the context of different *structures and spatial locations* (Kenway & McLeod, 2004, p.527). The relationship between field and *habitus*, position and disposition is central to an understanding of Bourdieu's reflexivity as it goes beyond a focus on the researcher's consciousness and incorporates the social and intellectual unconsciousness embedded in different analytic tools and operations (Kenway & McLeod, 2004). Their analysis of Bourdieu's reflexivity calls for an examination of the "epistemological unconscious and social organisation of the discipline of sociology" (Kenway & McLeod, 2004, p. 528) or, in this research, the unconscious or implicit knowledge and social organisation of nursing.

Webb, Schirato and Danaher (2002) note that Bourdieu's reflexivity takes account of three types of limitations. Firstly the social origins of the researcher, secondly, the researcher's position within the microcosm of the culture (in this study, nursing) and thirdly the interrogation of the *scholastic point of view* or forms of disciplinary bias (Kenway & McLeod, 2004, p. 528). The third element, the scholastic point of view, is significant in this study. Given my own positioning

as a cultural safety educator, seeking participants from nursing practice creates an inherent power imbalance. According to Kenway and McLeod (2004) and Webb, Schirato and Danaher (2002), I needed to pay particular attention to my intellectual bias and the set of dispositions produced from within my own academic field. Webb, Schirato and Danaher (2002) note that a scholastic point of view is problematic in research as there is a tendency to abstract practice from its context and see practice as producing ideas to be contemplated rather than issues to be addressed or solved. Kenway and McLeod (2004) suggest that there is a forgetting which occurs within a scholastic point of view which means that such a view is seen as natural, objective and as a given without history. According to Kenway and McLeod (2004), Bourdieu's point of view of the intellectual (or in this study the academic) is not only the "expression of an individual point of view but a point of view which derives from an analytic disposition that is in part formed by the collective unconscious of the academic field, its structures, modes and conventions of thinking within itself" (p. 529). A reflexive sociology requires scrutiny of how a scholastic view is privileged in research. Webb, Schirato, and Danaher (2002) note that there is a paradox within scholastic privilege because reflection itself is a habit or thought with a history formed in scholarly fields. Thus they say that the scholastic point of view is simultaneously a potential impediment to, and a condition for, the production of reflexive knowledge.

Returning to Holloway and Jefferson's (2000) prompts for monitoring positioning and assumptions; the questions, what did I notice?; why did I notice?; how did I interpret what I noticed and how did I know if my interpretations were right?, applied equally during the interview process and textual analysis process. During the interview process, I was aware of my positioning as a teacher of cultural safety with an established set of dispositions toward cultural safety in education as well as from a distant view of practice. The practice view was constructed from anecdotal evidence from people I knew who had experiences of being hospitalised that ranged from very positive to extremely negative events. I entered the interview process not knowing what would emerge from the conversation. I experienced anxiety from time to time as participants were talking and I reflected on whether the stories I heard were capturing stories of cultural safety. At the same time, I was aware that I had no concept of what a cultural safety story from practice might look like, as there had been little opportunity to explore the concept from the perspective of the nurse in practice. In this sense, then, my scholastic positioning as an educator and as a researcher was tested and I had to refrain from using my power positions to guide the participants toward giving me what I thought I wanted regarding stories of cultural safety. Similarly, when reflecting on texts, I had to consciously make an effort to notice when a reflection or thinking was deviating away from the text that was before me and becoming my

story rather than the participant's story. For example this happened when I made a statement about an aspect of a story and then started to explain from my own point of view. I recognised this was happening when I looked at the text and the voice of the participant was no longer there but had been replaced with academic language. This was not totally avoidable and when I returned a reinterpreted story to one participant she agreed with my interpretation but commented that she had no idea about "what the big words meant". This was helpful for me to hear because I had been careful to find a balance between accessible language and academic research language. I had been unconsciously privileging a scholastic point of view which was so internalised and taken-for-granted that I had little awareness that I was using language which was alienating. Other aspects of reflexivity were not so much a part of my reflective processes as I was more familiar with notions of autobiography, thoughtfulness toward the participant, my own biases and thoughts and feelings impacting the process. Bourdieu suggests that researchers need to be reflective in their attitude toward practices by reflecting on how forces such as social and cultural background, our position within particular fields and intellectual bias shape the way we view the world (Webb, Schirato & Danaher , 2002). Such a view resonates with the reflective intent behind cultural safety as a framework to guide practice. This exploration of my own experience of reflection in this study suggests that there might be some way to go before the reflective agenda of cultural safety can be fully met.

4.22 My researcher interest and positioning in the research

I have been involved in cultural safety education since its inception, therefore my position as researcher in this study is determined by my own relationship with, and experience of, cultural safety. My previous research explored the experience of nurse educators who taught cultural safety (Richardson, 2000; Richardson & Carryer, 2005). I am an English speaking, Pākehā woman of Irish, Scottish, English and French descent born and was raised in post World War II New Zealand. My primary personal and social orientation to the world is shaped by these characteristics. My political orientation and identity evolved and was shaped by the radical socio-political events of the 1960s, 1970s and 1980s. As a young feminist I was part of, and actively involved in, challenging white, patriarchal, heterosexual structures of the time and I lived the social, political and cultural changes of that period. The women's movement provided a place and a space where my personal and political values and beliefs were appreciated, able to be expressed and not silenced or excluded as they had been by the social and political structures I had grown up in.

My own daily experience of the potential for being marginalised in even the smallest way acts as a powerful silencer so to some extent I can identify with other people who experience marginalisation on an all encompassing level. For me marginalisation adds a dimension to my life which makes me work reflexively when relating with people. This means that subconsciously I assess, filter, monitor, and interpret how a person might respond to me or how I will react to them in any situation. However, I am also in a position where I can mask or blur my identity more readily than a person from a group whose identifying characteristics (such as colour or language) are markedly different from those of the dominant group. When anti-racism education and cultural safety was introduced into nursing education, being involved in teaching cultural safety was an extension of what was already happening in my personal life.

My entry into teaching cultural safety in undergraduate nursing programmes provided me with the unique opportunity of growing up with cultural safety and experiencing the resistance, or acceptance of its presence in the nursing education curriculum. My teaching in undergraduate and postgraduate nursing courses brought me in contact with the student nurse experience and the practice experience of registered nurses of cultural safety. It was while working with registered nurses that my interest in, and desire to investigate, the application of cultural safety knowledge in nursing practice was first stimulated. As part of a continuing education course for registered nurses, students were asked to reflect on an experience they identified as culturally safe or culturally compromised. They were asked to examine the experience using power as a framework. This exercise exposed me to stories where students were able to identify best cultural safety practice in nursing as well as practice that fell short of safe care. Within these stories there were tales of heroism in the face of repressive institutional structures, stories of resistance where nurses trusted their knowledge and beliefs and acted to provide culturally safe care in the face of seemingly overwhelming obstacles. It was when they needed to do what was right for a patient that they sometimes took personal and professional risks to ensure that the care they provided protected the cultural identity as well as the health and social needs of the person and their families. Some of the situations described had the potential for negative health outcomes for the person receiving nursing care, and for the nurse to be left with unfinished business. Over time, I have heard many stories of excellent, culturally safe nursing practice; I have also heard stories of powerlessness and frustration where nurses have been unable to deliver culturally safe care. It was these stories that stimulated my curiosity to further investigate cultural safety in nursing education and practice.

4.23 Credibility

This study aimed at examining individual stories about learning and applying cultural safety in everyday nursing practice by applying a post structuralist, interpretive approach where there are multiple readings of cultural safety, including complexities, contradictions and ambiguities. To achieve this aim I needed to ensure the research process was credible, to the participant, narrative research protocols and finally to the intended audience. The work had to withstand rigorous challenge from the wider research community of interest (in this study, the community of nursing) and to be able to stand as a credible exploration of the research topic. To be credible means ensuring that participants and readers of the research recognise the lived experiences described in the research as being similar to their own. I addressed the research needs of the participants and the readers in the following way.

4.24 Participants: Establishing a relationship

The first step toward providing culturally safe nursing is the establishment of a trusting relationship. The same need arises within a research relationship. While participants consented to participating in this study, they were also vulnerable because of the inherent power inequities in the research dyad. I had to be trustworthy in order for them to take me into their confidence and share their experiences of cultural safety with me. As a Pākehā talking with Māori participants I had the potential to perpetuate power imbalances mirroring a colonised/colonising relationship. To maintain an awareness, and reduce this potential, all participants were invited to have a whānau member or friend present during the interview (appendix 11). Following the interviews there was intermittent contact with participants to keep them informed of my progress. This was either by coming in contact in the course of daily activities or by letter. Following the final reconstruction of participant stories, I returned individual texts to each participant with surrounding analysis to enable them to see how I had reconstructed their stories as well as to share my interpretation of their story.

Holloway and Freshwater (2007) state that in narrative research the researcher is mindful of the participants' ideas, thoughts, and feelings, as the participant will only disclose thoughts and feelings if a relationship has been established. Similarly, in cultural safety, there has to be a relationship of trust between the nurse and the person before deeper levels of disclosure will occur. Establishing and maintaining this trust is central to both processes. Research rigour is one way of monitoring credibility and central to my process of ensuring rigour was attention to

reflexivity as has been fully discussed in the previous section. Such reflexivity was a constant reminder and monitor of the need to make the process of the study transparent. To do this I had to be open and reflective about how the study was conducted, and how the information gathered in the research was going to be used. It was also important that I represented the participant as a credible storyteller by removing extraneous material, such as repetitions, grammatical inconsistencies which were made visible in texts but were naturally occurring in an oral account.

4.25 Recipients of the research: the research community

At different stages of the research I presented work in progress where different aspects of the study were shared with colleagues. This gave me the opportunity to receive feedback and defend the emerging findings. I was also teaching registered nurses in different health care settings. As the research evolved and analysis of stories became more coherent and systematic, I was able to introduce my evolving thinking into the teaching sessions. To maintain trustworthiness with participants I was careful not to disclose personal narratives but rather brought the development of my ideas to health care workers in a way they could relate to and identify with. Responses to my evolving thinking indicated that the research findings had credibility, as evidenced by the ensuing discussions.

4.26 Rigour

This involved establishing and maintaining an audit trail providing for transparency at every step and stage of the research process. This was enhanced by the submission of six monthly reports to the Doctoral Research Committee providing evidence of progress in the research.

4.27 Validity

In narrative research there are different views on the relationship between the use of narrative interviews and internal validity of the information obtained (Elliott, 2006). I selected a narrative approach to this research because it was important to hear stories in which participants maintained control as story-tellers. Elliott (2006) considers that such an approach implies that interviews that consider individual narratives produce data that are more accurate, trustworthy and truthful than structured interviews. Narratives offer the advantage of providing a focus on a person's individual, subjective interpretation and the meanings they make of their lives. However

Elliott also recognises that this can have a distorting effect in that it obscures a clear description of life as it is lived. Internal validity is thought to be improved by the use of narrative because participants are empowered to provide concrete details about topics discussed. In this study narratives offered an opportunity for participants to use their own language, train of thought and experience of emotion to describe their own experiences. I did not want participants to reflect experiences of cultural safety but rather I wanted them to share meanings and actions related to the application of cultural safety knowledge from their perspective. A narrative was more likely to elicit meaning in an authentic way because the participant was stimulated to talk and share aspects of cultural safety in response to a question and, as the interviewer, I trusted that what the participant was telling me was attached to meaning for her, hence an affirmation of validity.

4.28 External validity

Issues of external validity revolved around the degree to which the results of this research were generalisable to other, similar populations. Elliott (2006) notes that for the researcher there are trade-offs between depth and breadth. I elected depth over breadth because there were few available stories of cultural safety in everyday nursing practice and I wanted to gain a deeper understanding and a richness which a smaller group of participants would provide. Issues of external validity in terms of generalisability were not a priority. However, as mentioned in the previous section on credibility, there was some resonance with the research in similar fields of practice.

Feedback from participants, the richness and depth of the stories presented and the generosity with which they were offered all suggest that I was able to establish a trusting climate within which the participants could share safely their experiences of learning about and working with cultural safety in nursing practice.

4.29 Summary

This chapter has explored my rationale for the choice of narrative methodology and described how I have used it to guide the data gathering and analytical processes in this research. I have established that there is no consensus as to what constitutes narrative research and I have chosen to focus on the analytical work of Blaikie (2000), Frank (2005), and Somers (1994) to provide evidence of my approach to narrative inquiry which would best answer the question about how registered nurses learn about and apply culturally safe knowledge in their everyday nursing

practice. The chapter identified the philosophical ideas of Bourdieu (1998) which provided a theoretical context for analysis. I described the research methodology design and method in detail, making explicit the process of data collection, analysis and ethical considerations. The chapter set up the parameters for discussion of the substantive findings of the thesis.

The next three chapters form the substantive core of the research and address the participants' narratives relating to their experience of cultural safety education and how they apply cultural safety knowledge in everyday nursing practice.

Chapter five: Learning about cultural safety and meanings of cultural safety.

5. Introduction

An analysis of participants' narratives identified three themes encapsulating cultural safety in education and practice: learning about cultural safety and meanings attached to cultural safety, the interaction between the nurse and setting and the habitus, *field* and *doxa* of cultural safety. The data showed that the extent to which participants adopted ideas and attached meaning to cultural safety was shaped by their personal backgrounds, values, experiences and the particular time in which they undertook their nursing. This chapter will explore these early influences and meanings.

Elizabeth's story, traces tensions in the trajectory of learning about cultural safety over time. Her story moves from one of initial resistance to cultural safety to an understanding of cultural safety as a result of personal experiences of vulnerability. Elizabeth reflects on how patients were cared for when she first qualified in comparison with how she cares for them now. She attributes this change to the introduction of cultural safety training within nursing education. A key tenet of cultural safety is that safe practice is judged by the person receiving care. While there is research related to the ways in which patients, who may feel vulnerable and disempowered, are able to comment on care (Wilson, 2008; Harris et al., 2006), there is little evidence from the everyday experience about the way the recipient of care experiences health encounters.

Debbie's narrative provides an account of her experience of seeking feedback on care. Debbie is a woman of Pacific descent whose appearance and dress signals to a casual observer an anti-establishment demeanour. She is conscious of the way she is judged by others and carefully monitors perceptions of people toward her by consciously providing opportunities for them to express the degree to which they feel comfortable and safe in her care. Other narratives in this chapter include those of Janis, Sally, Ruby, Patricia, Louise, June, Mary, Joy and Polly.

5.1 Transferring knowledge from education to practice

A nursing knowledge paradigm, informed by the work and thinking of nineteenth century health care reformer Florence Nightingale, was partly driven by a need to improve patient care by

providing the right environment for healing to take place (Crisp & Taylor, 2005). Nightingale was committed to improving the standard of nursing by claiming a moral position as a core quality of good nursing. Over time these concepts have been integrated into humanist philosophies of nursing privileging caring as a moral value, and as an interpersonal process guiding nursing interventions to meet people's health care needs (Benner & Wrubel, 1989; Mullholland, 1995; Watson, 1990). Neither of these positions, that of being moral or that of being caring, is incompatible with the agenda of cultural safety. A critical educational pedagogy on the other hand which informs the development of cultural safety challenges the construction of a system of education *and nursing*, (my italics) based on ideas of morality and caring presented as natural and normal. Deconstructing the notion of care and politicising caring does not need to mark cultural safety as being different or separate from nursing, but rather as another dimension of nursing. Cultural safety is consistent with core nursing values of relating, respect, compassion and the ability to create and build trusting relationships, however the paradigms from which the qualities of respect, compassion and trust arise and interpreted derive from different theoretical and philosophical positions.

Responsibility for cultural safety education in Aotearoa New Zealand lies within nursing education curricula in Technical Institutes and Universities. Since its inception, there has been a tension between what is taught, how it is taught and the implementation of the concept in health care settings. There are also tensions as to what constitutes care in a cultural context, with these tensions focusing on competing discourses of culture, transcultural care theory, cultural safety and cultural competency culture specific care. Three key elements separating cultural safety from other concepts of cultural care are, firstly, that cultural safety is about nurses, their behaviour and attitude towards patients and their ability or otherwise to create and build trusting and effective relationships. A second key element is that central to the development of effective health care relationships is the focus on power, difference and identity and how these shape the relationship. A third element is that cultural safety cannot be examined without taking health care systems and structures into account.

Cultural safety education has tended to focus on the responsibility for delivering culturally safe care on the individual nurse through negotiation between the nurse and the person for whom they care in the context of the nurse-patient relationship. Education has taken into account the health system within which the nurse works but has not always been successful in equipping the nurse with skills to work with power and difference in a powerful and political health care system. The participants in this research identified the ways in which they have come to understand cultural

safety as a framework for providing effective nursing care. Each woman has come to this understanding through her own life experience and subjective positioning within her relationships with people for whom she cares. They have also come to this understanding professionally by working in nursing situations which are difficult and which either constrain or enable the delivery of nursing care in different health care settings.

5.2 Coming to know about cultural safety in nursing and coming to nursing knowing about cultural safety

Coming to know about cultural safety and coming to nursing knowing about cultural safety is consistent with findings identified by McEldowney, Richardson et al. (2006). They found that nurses who had been in nursing practice for many years learned about cultural safety when coming into contact with the concept through their relationships with nurses who had graduated from technical institutes and professional development courses. New graduates, on the other hand, came to nursing knowing about cultural safety and were reliant on more experienced nurses to guide integration of the concept into their everyday practice.

In recalling early memories of coming into contact with cultural safety, all participants had memories of hearing about cultural safety and their interpretations of this learning were shaped by where they were positioned over a 20-year time span in relation to undergraduate nursing education. Janis, Sally and Ruby demonstrate this in the following short extracts.

Janis, who had undergone her nursing education in the 1950s, recalled that prior to cultural safety:

We hadn't been acknowledging [that] Aotearoa New Zealand had two major cultures. (Janis)

Sally's first experience of coming in contact with of cultural safety was after she had graduated:

When I was an undergraduate which was 83 to 85, there wasn't bi-cultural training or any specific Māori or Pacific training separated out the way that came through more in the 90s but there was a course that we did, I think it was once a week for an hour called Cross Cultural Communication. (Sally)

Ruby graduated in 2005 and her first contact with cultural safety was in a cultural safety class

...Cultural safety, it took a long time for the whole concept to really sink in, you know, it was like 'what are you talking about? I do that, and I do that and I don't really know what you mean' and everything was quite hard, it was like 'oh I've got to write about my culture. But I haven't got a culture, I'm just from NZ and you know' and then when we did that, I was like 'Oh, I get it'. (Ruby)

These texts trace a timeline from a sameness of culture based on the dominance of one, to a construction of difference in relation to ethnicity and then to an interrogation of difference based on an understanding of self as a culture bearer, the latter idea being a key tenet of cultural safety. While Sally's memory is narrated as a disembodied observer, Ruby provides a subjective account in which she presents herself as the reference point of difference. These two narratives trace historical variability in educational approaches to thinking about difference, with Ruby's reflexive account reflecting a contemporary approach to cultural safety. Ruby describes how her cultural safety training facilitated a process by which she became conscious of her own culture and this awareness has become embodied, incorporated into the very way that she thinks and talks about difference. Collectively the accounts provided by Janis, Sally and Ruby identify shifts in social awareness of cultural difference and trace a trajectory from monoculturalism to multiculturalism and cross-cultural communication and then to self.

Following on from her earlier comment, Janis shared an insight into the nursing values she was exposed to during the 1950s.

We had been doing everything our way, the white middleclass way and there were those that didn't consider that there was any other way, they didn't consider that it's the old adage – you grow up in a culture and you believe that's how things are done and it's not until somebody's given a bit of further education that you understand more fully that there's other ways of doing things. You know, if you've grown up with your own set of beliefs, your own way of doing things, your own way of dressing, your own food, your own language and you think that's it, and it's not until you grow from that, that you begin to realise that there are other ways. (Janis)

Janis's account of coming into contact with ideas associated with cultural safety is a personal reflection about the need for cultural safety. She positions herself in relationship to me as a contemporary; she does not have to explain some of the detail because she knows we have a shared history by the way I look and speak about my own experience of nursing. We have similar past experiences as 1960s nurses and we both know the mantra of *treating everyone the same*. We have both learned with further education that this was not appropriate and in light of current knowledge, treating everybody the same means *treat everybody as if they are like me – same colour, same values, same ideas*

Janis is Pākehā and acknowledges her class perspective; for example, *we had been doing everything our way*, that is the white middle class way. She then qualifies her use of *the old adage* and uses a group of words that express beliefs that can be taken as being a general truth. Janis then offers a view that once there is a realisation that there are other ways, change will happen. However, such an understanding is not automatic and Wood and Schwass (1993) claim that it is the degree to which a value or attitude is held that determines change or resistance to change. Attitude change is also dependent on how the value and attitude is held up and secured by the talk and actions of people who share a similar value or attitude.

Janis's 1960s nursing education was informed by the ideas originating from the nineteenth century nurse reformer Florence Nightingale (Nightingale,1860). Nightingale's model was threefold. Apart from applying a moral element to nursing, her primary focus of care was on the sick and needy, secondly on a desire to improve the health of the public and thirdly to ensure nursing as an occupation provided security of employment and accommodation for young middle class women in return for providing services to the sick in hospital settings (Nightingale,1860; Gordon, 2005). Nightingale's model of nursing continued to inform the development of nursing well into the 1960s and the concept of the moral nurse is present in nursing today, although not always articulated as deriving from Nightingales work directly. One enduring belief attributed to Nightingale was the idea that *all* people should be treated the same. However while this may have been well intentioned and in keeping with the thinking of the time, the phrase *treat all people the same* ignores individual, class, social and cultural differences.

Far from honouring the value of treating everybody the same, Patricia, a Pākehā woman recalls a memory of her learning about cultural safety in a classroom situation:

Well I thought it [cultural safety] was really good, I thought it was quite interesting because it certainly showed you people have got different attitudes and if you are socialising and talking to people who have the same kind of political viewpoint as you, then if people say quite shocking things and you are not in the majority (laugh) a lot of people will disagree with you. I remember one very heated discussion [in a] sociology tutorial, we were talking about cultural safety but we were talking about health disparities as well and one of the other students insisted that her mother's best friend who was a nurse said that it [health disparities] was just a load of old cobblers, 'Māori having higher diabetes rates, [because] they faked the blood tests and that they did it to get higher benefits', and I remember there should not have been that discussion. But some people said 'Is that right? Is that right?'. (Patricia)

The impetus for cultural safety education arose out of the need for health care professionals to examine the way they delivered health care services to Māori populations. A critical pedagogy underpinning cultural safety, shaped the teaching environment where nursing students could learn about inequitable power relationships and the effect of these on health care. Patricia's account reflects the reality of what happened within this new learning environment which, instead of developing a critical understanding of inequity in health care focusing on difference, sometimes gave a student a sense of entitlement that they could express racist comments without fear of censure. This narrative also demonstrates Reid, Robson and Jones (2000) assertion that failure of the health service to deliver appropriate care can result in the recipient of care being blamed for their health situation and perpetuates stereotyping as well as personal and institutional racism. Patricia was older than many of her classmates and identified as lesbian, and had many years of working in unions and industrial relations. This life experience brought her into contact with different working class groups and people from different cultures, so Patricia considered that she was immune to anything that people might relating to class or cultural difference.

Patricia recalled thinking that while *she* embraced cultural safety, she was shocked when others did not share her view of tolerance and acceptance of difference. Because of her own marginalised positioning as an older woman and lesbian, she positioned herself as *other* and as separate from her colleagues. Her talk suggests that she may have made choices about not challenging what was said. She situated herself as an observer rather than as a group member, perhaps for safety reasons, as she listened to her colleagues express attitudes that were derogatory, racist and hostile and in stark contrast to her own life experiences.

The use of marginalising language is evident in the above example of unfiltered racism, in which Māori are implicitly constructed as dishonest and indifferent to their health. Language is used to indicate difference in a negative way. The attitude expressed by the student is supported by other group members and is therefore more likely to silence any opposition by other individuals in the group. Patricia's account of her classmates agreeing with the speaker – "Is that right, is that right"? identifies the powerful strategy of group persuasion and Patricia can only observe in silence because of her own marginalised status within the group and think *this should not be so*.

Patricia's talk speaks to the reality of why cultural safety from the perspective of the health professional needed to be taught within nursing education. Patricia's personal experience of colleagues' resistance to learning about cultural safety is consistent with a public account of cultural safety discussed in chapter two. Cultural safety came to the fore in the public arena through articles published in two regional newspapers, *The Dominion* in Wellington and *The Christchurch Press*. There were claims that cultural safety was a form of social engineering driven by self appointed and highly paid Māori consultants and that these consultants would measure its success (Levine, 2005). Other media drew on language which inflamed rather than informed the public about cultural safety. Levine (2005) draws on commonly heard statements of the time to illustrate intense resistance to the idea of cultural safety.

Cultural safety is an instrument of tyranny with bullying, moral blackmail and the stifling of argument, it put the medical safety of patients at risk and compromised the educational programme of nurses and finally 'cultural safety's thought police were turning Pākehā patients and students into victims of social cleansing'. (Levine, 2005, p. 11)

Patricia's account of her classroom conversation and Levine's description of public responses to cultural safety are examples of the way in which public and private discourses were used by the dominant European group to question the place of cultural safety within the nursing curriculum. Derogatory language was used to discredit Māori attempts to link access to safe health services for Māori with the attitude and behaviour of the dominant social group. The talk of Patricia's colleagues reflected public discourses that attempted to deflect Māori challenges to the dominant ideology regarding race and ethnicity.

Louise's narrative, about encountering hostility to the idea of cultural safety outside of nursing contexts, reflects controversy around the topic in the media at the time. Her talk about deliberately choosing to be silent has some similarity to Patricia's story.

We did a paper on cultural safety and you know when I used to talk to people when I was out, like we'd just be having dinner or whatever and they'd come up and be talking about what I was doing in my course and whenever it came up about cultural safety, it went directly onto the issue of race and it went directly to Māori and people would get their backs up. "Why are they being treated in a different way? So you'd quietly mention the thing about the Treaty and I'll tell you what, often times you'd just have to back off, because people would get quite heated, and I tried to explain to them that in actual fact it's not just about that, but it was about the Treaty of Waitangi. But yeah so I don't think we've got it right. (Louise)

As a mature adult Māori student, Louise was faced with choices when the subject of cultural safety came up in a social context. She had to decide to either try and correct incorrect information or stay silent. Her own experience of learning about cultural safety indicates she had developed a wider understanding of the concept than that of it being concerned with race. While she attempted a quiet approach to explain her views, the people with whom she was talking could not think beyond equating culture with race and the mention of the Treaty of Waitangi only intensified the resistance and any further attempts to explain were silenced. Her final comment suggests that this attitude still exists in her current experience of trying to explain cultural safety to others.

June's first contact with cultural safety as a concept arose out of her teaching experience and was grounded in her life experience.

I think in terms of my family values I really love people. I'm committed to supporting people and to advocating for people, those sorts of values, which is kind of innate. Well, they were family values really and so it came naturally, and then I also taught, I decided to teach in communications in nursing I taught about listening, like reflective listening, actively listening to people and putting yourself in their position really, so those two always seemed to go together for me, like cultural safety and empathetic listening really. So that's how I first came into it...And I always think that when I came here I framed that, [family values and advocacy] as cultural and I thought it was just kind of a personal, but I was always aware of where people sat in terms of the society you know, in terms of their social status and their economic status. (June)

For June, coming in contact with cultural safety was a natural extension of the way she lived her life and when she started teaching cultural safety she was able to name and identify her lifelong values as being consistent with the values of cultural safety. Cultural safety provided her with a way of giving meaning to her beliefs and this extended her core values of social justice and careful communication in the context of her cultural safety teaching.

5.3 Sameness in contexts of difference, reflecting on marae-based learning

Mary's first contact with cultural safety was as a student in a provincial polytechnic in an area where there was a large Māori population.

I don't remember cultural safety being driven home in terms of assessment and clinical. We were just told that we had to go onto a Marae and that was it— we had to give up a weekend and go on the marae. I think there was lot of resentment about that because there was not a lot of understanding, we didn't know why it was seen as part of your cultural safety component....I felt that we were actually really intruding, I'd describe us as a bunch of white girls turning up on the marae with no idea what was expected of us. (Mary)

Mary's narrative demonstrates tensions between cultural safety, transcultural care and bicultural education. It was seen as an 'add on' to nursing rather than central to nursing. This was reinforced by the absence of any assessment of the concept in clinical practice. As a student, Mary was caught in emerging and conflicting paradigms. What cultural education she had been exposed to was drawn from North American transcultural concepts, which involved developing an understanding of cultural patterns and mores of a group in order to know how to care for them.

Another factor was the development of the New Zealand Government's recognition of Aotearoa New Zealand as a bicultural²⁵ nation and a strengthening of Te Tiriti o Waitangi relationship between the Crown and iwi. State recognition of biculturalism brought culture to the fore. It was therefore understandable that people new to concepts of two cultures would focus on culture as ethnicity. Cultural safety, with a focus on power, was just beginning to make its presence felt within nursing but was not yet officially part of the curriculum. Attending to power inequality in

²⁵In New Zealand, biculturalism was the outcome of a close alliance developed between the leaders of the Māori revival and a post-war new professional class. The latter group, mainly settler descendants of working class origin were redefining themselves according to the identity movements of the time (Poata-Smith, 2001).

a bicultural relationship was still to be realised. Part of calls by Māori for Pākehā recognition of their Tāngata whenua status was expressed in a desire to educate white Pākehā New Zealanders about the culture and health care needs of Māori. To achieve this, nursing students were taken onto to local Marae to learn about the health needs of iwi. Mary's expression of discomfort and feelings about intruding suggests that she was suddenly confronted with her own whiteness and without any apparent support for the feelings generated by this awareness, she was bewildered, embarrassed, felt out of place and was unable to see the relevance of such visits to her future nursing. For Mary and her colleagues this had consequences.

We were so sick and tired of it, we saw it as something we had to do and we were told to do it. (Mary)

Mary's comment refers to her overall experience of learning about cultural difference in her early education. She could not connect with the purpose of culturally focused education, experienced a sense of compulsion and did what she had to do in order to pass.

Joy had a similar experience but with different outcomes. Her narrative provides key insights into a critical time of change in nursing education.

I started my undergraduate nursing education from 1977 and finished in 1979. There was no term such as 'cultural safety' in those days and there was no recognition of nursing culturally diverse people as such, like I'd never heard of Madeline Leininger in those days or anything like that. However I do think that the nursing tutors that we had recognised in a basic way that there were different cultures within Aotearoa New Zealand and to that extent on a yearly basis the students were taken to a marae in [names town] called [names marae] and we stayed there over a weekend. We went up on a Friday and came back on a Sunday and I don't think a lot of people appreciated what it meant for the people on the marae to actually be there to awhi²⁶ for us, to cook for us and to look after us because they just didn't have really any idea of what it meant to belong to a marae, so people would take off work to be our cooks and to do our cleaning and things like that. (Joy)

²⁶ Help

In contrast to Mary's experience, Joy was supported during her visit to the Marae and had an understanding of the effort local people made to support the students. This may have been because she was an older Pākehā with Māori whānau. Significant in Joy's story is her perception of the tutors at the time as having a growing awareness that there were different cultures in Aotearoa New Zealand. While it may have been evident that different cultures existed, the implications of this for health care delivery was not always as obvious, and in this context as in Mary's situation it was appropriate that students learn about the health needs of people from different cultures by learning about their practices and finding out what was important to them. What was not obvious at this time were the consequences of inviting and imposing a dominant culture on the culture of a marginalised group.

Joy's next memory recalls this consequence more fully.

I remember the speakers who came to speak to the students were really of exceptional value. In those days we wouldn't have appreciated them like we do now because they weren't quite so famous, but we always started off with a kaumātua who would talk about the meeting house and the tukutuku panels and the kowhaiwhai and the stories and what that meant to the tribe and spoke about the different aspects of culture within that marae and so that was usually done on the Friday night after we'd arrived and then I remember the very first time that I went there we had, well he's professor or doctor, but anyway we had [names person] and he came and spoke to us about the importance of culture in terms of psychiatry and looking after people with psychiatric illness. We had a chap called [names person] who was ____'s brother, and came and spoke to us. I remember we had a Māori midwife and a Māori psychiatric nurse who worked in [names institution] and they came over and gave freely of their time and spoke of the differences between caring for somebody within the Māori culture in particular areas of nursing. And another year I went up there after I had finished, we had [names person], and yeah, so that was kind of really in my whole recollection of my three years. There was nothing done to prepare us and having been familiar with the kawa or the protocol on the marae I remember being alarmed the first time I went up there when I was still a student because one of the tutors took her husband and her three boys, and I remember being mortified at their behaviour, I mean common sense would tell us that that's not what you do when you visit somebody else's house, but I remember

being a little bit mortified by all there. But as I said, there was no preparation given up for us for that experience and maybe that's because the tutors didn't have any experience, but they didn't invite anybody else in either to prepare us.
(Joy)

Joy goes into some detail to explain the value and importance of visiting the Marae. She learns about the story of the people who have invited her to share their space with them and as result she develops a deeper understanding through this relationship. It is this understanding which she will take with her into her future nursing practice. At the same time her experience makes visible, behaviour which offends and Joy is aware of the lack of preparation students had for visiting the Marae. This kind of early experience has usually been framed as conforming to a transcultural nursing framework, however it also needs to be seen in relation to the introduction of ideas about biculturalism in Aotearoa New Zealand more generally. Joy and Mary's stories of marae-based training reflect the experiences of many student nurses in Aotearoa New Zealand in the late 1970s and 1980s, experiences which foreshadow the development of cultural safety education in this country. Early cultural safety education brought about an awareness that imposing groups of Pākehā students onto Māori communities might mean that dominant Pākehā values may be challenged but not changed. It was also recognised that inviting people into a different cultural space meant putting the hosts at risk of being offended. At this time, the view that it was not appropriate to learn about different cultural practices in situations that had the potential to put the teacher at risk within their own culture was yet to be developed. When I asked Joy why the Marae visits might have happened, she said:

I have a funny feeling that it had to do personally with the nursing staff that we had on faculty at that time, and we had some very caring women in the department, and women who were all doing further study which wasn't always the case, and I think that these women may not have had a very clear picture of what was coming up but they had enough of an idea to know that, how nursing was going was changing. (Joy)

Joy's comment suggests that while there was no institutional commitment at this time to provide cultural education in an Aotearoa New Zealand context, there was a sense that things were about to change. Individual tutors were expanding their awareness of difference and social justice through their own studies and bringing it into their everyday teaching. This, and the political

climate associated with Māori protest, provided impetus for the development of cultural safety nursing education.

The advent of cultural safety in nursing affected student nurses and registered nurses in positive and negative ways. For some it provided a language to help with understanding and finding meaning in some of the health care practices the person was part of but felt discomfort with. For others the same language became an instrument to silence opposing voices of those who rejected the idea that culture and identity had any part to play in health care outcomes. Cultural safety education became a site of struggle for legitimacy and voice within monocultural educational and health care institutions.

The experience of cultural safety education was taken into clinical practice along with other educational experiences and learned skills. However, too often the negative experiences of cultural safety education silenced nurses rather than providing them with a voice and a structure to work with and manage day-to-day clinical situations in a culturally safe way. Cultural safety education provided nursing education with a critical framework by which to critique nursing and health practices. The very act of critiquing and dismantling dominant ideas disrupted and broke down roles and relationships in the social spaces in which nursing took place (Bourdieu, 1972, 1998). As already mentioned, just because the student nurse was equipped with this knowledge did not mean that this would be automatically transferred into practical application.

In the first section of this chapter participants reflected how their attitude towards learning about difference and/or cultural safety was influenced by their experiences, personal views and the particular time period in which they were nursing students. Sally and Mary's stories illustrated the tensions that arose from the introduction of frameworks aimed at providing the nurse with knowledge about cultural difference. They were caught between transcultural care, cultural communication and the push for students to learn specifically about Māori tikanga and health care practices. Polly and June brought their own values and beliefs to their nursing practice and teaching and cultural safety provided them with a way to explain these values. Patricia, Louise and Ruby were the recipients of cultural safety nursing education. Their learning experience turned the focus of investigation onto the nurse but at the same time unleashed an overt expression of racism into nursing education for which enlightened students and well intentioned nursing tutors were unprepared and ill equipped. These intersections of the way culture has been addressed in Aotearoa New Zealand nursing over time have built on one another and continue to detract from a clear nursing-focused understanding of culturally safe nursing care. The next

section of this thesis examines stories relating to the meaning of culturally safe nursing which have embedded in them aspects of different understandings of culture in a nursing context.

5.4 Meanings of cultural safety

The following section will show that when the participants were asked about what cultural safety means to them, they talked about what nursing means to them. However this does not mean that cultural safety can be subsumed into nursing and neutralised as an 'aspect' of nursing. Cultural safety offers nursing a framework for clinical judgement and assessment guided by a conscious, active reflection in each nursing interaction. Cultural safety knowledge can alert the nurse to practice situations where communication, relationships and health care outcomes have the potential to be influenced by power, difference and identity and in this way provide a pathway for nurses to bring a critical analysis to their everyday practice. Ramsden's (2002) claim that cultural safety is a bicultural relationship supports a view that there are two people in any nursing relationship and that these two people bring their unique cultures to bear on what happens in that relationship. It is through examining the nurse in relation to another person that meanings of cultural safety are formed.

When people speak, they are speaking who they are-what their culture is, what influences their thinking their values and beliefs and how self reflective they are - what are the social discourses and power arrangements operating in the speech, and what things are happening during the act of speech. (Labov & Waletzky, 1997, p. 74)

Following are brief statements of what cultural safety means for selected participants. Elizabeth considers cultural safety to be about *good listening, being real, good manners and respecting another person*. For Debbie, cultural safety means *feeling right about what I am doing*. Louise considers that cultural safety is *about knowing your own beliefs, seeing the person in a wider, bigger, family situation* and recognising her own stress. For Janis, it means *the protection of individual clients or patient's identity or beliefs, and being comfortable in yourself*. Meaning for Sally is *being respectful of another person's values and what is important to them*. For Patricia cultural safety involves *looking at where the other person is coming from and what their issues are and what they need and how they need it provided*. Cultural safety for Polly means *having your beliefs and values respected by others and being party to the decision making and planning*. June considers cultural safety in terms of *working with people who are different to you*. Ruby suggests that it is about *being able to check yourself, and recognise are you safe?*

Accounts of cultural safety in the talk of the participants identify that meaning is shaped by how the women position themselves in time, their values and beliefs about nursing, their identity and how they engage with their environment as individuals and as nurses. Although there is no consensus about the meaning of cultural safety, these accounts illustrate themes of meaning at work in the field of culturally safe nursing practice. These themes include, being a good communicator, knowing who you are, recognising difference, protecting identity, knowing what is important to people, being self reflective, participation, a sense of doing *the right thing* and working with a person in a context of their wider family and social relationships.

Cultural safety provides a cognitive framework which may assist in managing the subjective experience of nursing. An understanding of the way health care is influenced by power, difference and identity can provide the nurse with a mindfulness and alertness to when and how these factors are shaping the health care relationship and potential health care outcomes. A self awareness and consciousness of power and difference theoretically positions the nurse as an engaged person who practises nursing in a considered and reflective way, enabling her to create an environment for improved client focused health care outcomes.

As already established, cultural safety became a driver for unsettling notions of nursing as a caring, compassionate and informed profession. Instead it suggested that nurses in New Zealand and especially European Pākehā nurses were the product of a racist society born out of British colonial structures of power and control. This group were unconsciously ignorant of other worldviews and narrow in their understanding of the health needs of people who were different from them in part because it had not been part of their nursing education. Initially the concept not only disrupted the public concept of a gentle, white, middle class, apolitical nurse; it also disrupted nurses' views of themselves. This disruption was more acute for nurses who were proactive in dealing with the publics' response to cultural safety and in a less visible way for nurses who were engaged with everyday nursing and not directly involved in the conflict. In short, cultural safety called for a re-examination of not only what it meant to be a nurse but what it meant to be a culturally safe nurse.

Cultural safety sent a message to nurses that they were in fact not the caring health professional they had been taught to believe they were and this put them in conflict with what they knew to be nursing and what they were told was culturally safe care. Nurses were faced with an identity crisis and had to change. Scott (1992) asserts that there is nothing inevitable or predetermined about taking on a new identity. Scott notes that "a new identity will always exist in the format it

was given". This means that a nursing identity was underpinned and shaped by 19 century concepts of what nursing was and was not. Scott also notes that "new identities are given within a particular political movement or at a particular historical moment" (p. 33). This means that cultural safety challenged the embedded identity of what a nurse was and challenged nurses to change practices so that they more appropriately met the cultural needs, as determined by clients.

While there are standard definitions of cultural safety, there is little information about how these definitions are translated into individual attitude and practices. A precursor to practising from a self aware position is that the registered nurse needs to have an understanding about what cultural safety means for her and how these meanings might shape how she practices. Weedon (2004) suggests that meaning is a way of organising the world and constructing reality and explaining how things are. Blaikie (2000) suggests "that everyday reality consists of meanings and interpretations that people give to their actions, the actions of others, social situations as well as natural and humanly created objects" (p.115). The following accounts of the multiple meanings of cultural safety makes visible the way in which cultural safety and nursing are constituted through unity, difference and schism. The stories draw out multiple perspectives and insights into these meanings through the lenses of time, experience and identity.

5.5 Coming to know about cultural safety

Elizabeth's story shows that contemporary meanings associated with cultural safety may evolve from practice as a result of many different influences and experiences. Elizabeth's hospital-based training in the late 1970s occurred prior to the inclusion of cultural content into the nursing education curriculum. It was also a time of change in the direction of nursing philosophy, from a reliance on scientific positivism to a more relational, humanistic orientation (Bevis & Watson, 1989).

The social mandate arising from this new direction was to produce a nurse

...Who would give compassionate, humane care by helping people with their lived experiences within an ineffective health care system that continually denies the individual personhood both during and in the aftermath of medical miracle technology. (Bevis & Watson, p.350)

The world of nursing Elizabeth joined was one calling for more focus on the realising of human potential in the context of health care and this meant the development of a nurse with rational and

moral capacities as well as emotional, expressive, intuitive, aesthetic and personal capacities (Bevis & Watson, 1989). Such a paradigm provided the format for shaping and informing Elizabeth's thinking about her future nursing practice and continues to underpin her practice now. With the advent of cultural safety in the late 1980s, the humanist foundations upon which she had built her nursing came under scrutiny, challenging her established nursing identity. Her account illustrates the conflict she experienced in trying to reconcile her original frame of reference of nursing with a more socio-political, reflective approach which is a marker of cultural safety.

Elizabeth's many years of practice and her experience of feeling marginalised contribute to her interpretation of cultural safety in her nursing practice today. Her first account centres on stories of disruption of identity and resistance in relation to the presence of cultural safety. Her second account identifies how she came to understand the concept in her own practice, illustrating a seamlessness between nursing and cultural safety.

Elizabeth first came into contact with cultural safety as an experienced registered nurse of some twelve years. She recalls how people talked about cultural safety:

In a derogatory manner I think, I think people in the same way that they talk about political correctness. I really think it did have that kind of, "Oh, Cultural Safety [dismissively] oh that's something that radical nurses thought up in a technical institute" kind of thing. (Elizabeth)

Saying that something is *politically correct* suggests that a person or group identified as marginalised is receiving an inordinate amount of attention to which they are not entitled. In nursing this meant that Māori were receiving too much attention at the expense of other cultural groups, sometimes unspecified or generalised usually to Asian populations. Firstly, Elizabeth's comments are in harmony with the then public view of cultural safety. This view was that cultural safety was an idea thought up by nurses who were really of no consequence because they were located within educational institutions and this did not constitute serious nursing, as it was not in a hospital setting. Her paraphrasing "Oh that's something radical nurses thought up in a technical institute" suggests that linking nursing with critical thinking was incomprehensible and could therefore be dismissed as radical and alienated from what was considered usual for preparing nurses, that is in a hospital setting. There was a public perception that nurses could

not be thinkers as well as hands on 'doers' and this called into question the ability of the nurse prepared in a technical institute to provide adequate health care for people.

Elizabeth saw cultural safety as having little relevance for her as a nurse.

Now I'm hospital trained, and there has been in nursing a real shift where hospital trained nurses, I would say have been made to feel because no one can make you feel something, but where the attitude has been that we aren't quite connected up to the real modern stuff, if you know what I mean. (Elizabeth)

Elizabeth makes a distinction between her hospital training and nursing education within a technical institute. She takes responsibility for how she feels about this but nevertheless feels that her considerable nursing experience was seen as less valuable. She felt alienated by the merging professionalising agendas of nursing aimed at producing a skilful, clinically knowledgeable, practical nurse as well as a thinking, reflective nurse. For her, tertiary nursing education was *modern stuff* and learning about propositional knowledge or *knowing that*, rather than practical hospital-based knowledge or *knowing how*, was not part of her experience. She felt that her identity as an experienced registered nurse was devalued or diminished because the propositional knowledge of the tertiary institution was privileged over the practical knowledge acquired through her hospital-based programme.

Elizabeth then reflects:

Well I wonder if a better phrase could have been invented, I think one of my reactions was "What about my culture?" (Elizabeth)

She recalls that she felt that cultural safety was not about her but about the *other* and whom she might define as *other*. She interpreted culture as relating to an identified set of characteristics and at the time it would have been characteristics of difference associated with ethnicity, language and colour. It would be natural for Elizabeth to equate the term culture with ethnicity because her nursing experience would have been with people from different cultures and broader constructions of culture beyond ethnicity would not yet be familiar to her. Not only did she have to come to terms with changing approaches to nursing, she was also being confronted with

challenges to her personal and professional sense of identity. All that she had come to believe about nursing and who she was in the world as a nurse was destabilised and she had to make sense of this in a way where she maintained her personal integrity as Pākehā and her identity of being a skilled and knowledgeable professional nurse.

Scott (1992) claims that making the experience of a different group visible exposes the existence of repressive mechanisms. Cultural safety made the Māori experience of health care visible and this often centred on the way in which health professionals used repressive mechanisms, such as the use of marginalising language, stereotyping or unequal power relations, to affect access to appropriate health care. Scott suggests that while repressive mechanisms may be made transparent, the inner workings of such mechanisms are not all that visible. Cultural safety made Elizabeth aware of the oppressive mechanisms but not how they operate because, as a hospital prepared registered nurse, she had not had the opportunity to reflect on these factors in her education or practice. Perceiving cultural safety as being about the other meant that Elizabeth did not understand herself as a bearer of culture and this separated her from patients whom she perceived having a definable culture and which was visible to her. As well as introducing a political dimension to everyday nursing, cultural safety calls into question the meaning of the nurse-patient relationship. It does this by removing the symbolic hyphen between nurse and patient as in the nurse-patient relationship by introducing the idea of negotiation and dynamism or movement. Hence working in a culturally safe way can liberate both participants from positions of dependency or interdependency to one of possibility through recognition of difference, self-determination and autonomy.

Historically a nurse-patient relationship was constituted through a relationship of care and compassion. A caring nurse-patient relationship was, according to Crisp and Taylor (2005) characterised by a reassuring presence, recognition that each person is unique and the ability to keep a close and attentive eye on a person. A critical deconstruction of the relationship through cultural safety identified that it was a relationship of unequal power with the nurse having the power and knowledge to identify, respond to and meet the health care needs of the patient. Although there was room for the patient to assert their own identity in this relationship, the care was in reality based on the principle of the nurse claiming to know what was best for a person. A person's participation in their own care was encouraged, however if that participation was at odds with the care of the nurse in terms of treatment preference or cultural or personal needs and wants, the power of the health care service took precedence over these preferences.

This section of Elizabeth's account of meaning relates to her early interpretation of cultural safety. Elizabeth was the recipient of an unintended consequence accompanying the introduction of cultural safety into nursing and she was caught between paradigms of knowing. She felt that she did not quite come up to the mark of being an effective nurse and while she was being asked to consider the position of Māori in the health care system, there seemed to be little support for her as a registered nurse, hence 'what about my culture?' or 'what about me?'.

Supporters and early initiators of cultural safety unwittingly produced the behaviour they professed they wanted to change in nurses and nursing, that is stereotyping and discriminating behaviour. While they wanted nurses to develop a greater awareness of socio-cultural positions of people for whom they cared, sometimes they did not bring this awareness to bear on understanding the position of the hospital-prepared nurse. Consequently there was an unconscious or conscious projection of this lack of awareness onto nurses in practice by claiming their colleagues were unsafe. Elizabeth was confronted with key changes in nursing at a professionally formative time of her life. She had to come to terms with difference in the context of her own identity as a hospital-trained nurse and the identity of the people for whom she might care. Scott (1992) notes that "while difference exists, we don't understand how this difference is constituted relationally". To do this, she says, "We need to attend to the historical processes that through discourse, position subjects and produce their experiences. Individuals do not have experiences but subjects are constituted through experience" (p. 25). Elizabeth's difference as a nurse was being constituted through her experience of coming in contact with a different and new kind of nurse.

The transfer of nursing education from hospital-based programmes to technical institutes led to a split between nurses who were '*hospital-trained*' and nurses who were *tech-educated*. With the introduction of technical-based nursing education there was sometimes both overt and/or covert shared animosity between the two groups. Hospital-trained nurses were charged with representing all that was *wrong with nursing* while technical institute nurses were charged with belonging to an *elite* group, who were out of touch with *real nursing*. 'Elite' was used pejoratively and conveyed disapproval rather than enhanced social standing. Each group was shaped by the practical and educational discourses which positioned their experiences within particular historical contexts.

Wilson (2001) notes a shift post World War II from illness to a health promotion focus in health care, opening up gaps between hospital registered nurses and a growing orientation to primary

health care. There was also a growing awareness of the dominance of a medically oriented health system and the growing inefficiency of an apprentice based education system. These factors added to the momentum for change for an improved system for nursing education in New Zealand (Carpenter, 1971). One discourse privileged practice built on history and tradition, while the other opened up opportunities for producing a different kind of nurse through the adoption of a critical lens. The latter meant discarding tradition rather than enshrining it and included a challenge to traditional notions of caring. Cultural safety in the 1990s supported the development of a different kind of nurse and at the same time alienated registered nurses like Elizabeth, who had already built up some years of effective nursing practice. Cultural safety was a strong signal that nursing was positioning itself differently so that it could be seen as the caring profession it professed to be in the eyes of the person receiving nursing care.

The educational agenda of cultural safety made the need for nurses in education to address difference and inequities in health care delivery in a much more explicit way than had been previously. Student nurses were asked to critically challenge taken-for-granted assumptions about the nature of nursing. Elizabeth had been socialised into nursing through discourses of late nineteenth century to mid to early twentieth century models of nursing education. Collectively such nurses became the object of critical interrogation by nurse educators, who had been socialised in the same tradition as their hospital colleagues, and by students in the technical education environment. Accompanying this process was the uptake of advanced nursing studies and university study by older hospital-prepared nurses. These nurses were coming to terms with a growing awareness of the currency of their nursing practices within health care environments.

Elizabeth was at the end of an era in terms of one kind of nursing preparation and she did not join the new education environment of some of her peers who had entered tertiary nursing education programmes. The uptake of advanced nursing studies by hospital-prepared nursing meant, for the first time, that they came in contact with new ideas about self, society and nursing. This new-found awareness and knowledge meant that they were able to reflect on their own practice and embrace the need for change in nursing. To follow through on this, many changed their scope of practice from clinical to education. The positioning of cultural safety education within nursing programmes added to a perception that it was something 'thought up' by 'the radicals'. Although cultural safety and nursing share fundamental core values, such as keeping people safe, respectfulness, trustworthiness and care for another person, the prefix of the word cultural to safety, positioned the concept as radical and political. Such concepts are anathema to

notions of a nurse embedded in a traditional humanist structure and who is a neutral, apolitical person providing neutral, apolitical care.

5.6 To understanding

The previous section of Elizabeth's talk positions her between two paradigms impacting nursing. She identifies tensions in reconciling her identity as a professional nurse and new developments in nursing knowledge. The next section of Elizabeth's talk demonstrates her trajectory from resistance to understanding cultural safety and shows how her identity has been constituted through her experiences over time.

I asked Elizabeth what, in light of the early meanings she attached to cultural safety, she considered cultural safety meant for her now. She reflected on a recent personal experience which gave her insight into how cultural safety might apply to her nursing practice.

I've just been in a job where I felt terribly unsafe as a person and as a nurse, and I'm going to get tearful but that's alright, and I went through the 'Is there something wrong with me' and I tried to deal with it prayerfully and I tried to change and everything, and then you [she] saw one of those silly things, 'do not adjust your brain, reality may be at fault' oh yeah, and I go, perhaps it is and I was feeling so unsafe I thought 'Is this what's meant by cultural safety?' It was like a little light going on and I thought, do people, like new immigrants, is this is how they feel because all my nursing life I've been in a team where you could say to somebody "Oh my God" and know that you would get help, whereas where I've been working all you would get is criticism, or no help at all. And it just made me think, "Hmm this is perhaps what it feels like you know".
(Elizabeth)

This experience produced a sense of not feeling safe. Elizabeth identifies with what it might be like for new immigrants as a means of conveying a sense of 'not fitting' in or 'feeling alienated'. Her own experience triggers an intuitive realisation or epiphany that led her to gain a deeper understanding of cultural safety. For her it was 'like a light going on'.

The experience of feeling vulnerable created for Elizabeth a personal understanding of cultural safety, making it more meaningful for her. According to Bruner (1990), narrative makes a link between the ordinary and the exceptional and “stories achieve their meaning through explicating deviations from the ordinary in a comprehensible form” (p. 48). Elizabeth’s account demonstrates Bruner’s assertion. She is made aware of what is not there but only in the absence of what is usually present. Davies and Harre (1990) observe that, as speakers, people acquire beliefs about themselves and these beliefs do not always form a unified whole. They suggest that people shift from one to another way of thinking about themselves as the discourse shifts and as their positions in different storylines are taken up. Elizabeth makes a link between her own experience and that of an imagined other. Her earlier talk about her culture and her identity takes on a different hue, her experience matters, culture safety includes her and she can connect her experience with that of another person because of her own experience of being made to feel different and isolated.

Elizabeth then related a story illustrating what cultural safety meant for her now. Although this story mirrored what Elizabeth considered to be everyday nursing practice, her sharing of it brought out meaning for her and made it an exception to the ordinary. Out of a multitude of nursing stories she could have chosen to tell, she told this one. It is interesting to note that this story is a template for a common story within medical or surgical settings. At times of acute illness there can be a perception that, although the need for family to be near their family member is important, the life threatening nature of a situation can take precedence over this. This can sometimes create tension and conflict between the nurse, the person and the family. Elizabeth’s account captures the essence of cultural safety for her. She is caring for a person from a Pacific country. His situation is life threatening and her actions need to be swift and life saving. At the same time she is aware that his family needs to be close to him during this critical time to give him strength, support him and offer prayer.

The guy, I had to prepare him for theatre, he was exsanguinating and they [family members] kept coming in, coming in and coming in and in... ...In the end I said “OK you let me do this bit, and then we’ll get you all in together and he can address you and then we’ll go to theatre”, ...and everybody was really happy about that. I got my bit done. I think what nurses, [rephrasing] ...we have to value what we do, because what we have to do has to get done, you know what I mean, and it has to be done safely and it can be done in a negotiated way. (Elizabeth)

The repetition of *kept coming in, coming in and coming in and in* conveys the degree of tension that Elizabeth was feeling. She felt pressure between her requirements as a nurse to administer life saving intervention and to balance this with the need for family to be present. At this point Elizabeth had choices in terms of how she would or could assert her power in this situation. At times of pressure and tension it is more likely that the nurse will invoke her institutionally-legitimated professional power to manage a difficult situation. In this case she could have removed the family by claiming the need to address life-threatening circumstances. She chose otherwise and what happened next indicates that at some level of her consciousness she was reflecting, problem solving and using her clinical judgement to assess how she could address her needs as nurse, the patient's needs and his family needs to do what they needed to do, to sustain them all at this time. Elizabeth then proposed a solution where the needs of all might be met through negotiation. Her words convey a confidence in her practice as a registered nurse and an ability to manage nursing needs and family needs in an authoritative, considered way in the face of high stress and a potentially life threatening situation. Such decision-making is born out of experience, maturity and confidence in her practice to combine acute nursing intervention and maintain the integrity of client and family. She orders her priorities and keeps the family involved in the nursing activities and has the confidence to offer a solution which she is aware may not be acceptable to the family.

Elizabeth then expanded on this story.

Nursing is a relationship; it's not going to work if I say, "You're too fat or you have to give up smoking." It's not going to work, not going to work for anyone, [it] has to be a relationship thing and if I say to these people "Look I have to get him ready for theatre because as you can see his life is in danger, but also you need to speak to him before he goes to theatre, are you happy? Yes fine." Cultural safety is about good listening, being a real person and I don't see why it has to be made into something special with a capital C and a capital S. To me that's just good manners, and an awful lot of the cultural safety to me sounds like listening and respecting that's all it sounds like to me. (Elizabeth)

Elizabeth's cultural safety practice is embedded in her everyday nursing. She does not consider that her practice is culturally safe, as she does not equate listening and respecting as indicators of cultural safety. Elizabeth's early experiences with cultural safety have shaped her perception of it as a concept she cannot relate to. Before the advent of expectations of

culturally safe practice, nursing education was charged with inculcating qualities of care, respect, politeness and good manners into young nurses. For Elizabeth these qualities were not part of cultural safety which was *something that radical nurses had dreamed up in a technical institute*. Being a hospital-trained nurse excluded her from identifying or claiming cultural safety concepts as qualities that informed her nursing practice. This suggests that, for Elizabeth, cultural safety and nursing are incompatible. She believes nursing is concerned with a standard of behaviour, while cultural safety is about politics. Towards the end of our conversation she reflected on shifts in attitude over time.

One of the things when I first started nursing, it was in [place named], where there were Māori and there were Pākehā, that was in the late 70s, it was made very clear to us, you know, this is how Māori do things, you know, Pākehā they can have two visitors, Māori need more for example, you know. But in those days we were culturally insensitive to everybody because we had the bloody door shut and it was “No, it’s not two o’clock” you know. And children, we owned them, when they came into hospital we owned them and I have really noticed since then, that’s 30 years, we don’t own our patients anymore and I think, as I talk about it, it’s becoming clearer in my mind, this is what you were saying isn’t it, we still have to stop thinking that we own people. (Elizabeth)

As Elizabeth talks, there is a shift in consciousness about institutional power and at the same time she offers a caution that although this may have been an attitude in the past, the past is still part of the present. Three qualities of narrative according to Bruner (1990) include: meaning is given to action depending on the point of view and positioning of the speaker; narrative forges links between the exceptional and the ordinary; and meanings mean little unless they are shared and brought out into the public arena. Elizabeth’s narratives of her interpretation of what cultural safety means for her demonstrate how meaning for her is shaped by her positioning within different nursing discourses and over time. She makes a distinction between the ordinary, nursing and cultural safety, the exceptional. The last section of talk suggests that new meaning arose through the process of bringing her thoughts and reflections into the open through our conversation.

5.7 Coming to nursing with cultural safety.

Debbie's story provides a point of contrast to Elizabeth's stories and this account of meaning draws on Debbie's personal identity to illustrate how her identity is linked with her everyday nursing practice.

Debbie is a registered nurse who is strikingly different from the rest of her nursing colleagues on first meeting. Debbie's identity is constituted through being Māori, Pacific and oriented to being gay. She dresses in a way which on first meeting might be judged superficially as anti-establishment. At the time of the interview she had a number of visible tattoos and wore a variety of body piercings. It was these external markers of difference that influenced not only how she saw herself as a nurse, but also how others perceived and reacted to her as a nurse, and as a person. Who she was shaped her nursing practice and to demonstrate effective accountable practice, Debbie mediated and negotiated her identity as part of her everyday practice to ensure that she provided care she identified as culturally safe.

Debbie's identity and the way she practised her nursing were inextricably bound together and guided the way she nursed. Her own marginalised positioning meant she filtered, assessed and monitored her way of being in the world as well as monitoring how she saw others perceiving her in their world. This made her highly reflective about what she saw, how she responded to patients and colleagues and how they responded to her. Ramsden determined that cultural safety is concerned with the nurse undertaking a process of reflection on his or her own cultural identity, as this process results in a raised consciousness, recognising the impact that personal culture has on professional practice (Ramsden 1993, 1995, 2002; Wood & Schwass, 1993). Debbie's story demonstrates how she used personal reflection and self consciousness in her everyday work. I have drawn on elements of Debbie's story to illustrate how her identity shaped her understandings of working in a culturally safe way.

The following talk from my conversation with Debbie identifies how she constructs her identity as a nurse. I asked her if she could recall any occasions where the way she looked had influenced how patients responded to her when they first met her. This is what she said about how she *imagines* patients reacted to her on first meeting and how she was represented in her own and the eyes of others.

I'm not sure if it's my culture or what it is, I guess when people, initially, see me they're like "Oh my God I got the shit nurse" (laugh) you know. ... They say to me "Are you actually a nurse?" "Where's your uniform?" "We wouldn't have that in my day." ... Yeah and those tattoos and that piercing.... but yeah initially people look at me and they think you know, there's something not right, you don't meet the little mould of being a nurse. (Debbie)

Debbie knows she looks different and expects that, on first meeting, patients will react to her appearance as she does not fit the usual perception of what a nurse should look like. The public myth of nursing as a profession presumes that a nurse is white, female, middle class, and heterosexual. Such a myth constructs a subject "who inhabits a context of medical and administrative dominance; of oppression by gender, class, race, and sexuality" (Street, 1995). Debbie's appearance reflects a number of marginalising stereotypes, including her skin colour and the fact that she dresses in a way that suggests she is both anti-establishment and gay. Collectively, these characteristics challenge the dominance of Street's subject in that she is neither white nor middle class. Debbie's visibility constantly risks censure, judgement or stereotyping by others. Therefore she has to continually monitor and assess her interactions for any signs of prejudice, hostility or negative reaction which may marginalise her or put her clients at risk of not feeling *safe* in her care. For Debbie nursing in a culturally safe way means having to care *for*, that is nurse the person, as well as care *about* the person, that is be mindful of their response to her appearance. She is aware that any aspects of her identity can misrepresent her as an effective and safe nurse and this has the potential to complicate her relationships with the people for whom she cares.

She continues and explains how she responds when this does happen.

And I'll go "Uniform is optional and I prefer not to wear it, I feel more comfortable in my own clothes. I'm going to be giving you the best care I can, but if you're not happy with me as your nurse then I can go and find someone else." ... and then this other patient piped up from way across the room "No, no take Debbie she's the best nurse here." And it was like, yeah! Do you know what I mean? (Debbie)

Debbie is confident with her identity. At the same time she is aware that her outward appearance has the potential to draw an anxious response from the people she cares for. She imagines they

might be thinking *can I trust this person to look after me well?* By anticipating such a response she is quick to allay concerns a person may have about her ability to care for them because of her appearance and she provides them with a choice. Debbie affirms the person's fears and does not dwell on her appearance but rather reassures them that she is safe and will provide the care they expect. The comment from the other patient, *no no take Debbie she is the best nurse take her*, is confirmation that Debbie is safe and it is her established relationship with this person that validates Debbie's comment that she will give the best care. Debbie's identity is affirmed and sustained even though everything about her speaks difference and deviation from the accepted traditions of how a nurse should look. Although Debbie sees other people as judging her because of her outward appearance, she expects that this will happen and has strategies to deal with it.

Cultural safety is about the transfer of power from the service provider to health care consumer. Debbie offers an opportunity for the recipient of care to judge her acceptability. To do this Debbie has reflected on the power her appearance has to influence health care and the development of trust. Without an awareness of how she comes across to people, Debbie could potentially affect the development of her relationship with her clients. Cultural safety aims to reduce risk to patient or client and protect from hazards to health and well-being. It includes regard for the physical, mental, spiritual and social aspects of the patient and the environment (NCNZ, 1995). Through working reflexively, Debbie not only reduces the risk of hazard to the health and well-being of a person but, because of who she is, she anticipates risk and incorporates this into mediating and building positive relationships with patients.

In negotiating her own difference Debbie has to mediate a number of relationship positions. She has to consider her impact on patients, nursing colleagues and other health colleagues. For her, being culturally safe means having to be consciously reflexive in her relationships. How she positions herself and how others position her is highlighted by her own dramatic appearance. She has to be self-conscious about who she is and is ever mindful that how she looks might affect how her caring is perceived. For Debbie, being an effective and culturally safe nurse is a core aspect of her identity. I asked her "What tells you that you are nursing in a culturally safe way?"

I think because I feel right about what I'm doing. When I don't feel right it's usually because I'm not doing something right, you know culturally perhaps... It's a feeling like am I putting on a pair of shoes that are too tight? I feel uncomfortable if I've compromised; it feels like it compromises my nursing if I do something that's not culturally appropriate. (Debbie)

Debbie uses a metaphor of shoes being too tight to convey what nursing in a culturally safe way means for her. The shoes are too tight when she knows she is not doing something culturally right. She has high expectations of herself in delivering culturally safe care and any action that does not meet this standard makes her feel as if she has compromised her nursing care.

Debbie recalled a situation where she had experienced being uncomfortable and compromised, or when the 'shoes were too tight'.

More probably when I was a student and I was working on a ward and someone had died and they were just totally disrespecting the body and I was just, I felt awful and I felt like I was compromising my nursing and myself. (Debbie)

Debbie experienced tensions between what she knew to be right and her perceived powerlessness to be able to do anything about what she was witnessing. She has an internal sense and feeling of *rightness* and when she observes nursing practice which she experiences as unsafe, she feels responsible, not only on a professional level, but also on a personal level. Central to cultural safety is the nurse's willingness and ability to be self-reflexive and to understand that safety underpins all aspects of nursing care and competence. Ramsden (2002) identifies an absence of cultural safety as being initiated by any action which diminishes, demeans, or disempowers a person. There is an assumption that if one operates from a position of self reflection then one can act on this reflection, act in the interests of the patient and prevent any action that that risks diminishing, demeaning or disempowering another person. Debbie's account suggests that to act one has to be in a position to act and as a student she was not in such a position so she had bear with her tight shoes.

Debbie reflects:

You know I've just got to be who I am, I've tried to be other things, tried to fit in but it just doesn't fit so I just be who I am now. (Debbie)

This is who Debbie is and she has to be true to herself even it means creating a potential for her clients to see her as not being safe for them; to be otherwise does not work for her. She acknowledges this in her talk and makes a space in her everyday practice to negotiate difference with her client. This is what culturally safe nursing means for Debbie. Debbie makes no separation between her personal and her professional identity. Her physical appearance demands

that she not only cares about the people she cares for and their responses to her but also is also confident of her ability to care for them and to be able to meet their needs.

5.8 Knowing your own beliefs

Louise, like Debbie, was a recent nursing graduate from a technical institute nursing programme. Louise started her nursing education later in life. Having been mother to her children she felt that she needed to do her nursing training, something she had wanted to do for some time. At the beginning of the interview, she said:

Well I think it's about knowing your own beliefs and recognising those as your own and not beliefs that you should put onto other people, so that's from my perspective and then from the perspective of the patient it's about getting to know what their values and beliefs are and that means you need to have a bit of time to listen to them, yeah. And to consider their family; the wider, bigger family situation. That a person's not just a person on their own, they've got husbands, children you know fathers, mothers, and all that sort of thing, and all their other issues whether they be financial or whatever. So to me I try to consider all that. And then also recognise that yeah also if I might be getting stressed or whatever, to recognise that as well. (Louise)

Louise's meaning of cultural safety encompasses the more general qualities associated with the concept. Her approach incorporates a community focus where each person's perspective is acknowledged. Starting with herself as the nurse, she recognises a relationship between her and the person for whom she is caring, *from my perspective* and then *from the perspective of the patient* as well the person's wider family and other variables such as finance. Embedded within Louise's comment are three key factors identifying cultural safety principles in nursing practice. These are; the need to recognise one's own values and beliefs and the effect of these on care; the importance of listening and the ability to reflect. In Louise's story reflection is a conscious act which helps to make her aware of when she is stressed. When Louise says that you *need to take time to listen* when finding out what people might need and the need to recognise her own stress, she demonstrates an awareness of herself as an active participant in the relationship.

Cultural safety is concerned with the proper use of power. By proper use I mean that within nursing in New Zealand, power is recognised as a critical factor in delivering care that is considered culturally safe by the person receiving that care. Any action or intervention that

disables or compromises a person's ability to maintain control over self is deemed to be unsafe care (Papps & Ramsden 1996; Richardson, 2000; Wepa, 2001). Louise identifies that, for her, cultural safety means not only knowing about herself and the person for whom she cares, but that this knowing can be influenced by time and stress. Louise's position suggests that she is confident in her belief and ability to provide care in a way she considers to be culturally safe in spite of the variables of time and stress.

5.9 Protection

Another participant, Janis registered as a nurse well before the introduction of cultural safety into the Aotearoa New Zealand nursing education curriculum. Her knowledge and views about cultural safety were, like Elizabeth's, gained through a process of heightened self-awareness of changes in nursing over time, a commitment to nursing, and a willingness to maintain currency of nursing ideas through study and involvement in nursing organisations.

For Janis cultural safety means:

The protection of individual clients' or patients' identity and beliefs and the preservation of their dignity; generally just respecting their beliefs, their values, what they want. We're there to assist them to achieve health, because we're a health provider, a health carer and we must, we as nurses must provide that in a manner that safely guides them through that and it's nothing to do with our own beliefs – we have to put them aside very often and we have to be mindful of that person that we're caring for, that individual, we have to give them what they're comfortable with, with what fits their family circumstances, their beliefs, that's what I think cultural safety's about. You have to be very comfortable in yourself, you have to know who you are. (Janis)

Located within Janis's talk about what cultural safety means for her are a number of positions, all of which sit comfortably with her. She provides an integrated explanation of how this meaning is shaped by her early socialisation as a nurse. Ramsden (2002) asserts that a defining quality of cultural safety in nursing is that the nurse cares for people *regardful* of who they are in the world, rejecting Nightingale's view that nurses care for people *regardless* of culture which was a concept underpinning Janis's nursing education in the 1960s. Culturally safe care requires that the nurse be self reflective in relation to her own position of power and this means that she cannot put her values and beliefs aside, instead she has to be mindful and aware of how they might affect

her care, as in Debbie's case. Before *putting aside* a value or belief one must first be able to recognize that a value, belief or attitude is influencing what might be happening and may or may not be in conflict with the values or beliefs of the person receiving care.

Janis's talk rejects a discourse within cultural safety rhetoric that marginalises the older nurse as not knowing about, or understanding, cultural safety or, in more extreme cases, being deemed to be culturally unsafe. This automatically excludes people like Janis from the cultural safety dialogue and assumes that she will take a position in opposition to the concept. It is considered that nurses who became registered prior to cultural safety education needed to be educated about cultural safety through professional development courses. Janis reflects the qualities of culturally safe practice and nursing in that she identifies self-awareness as an essential quality in care delivery. She is person focused. *We have to give them what they're comfortable with, with what fits their family circumstances, their beliefs, that's what I think cultural safety's about.* The use of the words comfortable and fit are nursing terms and are consistent with culturally safe nursing as well. Janis brings the two together seamlessly as if they are one and the same. She positions herself as an active partner in the nurse person relationship when she says that, "we as nurses must provide that in a manner that safely guides them". Her use of *must* indicates that this is a nursing imperative that is not negotiable and she sees herself as a safe figure, a guide who is a knowledgeable nurse and responsible for providing the right care based on her knowledge as a health professional. The meanings of what it is to provide culturally safe care for Janis and Elizabeth have emerged from their many years of experiences of nursing care which, while identifiable as nursing, are also identifiable as culturally safe care.

5.10 Cultural safety is about manners and being respectful.

Sally has been working in an acute care area for some years and has absorbed culturally safe care into her practice as she has come into contact with nurses who have had more formal preparation in cultural safety. In the following narrative Sally starts off by aligning her meaning of cultural safety with the ethical principles associated with a medical discourse.

Do no harm principle which is medicine, which is what the nursing discipline is and the main differentiator for it is caring, and I think if you are someone who wants to do no harm and wants to care and support people through having to use health services and whatever that means for them, part of the principles that underpin that are wanting to be respectful, kind and courteous and

acknowledging that someone's belief system or set of values is important to them. It is just the same as acknowledging that being a vegetarian is important, or being on a restricted fluid diet is important to their health, so are their spiritual and cultural issues. (Sally)

As has been established, Sally, like Janis, Elizabeth and Polly graduated prior to the introduction of formal cultural safety education and, as a registered nurse Sally needed to consider culturally safe care as it became more visible in nursing. In describing what cultural safety means for them, each have used words that reflect values that are sometimes associated with humanist or traditional, feminised discourses about nursing, for example: kind, courteous, manners, comfort and polite. These discourses have quite rightly been critiqued through a feminist lens as being qualities historically associated with gendered nursing roles (Street, 1995). However it is notable that this language and these qualities need to be considered as key ingredients of culturally safe nursing practice.

Frank (1995, 2005) uses the term generosity to convey to health professionals that a generous disposition is a contributing factor in healing. His views resonate with the ideals of culturally safe nursing and words such as: generosity, welcome, guest and consolation are used to illustrate a need for health professionals to provide care which is respectful of the person and protects a person from harm through a caring, thoughtful, compassionate health care relationship. Frank considers that “fundamental to medicine are face-to-face encounters with people who are suffering bodily ills and other people who need both the skills to relieve this suffering and the grace to welcome those who suffer” (Frank, 2004, p. 1). Sally's meaning reflects Frank's view as well as recognising the importance that a set of beliefs has for a person. Rather than use the more common reference to ethnicity to identify values that are different from hers, she uses a person's preferred nutrition to explain what she means.

Sally's next comment positions her previous observations within a relational context.

... therefore cultural safety to me means being respectful of another person's values and what's important to them and incorporating that into how you interact with them. And it's really simple stuff. And it can be as simple as saying, “I don't know what's important to you and your culture, tell me about that so that I don't make any mistakes while we're working together.” But I

don't see that understanding evidenced in how I see people providing care.

(Sally)

Sally's view of culturally safe nursing mainly involves coming from a place of respect and if respect is valued then understanding cultural safety is simple. Sally indicates that knowing what is important to a person is what will shape the interaction. She says that culturally safe nursing is simple and she cannot understand why it is not self evident in the care she sees being provided around her. For Sally it is important to position herself relationally with each new patient and this means being comfortable with coming from a place of not knowing, and through finding out what is important, to a position of knowing.

5.11 Cultural safety is about listening

Patricia is another older woman and a more recent graduate of a Bachelor of Nursing Programme. Patricia had many years of working in the union movement and therefore brought a social justice lens to her work as a registered nurse. For her cultural safety:

... Involves looking at where the person is coming from and what their issues are and what they need and how they need it provided, so it's different for different people. And you know trying to listen and see what, you know, a lot of people haven't been listened to they've just had a prescription chucked at them and told to go away. Well ideally it's people feeling okay about the person they're with and feeling confident that they'll be treated well, they'll get, you know, treatment the same as everybody else and they'll get it from somebody who respects them as sees them as a whole person. (Patricia)

Like Sally, Patricia expresses a strong relational and partnership element in her articulation of the meaning of cultural safety. For her, there is a contextual element to cultural safety and the way issues and needs are provided for is not the same for everybody. She draws a comparison between what she does in terms of listening to people and what she experiences from her observations of care by other people. Her use of the words *try* and *ideally* suggests that, for Patricia, cultural safety is a standard or a level of care or service that is desirable but may not always possible.

5.12 Cultural safety is about difference

Polly is an experienced registered nurse and has had a number of years teaching cultural safety to undergraduate nursing students. Polly has a background in social and political activism and was at the forefront of protests during the 1981 South African Springbok rugby tour. She works in the community with people who have diabetes. Her university studies prepared her for teaching cultural safety. It was through these studies that she came to learn about Te Tiriti o Waitangi and inequities in health between Māori and Pākehā. Polly's exposure to new and different ideas about difference had a profound impact on her and deeply influenced how she practised her every day nursing.

For Polly, working within a Cultural Safety framework means

Having your beliefs and values respected by others and being party to the decision making and planning, be it health care or whatever the project is, that there is an equity in power, not a hierarchy in power and certainly having your cultural values and, as I say respected and incorporated and catered for within a system. So while cultural safety for me brings to mind primarily the relationship between Pākehā and Māori and then perhaps other ethnic groups, or ethnic minorities within the country, it also relates to other groups who I think are at risk, other minority groups, the gays, the lesbians, those with disability, adolescents, elderly, children, women – although we are not the minority, there is an equity issue in power sharing between men and women still within NZ. So cultural safety again just reiterating, I think is about who has the power of decision making, who has access to information and education, how does the relating, the communication occur, who has the power in that process, and culture is about all those things that we know about, about language, about dress, about diet, about who we mix with and if care is to be culturally safe it needs to identify, acknowledge, address and incorporate all these aspects of who we are respectfully and then modify the care accordingly, not the other way around. And I think, especially in chronic care it's many little steps will climb the mountain. (Polly)

Polly extends the meaning of cultural safety and describes how it goes beyond what happens between the nurse and the person for whom they care or work with and broadens it out to any

project that involves decision-making and planning. Here she alludes to the notion that the need for cultural safety includes any relationship or relationships with the health care sector and not only those relationships between the nurse and the patient. Her narrative reflects her socio-political influences and she brings these into her culturally safe practice. Davies and Harre (1990) observe that “an individual emerges through the processes of social interaction and as one who is constituted and reconstituted through various discursive practices in which they participate” (p. 45). Polly’s political socialisation, and sexuality, bear testament to this statement. Cultural safety for Polly means taking multiple social, political, personal and professional factors into account combined with an understanding of how these factors impact on everyday nursing practice with her clients.

5.13 Cultural safety is about communication and difference

Whereas Polly views culturally safe nursing through a political lens, for June cultural safety is about how relationships are played out on in the context of difference. June practices in a community mental health team. She returned to the practice field after many years teaching cultural safety in an undergraduate-nursing programme. Her past experience as a cultural safety teacher means that her practice is grounded in cultural safety concepts with communication and relationship being primary.

I think that the whole thing for me around being able to relate to people one on one has always been kind of how I’ve... ’cos that’s what I see cultural safety as in terms of working with people who are different to you and often you know it might be somebody who is different ethnically. (June)

June comes from a strongly relational framework consistent with nursing and the key to this relationship is difference between her as the nurse and the people or person with whom she works. Her use of the word ethnically to mark difference illustrates the ease with which even an experienced and aware person can draw on this one word as an identifier of difference. June’s view about difference is much broader than she indicates in this section of talk and demonstrates the power of language to unconsciously denote difference.

June’s next section of talk provides an explanation of how she frames cultural safety as relational and as communication. June described a situation where she had explored communication with

registered nurses in a teaching situation. The situation involved managing conflict. She reflected on this situation in relation to her understanding of difference in cultural safety.

As a registered nurse I think that you're responsible for diffusing all sorts of [conflict] situations [involving distress in the context of difference]. That you are the ones, you don't wait for them to, [deal with the situation] you know they [patients] are ones who are distressed, I mean it's really conflict resolution, it is conflict resolution you know. (June)

June highlights the need for the nurse to manage stressful situations related to difference rather than expecting a patient to manage the situation. Cultural safety for her can mean being proactive in dealing with conflict situations and providing protection against stress and conflict.

She then followed up with a comment about what happens when nurses are faced with difference.

But often we're [registered nurses] more distressed around people that we don't understand and who are different to us and we don't know where to find a way in, you know, how access the person. I used to say, "Listening is really good." You know, listening you don't have to say anything; you just kind of reflect back their concerns. (June)

June touches on a common theme in nursing and cultural safety, that of powerlessness as experienced by the nurse. Spence (1999) notes that nurses experience greater uncertainty when nursing people from other cultures. She asserts that difference is sometimes associated with difficulty because "the nurse cannot assume that the patient will share, or be able to understand the values and beliefs that inform nursing practice" (p. 50). The sense of powerlessness can then arise because the identity of the nurse becomes destabilised. It is at these moments that the nurse may resort to the forms of institutional power conferred on her by her position within the organisation in order to regain control. However this may disempower the person with whom she or he is relating. This can take the form of asserting the institutional rules to regain a sense of control. Hatrick- Doane, and Varcoe (2005) suggest that moments of being faced with difference can become hard spots and these are most evident when nurses experience difficulty or find a situation challenging when relating to particular people. It is then that the situation can result in the nurse feeling a sense of powerlessness or feeling frustrated at other people's actions. June

suggests that at times when a nurse is feeling distressed by differences that she is unable to work with, she needs to stop and listen and be present for the person.

5.14 Cultural safety is about reflection – Being able to check yourself

In the following extract Ruby adopts a reflective stance about what cultural safety means.

Recognising your own beliefs, your own experiences and how you feel about those. And by acknowledging that sometimes you can think you know, 'yes I read that thing and I think, you know I've always', or maybe you've had experiences with [Government Department], I mean we all have our own journeys and things, and it's sort of about being able to look deep into those and say 'Well maybe I'm not thinking from a nursing perspective, I'm thinking from a personal approach' you know? And that's the whole thing about cultural safety isn't, it's sort of about being able to check yourself, you know, and recognise are you safe, and is that a safe way to practice. (Ruby)

Ruby starts from a position of self and the need to monitor her own thoughts and actions in relation to every interaction she has, not only with clients but also with colleagues in other work settings. For her cultural safety is a personal journey as well as a professional journey with both occurring concurrently. Her talk implies action that is ongoing over time. Her experiences require that she reflect on her actions as a way of monitoring her own nursing practice and assess those actions against what she considers might be a personal rather than a nursing response. Ruby is one of the more recently graduated participants. She is beginning her nursing career equipped with the tools of cultural safety, unlike Elizabeth, Janis and Sally, who have come to acquire cultural safety knowledge through nursing experience. She shares with Janis a recognition of the importance of her own personal beliefs and the need to be able to self reflect to monitor how such beliefs may influence her practice. In her everyday nursing practice Ruby is aware that cultural safety goes beyond what happens between herself and her clients. Like Polly, she is aware of the broader influence of other institutions on her practice. Ruby works in new community agency. She is part of cohort of health professionals providing care for a specific group and is mindful that if she did not practise in a culturally safe way then she would not have a group to work with. For Ruby culturally safe nursing is at the forefront of her practice and her job depends on being

able to reflect and engage in a way that requires consistent reflection on practice in every nursing encounter.

5.15 Summary

This chapter started with Elizabeth's stories of meaning of cultural safety and ended with Ruby. They are connected by professional identity and separated by time. Elizabeth, a registered nurse with 30 years experience related how she came from a position of resistance to the concept of cultural safety, to one of understanding. For her cultural safety is implicit in her nursing practice, although she does not recognise this in her account. Her early perception of cultural safety is tinged with a view that it was a political activity. Also, because she undertook her nursing training in a hospital-based programme, she felt excluded from taking part in any ownership of cultural safety knowledge. She came to understand cultural safety through nursing. Ruby, the most recent graduate came to know nursing through cultural safety. By this I mean that Ruby has the tools and knowledge for understanding cultural safety and it will be these which develop and guide her nursing practice. Elizabeth and Ruby occupy complimentary positions which trace the interconnectedness of nursing over time. Their positioning collapses the notion that older nurses are not culturally safe because of their nursing preparation. These narratives show that identity is not fixed and changes over time according to experiences and how these experiences are interpreted. A consistent theme each woman demonstrated was that meaning is shaped by history, personal and professional identity. Meaning changed over time and the personal identity and way of being in the world shaped their understanding of cultural safety in their everyday practice.

The above narratives of meaning illustrate a range of personal and subjective interpretations of cultural safety in everyday practice. Whether from the most experienced or least experienced participant, accounts of meaning resonate with one another and at the same time reflect diversity of meanings attached to cultural safety. The meanings identify shared values which include knowing about self, knowing that behaviour and attitude can shape how the participant sees herself and how she perceives how others see her. Each meaning includes some aspect of respect, mindfulness, good listening, compassion and the provision of health care according to patient need. For some there is an overtly political element as evidenced by resistance to the dominant discourse of nursing; for others humanist qualities of caring are brought to the fore. Together, the stories provide a snapshot of the landscape of cultural safety. Cultural safety is

embedded in everyday nursing practice and may not be visible until there is a deviation from the usual nursing activity or some aspect of nursing care indicating patient vulnerability stands out. Meanings of cultural safety are subjective and shaped by worldview, socio-economic positioning and the personal experience of being in the world.

This chapter has demonstrated the relationship between identity and the construction of meaning in relation to cultural safety. The next chapter examines in depth the narratives of four participants to illustrate the application of cultural safety in the context of health care settings to show that working in a culturally safe way is shaped by the context in which it takes place.

Chapter six: Settings and identity- Structure and agency - Toward a settings approach

6. Introduction

Nurse-patient interaction makes little sense without an understanding of the structural location of the nurse and the patient. This location influences, if it does not determine some of the ways in which interaction takes place, which is in turn influenced by broader social, economic and historical factors (Nairn, 2009, p.192).

Chapter five provided accounts of participant stories, identifying historical descriptions of tensions associated with the introduction of cultural safety into nursing education. This chapter draws on health promotion settings, relational settings and narrativity to provide a framework for an analysis of how participants construct their identities and how these are constructed by broader social and structural influences within culturally safe nursing.

The narratives suggest that while cultural safety is interpreted differently at a personal level, its emergence from political activism and positioning within emancipatory discourses presumes an understanding by the nurse of social and political influences on nursing practice. I argue that sometimes the responsibility for providing culturally safe care rests with the individual nurse and broader structural factors such as values, philosophies and practices can be overlooked or are not always taken into account in the practice setting. There are two parts to each participant's account.

Themes within each of the following narratives illustrate the complexity and subtlety of providing culturally safe care. Christina's account takes place within an iwi based Māori setting and draws on explores cultural safety the context of cultural difference between Māori and Pākehā. Barbara's narrative focuses on cultural safety in a bicultural setting which acknowledges Te Tiriti o Waitangi but where pākehā values dominate. Jill's account draws on her experiences in a hospital-based surgical unit where the setting itself becomes a barrier to providing culturally safe care. Ruby's narrative, from within a contemporary primary health service, identifies how the policies, practices and relationships of the service are aligned with cultural safety principles and the focus of care is able to be on the recipient of care. Common to all narratives are themes highlighting the structural, relational, and ethical contexts of care.

6.1 Defining a settings approach

A health promotion settings approach is a useful framework for analysing themes in this chapter because cultural safety resonates with a health promotion philosophy as both attempt to reorient health and education away from traditional notions of care towards an approach to health care that is both socially and political active. The Ottawa Charter for Health Promotion (World Health Organisation (WHO), 1986) has been instrumental in providing a new direction in the delivery of health care worldwide by declaring that “health is created and lived by people within settings of their everyday life; where they learn, work, play and love” (Dooris, 2006, p.4). The Charter is considered a catalyst for shifting the focus of care from a deficit model of disease to one in which the potential for health may be realised within the social and institutional settings of everyday life (Dooris, 2006). In Aotearoa New Zealand, cultural safety reoriented nursing education and practice by providing a structure for an analysis which initially included the impact of colonial power structures on Māori health and subsequently considered the impact of power on shaping all health care relationships (Browne & Smye 2002; Ramsden, 2002). The concept has contributed to a shift in focus away from a biomedical model and an individualised nursing care model toward relational models and an analysis of the structures and influences shaping health care relationships.

Health promotion approaches to health care tend to be associated with community health care and though there is a wide acceptance of health promotion frameworks as service models, two early initiators of the concept have expressed concerns about its application in practice. Kickbusch (1996) notes that the approach is problematic as it does not fit easily with the more readily acceptable evidence-based practice model, this in part being that a health promotion model requires a focus on health through a social and political lens. Whitelaw, Baxendale, Bryce et al. (2001), drawing on Wenzel (1997), highlight a tendency to confuse health promotion *in* settings with *health promotion settings*. This means that a settings approach can be confused with the application of health promotion programmes within a tradition of individually focused care. Cultural safety and health promotion models both turn attention to the need for a socio-political focus in the delivery of contemporary health care and yet both concepts appear to be poorly understood and unevenly applied in practice (De Souza, 2008; Wilson, 2008).

According to Poland, Green and Rootman (2000), the building blocks of a health care setting are: its physical structure and layout; the temporal patterning of behaviour or the shaping of behaviour over time; the material milieu such as objects and things; and the social environment. A second

feature of a health promotion setting is the pattern of interaction determining how and by whom the setting is defined and how social roles and resources are allocated (Poland et al., 2000). A third feature draws attention to the shared social assumptions accompanying social roles and the subsequent shaping of the nature of the interaction within a setting. The expectations or norms regarding how a person should act in a setting are yet another feature of a health promotion setting. Poland et al. (2000) note that what is normal or usual in one place may be different from that of another place, and that broader social relations, for example those based on race, gender, occupation and age, cut across all settings. One key point to be drawn from Poland et al.(2000) is that the structure of the New Zealand health care system is still largely monocultural. Over the last 20 to 30 years philosophies and policies have moved the system toward more inclusive approaches to health care delivery. However, these have occurred more at the margins of the health care system and the building blocks at the centre of health care delivery continue to be underpinned by the values and beliefs of a monocultural system established and anchored in dominant discourses of health, cure and treatment. The stories presented in this chapter demonstrate the relevance of a settings approach to the application of cultural safety knowledge in everyday nursing practice. They will show how different health settings and diverse social, political and historical influences impact on, and shape, the identity and culture of the nurse, the client, their interaction, relationship and health care outcomes.

6.2 Defining narrativity and relational setting: Agency/structure

Health systems are inherently relational and so many of the critical challenges for health systems are relationship problems (Gilson, 2003, p.1453).

The following narratives identify the struggles, conflicts and moral concerns participants' experience as they work to construct and reconcile their personal and professional identities within a network of collegial and institutional relationships. Somers' (1994) concepts of narrativity and relational setting, discussed in chapter three, provide a second theoretical lens for this chapter. As discussed in chapter four, Somers (1994) identifies four dimensions of narrativity; ontological, public, meta and conceptual. Ontological narratives are the stories that social actors use to make sense of how to act in their lives. Stories and actions define who a person is, as it is through temporally situated, shared interaction that identities are co-constructed, hence the focus on a relational setting in this chapter. A relational setting consists of patterns of relationships among institutions, public narratives and social practices and these are made visible through relational and social networks. Public narratives are connected to cultural and

institutional structures that are larger than the individual and these narratives construct networks within cultures and institutions. Such narratives shape and are shaped by particular understandings of the world which tend to prioritise one meaning over another and therefore public narratives are not neutral (Phibbs, 2007).

Metanarratives encompass the storylines in which people are embedded as “contemporary actors in history” (Somers, 1994, p.619), and as such usually operate beyond the level of awareness. According to Somers these narratives attend to the “epic dramas of our time, for example Capitalism vs Communism or the individual vs society” (Somers, 1994, p. 619). The everyday actions and interactions of the participants in this chapter are impacted by meta narratives; for example tensions between agency and structure, the impact of colonisation, or the role of medicine in the enlightenment project.²⁷ In this chapter, relevant theoretical concepts examined are cultural safety, settings, identity, time, place and relationship. These represent what Somers (1994) calls conceptual narrativity as they provide an analytical template against which to examine how actors make sense of their social lives or, in this study, how participants make sense of cultural safety in practice. The following stories examine how each woman in this chapter constructs identities that shift and change over time and place as they engage in relationships which shape, and are shaped by, personal, cultural, professional and institutional influences.

6.3 Introducing the participants and the settings

The participants have been introduced in chapter four. The four participants in this chapter are introduced again in the context of their practice setting. Their narratives show how they come to make sense of their actions, who they are as nurses and how they strive to practice in a culturally safe way in their work settings. Accounts have been selected which best identify and explain how identity, setting, relationship and culture work to support and/or constrain culturally safe nursing practice.

6.4 Christina

Christina is Pākehā and works in an iwi-based primary health care service. Her story is about her shifting cultural and professional identity over time and in relation to place. Christina works in

²⁷ The enlightenment project spanning the late seventeenth to the mid-eighteenth centuries was a time when changes in European intellectual thought initiated intense epistemological transformation away from a reliance on nature to a reliance on science to explain, diagnose and treat the body. Lupton (2003) notes that during this period ideologies, discourses and practices surrounding current approaches to biomedicine became dominant by claiming an enlightenment ideal of faith in the progress of society assisted by the developments in science and technology and a belief in the power of reason in shaping human understanding.

an environment where there is an emphasis on providing a health care setting which sustains the cultural integrity of the client and attends to the person's health needs in the context of their life situation and everyday surroundings. Christina's setting provides health care in an environment reflecting the values of the people using the service.

6.5 Barbara

The cultural identity of the nurse is also the focus of Barbara's narrative. In contrast to Christina's story, Barbara struggles to make her identity visible and this experience resonates with that of a client she is working with. Barbara works in a community Māori mental health service situated within a mainstream community mental health service. Te Tiriti o Waitangi is recognised in this setting with the specific health needs of Tāngata Whenua affirmed in their right to appropriate, accessible, affordable and achievable health care. Barbara's story identifies how the mainstream culture dominates the organisational setting in which she works. Barbara negotiates three different structural categories - Māori, Pākehā and nursing - describing how she mediates her identity within and between these three social groups. For her this means working at the margins of all three and to do this she brings a unique and personal perspective to cultural safety in her work.

6.6 Jill

Jill is Pākehā and works in an acute specialised unit in a large city general hospital. Her story is narrated within the context of a traditional health care institution where the organisational values and the roles within the setting are informed by, and structured in relation to, a medical model and individualised nursing care. Her story identifies how the physical structures, practices and routines employed in the unit may enable or constrain culturally safe practice.

6.7 Ruby

Ruby is Pākehā and works in a recently established primary health care service with a focus on young people. In providing an account of her process of developing a culturally safe stance and consciousness, she offers a story about the nurse as a bearer of culture. Historical stories of self and nursing experience are resources that Ruby draws on to show how these shape her current practice. Her narrative identifies how the values and structure of a health setting guide the

philosophy and practice of person-centred health care environment. This enables Ruby to focus on cultural safety by drawing on the original intent of creating safe environments of care where identity is protected and sustained.

6.8 Christina’s story: Cultural safety: “A bit hazy in the middle”

Christina’s story initially identifies how, as a Pākehā, she came to work in an iwi primary health care organisation and outlines the cultural challenges she had to confront in terms of her own identity and her relationship with indigenous Aotearoa New Zealanders. Her accounts focus on episodes which demonstrate the way in which personal, cultural, structural and geographical influences shape her identity over time and in relationship with others.

Christina had been relating her experience of cultural safety education and how, at times, it had been inadequate for preparing her to work within an iwi-based health care setting. She wanted to work in primary health care and a vacancy came up for a nurse within an iwi primary health care agency. She said:

I ended up working at the marae and suddenly worked out that we didn’t know very much and it concerned me that a lot of people weren’t learning about cultural safety. The job was working in primary health care and it was working with people with diabetes and who were overweight, this was in the job description, nutrition and that’s what I really wanted, and I kept thinking I’d done the wrong thing [applying for the position] ... I said to my husband “that’s the job I want” ... I said “I want that job and I’ll never get it because Māori will hire Māori because that’s how it’s got to be you know, to benefit them”. He said to me “but you’ll never know until you do it” and I said “Oh okay then” so I did and I got it which floored me really. (Christina)

Christina felt that as a Pākehā, she was not an appropriate person to be working for a Marae-based health care provider in which delivery of health care was based on Māori health perspectives. She reflected on her past learning and realised that she and her Pākehā colleagues, indicated by the use of the term ‘we’, knew little about cultural safety or working with Māori clients. She excluded herself as being a suitable candidate by assuming that the position would naturally be offered to a person who was Māori, illustrated in the statement *Māori hire Māori because that’s how it’s got to be*. Her perception suggests she has a view that Māori health

development needs to be defined and managed by Māori (Durie, 1994; Greenwood, Wright & Nielson, 2006; National Council of Māori Nurses, 1986). Timu-Parata (2007) identifies health services delivered by Māori as being characterised by “traditional values and beliefs, processes and structures” in response to health issues and in the context of ongoing change and challenge of living in modern Aotearoa society (p. 34). These include health promotion approaches and strategies, which help “make Māori feel comfortable about health care delivery” (p. 35). For Christina, her Pākehā positioning adds another dimension to her personal and professional self-awareness and means she has to develop a working understanding of traditional values and beliefs and learn how these play out in every relationship she engages in within this setting.

Christina’s self-consciousness about her own Pākehā identity and culture caused her to review her cultural credentials in relation to the position. Her sense of identity as stable or predictable within her own culture was destabilised by the thought of working in a culturally different setting and with encouragement she overcame her self-imposed exclusion. Even though she assessed herself as not being suitable because of her lack of knowledge about Māori health, her interviewers had judged her as being safe to work with Māori clients. Huygens (2007) notes that in the context of Te Tiriti o Waitangi, change is more likely for Pākehā when they experience a “shift in self interest toward a greater investment in the well being of Māori” (p. 173). As a potential health professional working within a Māori health setting, at this stage, Christina she may not have been aware of a Māori perspective about supporting the health of Māori, but she was committed to working in the area of primary health care, so she applied for the position. She was accepted, and subsequently began a process of negotiating and constructing a different cultural identity, one marked out by multiple differences, histories, identities, experiences and physical structures.

In accepting the position she is faced with her first challenge of being different, that is, being visible as a Pākehā and defined as different by members of the group for whom she will be working. Christina notes:

For me a lot of it has been going into another world because I’m the only Pākehā at the marae and I’m the only nurse and I guess I’ve just sort of tried to step back and let them tell me how they want it done. (Christina)

When I started I was scared I was going to do something wrong, really scared, yeah, and I had cultural supervision, and the man who gave me cultural supervision said ‘oh well don’t worry about it ‘cos you will [do something

wrong] and they'll tell you off (laugh) ...but I guess it is just the little things that, they know the thoughts and feelings behind it [actions, practices] and now I think I've built up a good enough relationship that if I did something wrong they would see it as an error, rather than something malicious or derogatory...I hope they know me well enough that I do try. (Christina)

As well as locating herself within a Māori health setting, Christina came to her new position with limited experience of Māori cultural narratives and with a Pākehā interpretation of Māori health care services. In entering a Māori world Christina became the other and the exotic, while her clients and colleagues were the ordinary or the normal. As a result her identity began to shift from being one of many like herself, Pākehā, to being the only one of her kind in a culturally different setting. By being Pākehā in a Māori health setting Christina had come to the borders of her own culture and to the edge of another where she was not familiar with the everyday cultural practices and ways of being of her clients and colleagues. Christina had been assessed as being an appropriate person for working in this setting, nevertheless she felt personally and culturally unprepared as she had not had any previous experience of working within an iwi organisation.

Somers's (1994) claim that ontological narratives define who we are resonates with Christina's account of her heightened awareness of cultural difference. According to Somers, narrative identity is constructed depending on how people locate themselves within a range of different narratives. By initially positioning herself as not being suitable because of her culture, Christina's perception of herself as a stable and knowledgeable *culturally safe* nurse is disrupted. Ontological narratives are social, and interpersonal and people act based on their understanding of their place in different narratives and these may be contradictory, ambiguous, multiple or fragmented (Somers, 1994). By entering a culturally different environment where she is now a minority, Christina has to construct an identity that will be more congruent with the needs and values of people within the new setting and this will involve negotiating uncertainty and experiencing ambiguity about how she sees herself and how others see her.

Christina was unfamiliar with the subtle and less visible routines and practices required to provide a safe environment because outside this setting cultural aspects of relating had been unavailable to her. This reflects Somers's idea that this experience could not have been available or predetermined in advance of her taking up the position. Having realised that she had entered an unfamiliar world, Christina was now self-conscious about her Pākehā identity because she did not know the rules of the marae setting or how things were done and she had to find these out by

watching and trusting the people who did know the rules. While Christina had demonstrated that her professional skills were adequate, she was concerned that she would do something wrong in this different cultural setting.

Cultural safety education challenges nurses to examine their own attitudes and Christina was in a pressing situation, which called for careful self-reflection. Her cultural supervisor's response to her fear about making a mistake is that the process of learning about being in a different cultural space ensures that making mistakes is inevitable; he gives her permission to be herself by creating a climate of acceptance and trust. Davies and Harré (1990) observe that narratives collaboratively unfold when other people draw on knowledge of social structures and recognisable roles allocated to people within those structures. They assert that to be recognised and acceptable, a person must operate within the terms of the social structure. Self and purpose are constructed and reconstructed in the context of internal and external relations of time, place and power (Somers, 1994). Christina came to understand her own cultural positioning by mediating and negotiating difference in the context of self and culture over time and space. She had to manage her reality and tensions related to working in a context where her usual cultural signposts were not immediately present or available. Her next account examines how internal and external influences shape a relationship between herself and a client.

The following story draws out complexity and the multidimensional nature of practice and positions Christina within a matrix of cultural, institutional, material and symbolic practices and relationships of power within one health care setting. Christina had been describing how she worked in a partnership framework where there was shared power. She had knowledge that her client did not have and that they had knowledge she did not have. She observed that there was a mix of knowing between mainstream knowledge and individual knowing but that this *got a bit hazy in the middle*. I asked her to expand on what she meant by the term *hazy* and she told the following story about working with a kaumātua who was becoming increasingly unwell. The story begins with Christina and her client exploring options for action in relation to his deteriorating health situation.

I guess [hazy] is best described by a kaumātua who said to me, because I said to him, what would you like, how shall we work on this together, you know, going back to the goal of partnership, participation and, protection and he said to me "well I never know what to say when people say that to me." I said "Why is that"? And he said "Because European came in here and took

everything from us and told us what to do for years...” and he’s 60-70 years, and then he said “and then you [Meaning her as a European], ask us what we do we want to do, how can we even think about what we want to do”. Yeah I thought, that’s right Yeah, and you know his answer was, “You decide”. I said if I couldn’t decide for you, what would you do?”. He said “Well I’d do nothing”. Well [I thought] it was just, can’t be bothered, don’t want to be told what to do; you know I guess that was about him but I said to him “Well if I make suggestions and then leave it with you, what do you think about that?”. “Yip, you can do that.” So I’ve left my suggestions and came back, and he said, “Well, no I think we’ll do it this way.” So he did nothing of what I wanted him to do but that was okay. The next time he had difficulty he rang me up and that’s when I thought it doesn’t matter what happened, there’s the connection.... I mean I think his options were diabetes nurse, or GP, or nothing and I was saying “if you do nothing you may be so unwell that we’re going to have to get an ambulance because there is a point where we have to do something”. So yeah, he told me he’d do nothing. So that’s quite hard to take really, but then he did decide to go to the doctor. (Christina)

This man’s response to a seemingly straightforward inquiry from Christina disrupted and destabilised her position as a nurse carrying out a routine assessment and care planning. The man’s response illustrates Somers’s (1994) concept of metanarrativity which makes visible the historical colonised/coloniser relationship within everyday interaction. Metanarratives are those narratives embedded in contemporary contexts and characterised by historical struggle. In this exchange Christina is presented with a counter narrative she was not expecting and one which challenged her position as the authoritative health professional. The kaumātua’s response could have been a historical explanation to help him cope with a difficult situation, indicating difficulty in providing an answer. A Māori perspective of health takes the environment into account and this includes the colonising effects of the loss of land, language and cultural heritage (Timu-Parata, 2007). The kaumātua’s view is valid because he raises the point that historically he has had everything taken away from him and been told what to do. Now he is being asked what he wants to do with few parameters and little knowledge upon which to make an informed decision. A feature of the public cultural safety discourse is the need for the nurse to be aware of how power permeates nurse-client interaction. In this account power is played out in an unexpected way for Christine. The response of the kaumātua takes her by surprise and causes her to reconsider her position in the relationship. As in her earlier account of not being suitable for the

position, her sense of identity as a knowing and empathic nurse is thrown into question. While she has authority as a health professional, from the client's perspective this authority may not extend to a cultural knowing or understanding.

Christina positions herself as an engaged nurse using her clinical judgement to assess what the statement might mean. Her clinical judgement lets her hear the words and not dismiss them as irrelevant or interpret them as perhaps consistent with despair and helplessness associated with long-term illness. She has to acknowledge that she has heard him and she reflects to herself, "Yeah I thought, that's right. Yeah, and you know his answer was *you decide*. Christina's response suggests that she had some understanding of what he was saying and attempted to interpret his statement within the discourses she had available to her, in this case a nursing and behavioural discourse that could suggest he *can't be bothered*. The same comments interpreted within a historical, cultural and age-related context could also mean that the kaumātua was testing her to gauge her reaction and this opened up a different way for Christina to be with her client. While a health care setting (for example the hospital) reflects values which privilege the power of the health professional, a setting which provides care based on cultural needs and kaupapa²⁸ puts power in the hands of the recipient of care. In such a setting other, more subtle dimensions of relationship may be more prominent and need to take into account relational aspects of age, culture and position. In this exchange, for example, it may mean that it would be inappropriate for a younger Māori woman to tell an older person what to do and even less appropriate for a European woman to tell an older person what to do, even though this person had the professional authority to do so.

The client in this account has moved the focus of inquiry for Christina from one of clinical assessment and care planning to one of interpretation of meaning and maintenance of the relationship and the development of trust. A key concept of cultural safety is trust and Ramsden (2002) argues that a trust moment can be fleeting or unspoken. Christina did not receive the response she had been expecting and although accepting her client's wish, his decision to do nothing did not sit easily with her. She chose relationship over forcing compliance to his treatment regime. Christina would have been concerned about what would happen if the man's condition deteriorated and he was admitted to hospital. She could be judged as incompetent or unsafe with possible consequences for her practice. Somers (1994) notes that in contrast to a view of identity in which people act according to internalised values, a narrative identity approach suggests that people act in particular ways because to not do so would violate their

²⁸ Māori term for strategy, theme or guideline (Ryan, 1999).

sense of being at that particular time and place. Christina's nursing knowledge and values would be telling her that to do nothing could mean a life-threatening situation and if she did not act she would be neglecting her duty to care. On the other hand, she assessed this moment as being critical to staying connected to this client or, recognising a trust moment, it was therefore important for her to choose this action rather than assert her professional power to coerce, persuade or direct him toward another course of action. Her earlier account of working within a Māori health setting suggests a shift had taken place in how she viewed herself and her client and while she experienced some anxiety about her client's decision, she was able to accept it. This episode illustrates Christina's claim that working in a culturally safe way is *hazy in the middle*.

In Christina's story it was important that the kaumātua maintained a sense of being in control of what was happening even though she did not share the same sense of control herself. Harré and van Langenhove (1999) observe that when a nurse and a patient are engaged in a nursing episode, their actions may be understood in terms of the roles enacted or taken up at that particular moment as well as the positions they occupied in their previous conversations. They also note that the act of positioning may be symmetrical or asymmetrical and this depends on how each positions the other or whether, in the positioning of one, the other is also positioned involuntarily or negatively. Christina's response, *I will make some options and leave it with you*, suggests that this was symmetrical positioning in that she repositioned herself in a way that harmonised with her client – an act which kept him in control of what was happening and created a climate for the continuing development of trust. In Christina's account of the interaction with the kaumātua there are several layers of positioning taking place as the interaction unfolds with the coloniser/colonised positioning being prioritised by her client. Other dualistic positionings that also have a presence in the narrative include patient/health professional, Māori/Pākehā, young/old and male/female. These differences also influence action. The public narrative of cultural safety tends to focus on a one-way movement of power in nursing relationships that is, from nurse to client. Christina's account identifies that, in practice, power is mercurial and circulates between actors according to the interaction and concomitant shifts in positioning and identity that arise from interaction.

Timu-Parata (2007) notes that kanohi-ki -kanohi, or, face-to-face approaches alongside Māori kinship networks of whānau, hapū and iwi are most effective in providing health care as Māori people are "more likely to be able to receive health messages if they are given the opportunity to create discussion and awareness through these structures" (p. 35). Christina's talk illustrates the *hazy* nature of applying cultural safety in everyday practice, conveying an in between position

where Christina was faced with accepting that this man had, for now, decided on a non-interventionist course of action. While this was consistent with cultural safety, Te Tiriti o Waitangi and partnership, protection and participation, there were concerns about what this might mean for the future health and wellbeing of this man. Christina's nursing need to respect and share power in the relationship was appropriate. However she also experienced some anxiety about his choice. This was a situation where, had she not focused on the meaning of what he might be saying, she could have used her power as a health professional to *do something* and direct the client toward a more interventionist course of action. Christina had to live with her personal and professional discomfort and accept that, *doing nothing* was a legitimate option for this person. Within this relationship Christina built choices into her talk which he knew would be available to him if he so desired, for example, *have to do something* and, *getting an ambulance*. Knowing that he was not going to be forced into an immediate course of action gave him the space and time to be with his private thoughts and feelings about what was happening for him and gave him time to make sense of what might be happening to him. Maintaining the relationship meant that this man was not going to be abandoned, rejected or judged because he was making a decision that went against what was expected of him. For Christina this was a *hazy* moment, the interaction between herself and her client was not straightforward and she had to consider her client's care with reference to the historical and contemporary contexts within which the relationship is embedded.

Christina's account of a *hazy* moment challenged her earlier assertion that cultural safety was about working in a partnership where each partner brings their own knowing to the relationship. Her story identifies that a nursing partnership is shaped and influenced by moment-to-moment interaction in which what happens as a result of an interaction cannot be predetermined but is connected through other narratives. Somers (1994) suggests that "narratives are constellations of relationships embedded in time and space and constituted by causal emplotment" (p. 616) in which actors discern the meanings of an event only in relation to other relationships set in time and space. The stories Christina chose to recount concerned stories of shifts in sense of self and uncertainty. A connection can be made between her entry into the service and her subsequent telling of how culturally safe nursing is *hazy in the middle*, a metaphor capturing a sense of ambiguity, incompleteness, something unfinished or fragmented. The story of her exchange between herself and the kaumātua showed that applying cultural safety in everyday practice requires vigilance and attention to reflecting in the moment. The phone call from her client was a relief for Christina, as his initiating contact confirmed that her decision to maintain connection and trust in preference to asserting power was the appropriate one. It is possible that if Christina

had acted otherwise, a trust moment might have been missed and there would have been no subsequent phone call from her client. Her response had proved her trustworthy, capable and safe.

Somers (1994) suggests that people make sense of what has happened or is happening for them by assembling or integrating episodes of interaction into one or more ontologically coherent narratives. People will act in some ways and not others based on previous actions or current expectations, which evolve from a limited repertoire of available, social, public and cultural narratives. Christina's early experience of applying, and being accepted, for the position and then having to come to terms with her own cultural difference, helped her establish a thoughtful, reflective position in which she took nothing for granted and in which her communication was interpreted in the context of the setting and the relationship within which she was working.

6.9 Barbara's story –Cultural safety: Keeping it simple

Barbara's narrative provides an account of how she made sense of cultural safety in a community mental health setting, working in a Kaupapa Māori mental health service situated within a District Health Board. This setting is one of a number of Kaupapa Māori mental health services in Aotearoa New Zealand which provide services according to a holistic framework and within "an environment that promotes cultural safety of tāngata whaiora²⁹ and their whānau and for those delivering the service" (Boulton, 2005, p. 281).

Barbara's story tells how she mediates and negotiates her identity in her workplace to maintain her own cultural safety as a nurse who is Māori and for the client with whom she works. It is a story about advocacy, resistance and challenge. Like Christina, Barbara's story is about working at the borders of cultures through exploring her personal interpretation of cultural safety in practice, her Māori worldview and as a registered nurse working in a Māori health service within Pākehā-dominated mental health services. Barbara uses an exploration of differences between Kawa Whakaruruhau, cultural safety and her own cultural identity as a segue into considering cultural safety in relation to ethical issues of client rights and protection from harm.

Barbara has been a registered nurse for five years. She began our interview with the following comment:

²⁹ A Māori term for mental health consumer.

I think there are two ways of looking at cultural safety for me, one as Māori and one as a comprehensive nurse. ... People don't realise that Kawa Whakaruruhau and cultural safety are two different things. Kawa Whakaruruhau is about understanding Māori and cultural safety is in the context of nursing. (Barbara)

Understandings of cultural safety and Kawa Whakaruruhau are not always clear within nursing, with cultural safety sometimes being seen as relating to broader elements of difference and overall communication and Kawa Whakaruruhau addressing the delivery of appropriate health outcomes for Māori within the context of Te Tiriti o Waitangi and nursing practice (NCNZ, 2005/2009). Barbara makes her own distinction and for her Kawa Whakaruruhau speaks to her identity as Māori, and cultural safety to her identity as a registered nurse. Her account shows that while experienced as separate entities, there are also similarities. For her to practice in a culturally safe way there has to be harmony between her Māori identity her Māori values and beliefs. Kawa Whakaruruhau provides a framework to protect *her* identity and within this, cultural safety supports the power of the person to decide. There needed to be congruence between what the institution values professed and how these values were enacted in institutional practices. Lack of attention to any of these factors has the potential to compromise her safety and that of her client.

To extend her understanding of the differences between Kawa Whakaruruhau and cultural safety, she recalls an exchange with her colleagues.

I just had a conversation with some colleagues and asked them if they knew the difference. For me the difference was more around Māori beliefs and values, that's where the word comes in, Whakaruruhau, you know looking at identity, where you're from, that's where the korowai comes around for me. (Barbara)

Kawa Whakaruruhau formed a korowai (feather cloak) for Barbara which protected her identity as Māori. The phrase *where you're from* possibly referred to her pepeha³⁰, suggesting that there was a more personal element associated with her interpretation of Kawa Whakaruruhau compared to cultural safety. The public narrative of cultural safety tends to focus on the identity and values of Pākehā, as the guidelines were developed with European nurses and health professionals in

³⁰ Pepeha, sometimes referred to as mihimihī in Māori. It is a short introductory speech which takes place at the beginning of a gathering. The person stands and speaks to establish links with whakapapa (genealogy and ancestral ties). The pepeha tells others where the person comes from and who they are. Retrieved from <http://www.korero.Māori.nz/forlearners/protocols/mihimihī.html>

mind. Understandings of cultural safety by a nurse who is Māori, or other than European, are considered to be the same. The research interview provided a place for Barbara to construct a cultural identity, which offered important insights into how the public narrative of cultural safety overlooks the personal and professional identity of the Māori Tiriti partner and how this can make the reality of cultural safety for this partner invisible.

Later she commented on what she thought cultural safety was.

I notice it more with Pākehā in the field I'm working in, like I hear all this client's rights and a lot of the time keeping it simple, cultural safety for me is 'keeping it simple' and this means taking account of all different cultures and that's clients rights. Lots of simple things are just not being followed. (Barbara)

It is important to note here that while Barbara worked within a community Māori mental health service, physically this was within the same open plan area as mainstream and Pacific community mental health services. This meant that while the service was conceptually separate from the mainstream service in terms of cultural values and philosophy, the service shared the same physical space with her general community mental health colleagues. Her observations therefore position her as looking inward to her own practice setting and outward to other practice settings at the same time. In this talk, the absence of culturally safe practice was more noticeable when observing the work of her Pākehā colleagues. Her repetition of the phrase *keeping it simple* suggests that for her cultural safety is about working with people from all cultures and it is about protecting the rights of the client.

In the following narrative, Barbara gives a detailed example from her own Kaupapa Māori mental health service to convey meaning at deeper level of what *keeping it simple* in relation to cultural safety might mean.

I'll give you an example. Multidisciplinary meeting okay, we have a team of professionals, we have a consumer advocate sitting in the room discussing a client. We also have [people from] non-governmental organisations sitting in, and I have a thing about that, I have an issue where we're discussing a client and I don't want to talk about [my client] because I feel uncomfortable with myself, because we're all talking 'consent', 'confidentiality' 'rights' and we're discussing my client at the table with non district health board staff sitting at the

table [my client is there] and anytime [now] she's going to say something, she's going to, you know...because that's what she's there for, right? And I feel she's just being there, that's where the tokenism comes in, she's at the table, but she doesn't get an opportunity to speak and I'm thinking this isn't right. This is how I feel, we're talking about a client in front of people that aren't really part of the thing. Here's a cultural safety thing, you know dial-a-Māori, dial-a-prayer, dial-a-karakia³¹. That's what my pōwhiri³² was like, I didn't go. The reason why I didn't go to is because I had already started work (laugh). Why would I (laugh)? Monday 10 o'clock. No I'm already in the building, my karakia, my beginning of my new job...I'm not going to go two weeks later to a pōwhiri for me, I've already entered the building. (Barbara)

Barbara's first section of talk suggests that there were people present who should not have been there and she was discomfited because she viewed them as not being part of the organisation. Her initial concern was about bringing her client to a meeting with people who had no obligation to maintain confidentiality as a standard of practice since they were not employees or health professionals bound by professional ethics and had not been formally introduced as Māori protocol dictates. This latter interpretation of Barbara's narrative suggests that, as some of the people in the meeting had not been appropriately brought in through protocols of invitation, they remained strangers and therefore it would not have been appropriate for Barbara to interact, or to share sensitive information about her client with them. Although she was part of a Māori mental health service, Barbara draws on this incident to illustrate how Māori mental health services are located and organised according to an organisational culture reflecting Pākehā structures. This meant that Barbara's commitment to providing care in a kaupapa Māori way was compromised by the dominance of the mainstream culture within the setting. Her expression *I feel uncomfortable with myself* suggests that this was more than simple discomfort about 'outsiders' being there. It suggests that at some level she was experiencing a degree of moral distress at not being able to intervene effectively in order to create a Māori-centred environment. As a result both she and her client were at risk of exposure to harmful elements as embodied in the term Kawa Whakaruruhau. For Barbara, welcoming protocols had not been adhered to in a way that afforded protection for her client, the visitors were still considered strangers and therefore not to be trusted.

³¹ Prayer, chant or incantation (Ryan, 1995).

³² A Māori welcome and a formal process to welcome visitors. Retrieved 14th February 2010. <http://www.korero.Māori.nz/forlearners/protocols/pōwhiri.html>

The tension is palpable in Barbara's words *any minute she is going to say something*, as she felt concern about the dignity and safety of her client and she had to manage this in a way that protected her client. With other people being in the room, the client's sense of integrity as a person was not being considered in relation to her rights and the need for confidentiality, hence Barbara's earlier comment that *cultural safety is tokenistic*. As already noted, central to cultural safety is the idea that safety is determined by the recipient of care (Ramsden, 2002). Barbara's need for vigilance and protection toward her client was heightened and she felt protective toward her while at the same time knowing that the client's presence at the meeting had little to do with her being able to speak on her own behalf. Rather it was part of an institutional ritual purporting to empower the voice of mental health clients. Her client not only did not get the opportunity to speak, but neither Barbara nor her client had control over who was in the meeting or their access to private information. While this setting should have provided safety and protection in terms of rights and confidentiality, the values and relationships of the organisation denied her both. She had to manage a number of care issues simultaneously and what should have been simple was complex. In this story Barbara shows the complex nature of the nursing relationship and much of what she describes happening would not have been visible in the minds of other health professionals and in the everyday routines and activities taking place in the setting. Barbara's story shows the intersecting influences of self, culture, setting and relationships in one seemingly very ordinary, everyday health care situation.

Earlier in our conversation, Barbara mentioned that while she learned about frameworks of analysis of social justice and critique during her nursing education, this did not equip her in her practice with the skills and ability to be able to challenge institutional discourses and practices which put her identity and that of her client at risk. In her previous narrative, related to her own welcome to the service, she elaborated further on her own sense of safety and cultural cohesion. While she had the skills to challenge the inappropriateness of the timing of her formal welcome, she felt unable to do so. Her own experience is in harmony with that of her client but as a health professional, she felt more in control of her own experience. Her comments support her claim that there is a difference between cultural safety and Kawa Whakaruruhau. Her account provides insight into her experience of trying to protect the dignity of her client and explains the sense of discomfort she felt during the multidisciplinary meeting. For Barbara it is important that cultural protocols are followed because they are an essential element of health and wellbeing of clients and may be more significant for Māori than for some other groups in society (Boulton, 2005; Durie, 2001; Timu-Parata, 2007).

Ramsden (2002) observes that cultural safety is about issues of communication and service access, and that culturally safe practice is grounded firstly in not diminishing the cultural confidence of the person using the service and secondly in the philosophy and practices of the institution. Ramsden (2002) claims it is the institutional philosophy that can create a barrier to service. Because Barbara stands confidently in her own culture, she chose not to go to her own pōwhiri as for her it would not be culturally appropriate. While the institution had Māori protocols in place, Barbara had a sense that they were not respected. For her, tikanga had not been followed and applied in her case. She had been in the building for two weeks and had established her own way of connecting with people but she was denied the ritual of getting to know people within her workplace through the protected environment of pōwhiri. By not going she maintained her own *cloak of protection*, her Kawa Whakaruruhau and the inappropriate timing of the pōwhiri could have been an influence on her experience within the multidisciplinary meeting with her client. For example, knowing the purpose of pōwhiri could mean that Barbara felt that the multidisciplinary setting was not safe for her client to be in because the rules for making contact had not been followed.

By using the terms *dial-a-Māori* and *dial-a-karakia*, Barbara conveys other aspects of how her work setting was not always safe for her. These phrases are used to explain the way health care institutions can express an attitude of insincerity toward Māori protocol. They can convey a sense that, when an institution wants to present a bicultural face to the community, they will literally dial a Māori person, either a designated kaumātua, or Māori staff member, who will provide a Māori welcome or a prayer for an important event. Outwardly, this will give the institution a cultural status but will not always recognise the deeper significance of the protocols.

For Barbara, Kawa Whakaruruhau is a Māori expression of cultural safety central to the proper functioning of health care settings, and is not limited to the mārae where protocols would be more strictly followed. Working in a culturally safe way for Barbara means doing the right thing, respecting and acknowledging that communication is well intentioned, difference recognised, and that what is important to another person is to be treated respectfully. It also means being able to assess, anticipate and use her clinical judgement to provide care, which protects the client clinically, physically, socially, emotionally and culturally. In other words, culturally safe practice for Barbara is responsive nursing practice driven by her personal, cultural, ethical and moral intentions in her everyday practice.

6.10 Jill's story: Cultural safety: No space, no time to care, no privacy

The hospital is a place fraught with competing meanings of anxiety, threat, despair, hope, fear and punishment. Most people, ill or well, feel uneasy in hospital, yet the hospital promises salvation and remediation for those who are ill (Lupton, 2003, p. 101).

Jill's story identifies how a hospital setting enables and constrains her everyday nursing practice. The story is directed toward communication within the nursing relationship. It identifies how Jill works to create a climate of emotional and spiritual safety for the patient in the context of the material and social culture of the hospital structure. I have argued earlier that the introduction of cultural safety into nursing education and practice created tensions between traditional approaches to nursing knowledge and contemporary ideas associated with socio-political influences on the health and wellbeing of a person. It is within a hospital setting where these tensions are most prominent from the nurse's perspective and at the same time most invisible from the perspective of other health professionals. At a personal level of interaction, culturally safe care may be momentary, fleeting or invisible to the nurse. By invisible I mean that a sense of safety may be experienced by a patient or client but this experience may not be available or articulated to the nurse. Similarly an experience of uncertainty, fear or vulnerability may not be overtly communicated to the nurse but will be observable in the person's responses and demeanour.

Jill suggested that rather than being a place of safety and protection, hospitals are not safe for anyone.

This is just a thought, but it would be worse for people of other cultures because [the unit] is a mainstream Pākēhā, male dominated set up and I mean, I don't mind hospitals too much because, you know, that's part of my culture and I understand a wee bit more, but I think it is frightening for people who do not understand the system. I think they [hospitals] actually promote unsafe practice, just the way they are set up, the physical set up. We got a new ward last year so you'd think they'd have incorporated things that would help us make practice safe and good for people staying there, but we still have no family room. There's not space to actually take someone away, because we are dealing with a lot of bad news as well, there's no place to go and actually talk privately or for someone to have time and have a good cry on your shoulder, or

for big families that come in. A lot of stuff gets done in the cubicles I guess it's an odd place, you come in there, you're going in for pretty radical things, like you have been diagnosed with cancer two weeks before, you end up on a ward. We're [staff] all there everyday and it's the same with surgeons... for us it's everyday work sort of thing. For someone who has been diagnosed, I don't think we have any idea of what it's like. It's not set up to deal with people's emotional problems. I mean I've seen grown men just literally quaking, they need to be heavily sedated before they go to theatre, it's so scary for them... They don't know what's going to happen and nobody tells them very much, there's no time or no space to talk about those feelings. (Jill)

Jill considered hospitals to be places where the emotional and spiritual needs of people were secondary to the need to treat as many people as possible in a short space of time. Johnstone (2000) asserts that hospitals are concerned with the treatment of disease and illness and this means that hospital policies and procedures can strip power and control from individuals and families in favour of diagnosis and treatment intervention. In recognising this, Jill positioned herself as a member of the dominant group as she understood the way the hospital functioned. This afforded her the social and cultural capital, and thus the confidence, to function effectively as a health professional in this environment. Her personal and professional culture was reflected in the structures that surrounded her and she wondered what it might be like for people from different cultures for whom the environment was unfamiliar.

For Jill a newly built ward could have provided opportunities to change the way care was delivered. Privacy was a factor in providing safe care and Jill felt that this was given secondary importance to the need to process people through the system as quickly as possible where time constraints shaped how people act and respond to encounters and situations. Jill positioned her understanding of cultural safety in the context of buildings and space and the impact this had on the delivery of safe nursing care. To do the emotional work with clients Jill had to resort to being with people in a very public cubicle space where there are other patients. Jill reiterated that whilst she and her colleagues operated in their everyday space, patients coming into this space not only had to manage an unfamiliar environment, but they also had to try and make sense of what was happening while coping with the consequences of hearing distressing information about their bodies and their health. A third factor in viewing hospitals as unsafe was Jill's assertion that she felt patients were not well informed about what was going to happen to them. The lack of space to address these issues is again referred to. This is a time when a person's sense of identity

and integrity needs to be maintained and sustained so that they may cope with the stress of diagnosis and proposed treatment. Jill identified that it was precisely at these times that it was most difficult for her to provide such care.

Jill has identified the alienating activities of the hospital setting and her talk supports Johnstone's (2006) view that hospitals are impersonal institutions in which the activities are mainly motivated by curative factors. Such institutions are characterised by a hierarchy of professional roles with the physician at the top of a diverse staffing mix. For Jill the culturally safe needs she identified as being most important, and the most difficult to respond to, were emotional and spiritual concerns and the provision of private space. Johnstone considers that health care institutions are a network of expert advice where wisdom is dispensed and the lives of others are controlled in ways that patients may experience as alienating (Frank, 1995). Jill could see little room in the system to respond to the emotional, human needs of a person undergoing diagnostic processes and treatment, and yet comforting and protective actions are what the nurse needs to attend to as this is central to both nursing and culturally safe care.

Jill's next account provides more detail about how the physical structure and the values of the setting influence the experience of the client. She observes that when a person is admitted they

leave their dignity and privacy at the door (laugh) of the hospital. I think a lot of people just think "Oh this is the way it is" as well, and they just kind of, whatever. So I guess one guy I'm thinking about in particular who was just terrified... and he came into the ward, he gets admitted, he's already nil by mouth, and we get him ready for theatre that day. You're doing your basic pre-op stuff in a cubicle, in a four-bedded cubicle, there's no other space, especially during the week because it's just really busy, there's no other space to take them to, to sit down and talk, and I think people will be very stoic anyway. I mean you ask someone how they are and they go "Oh yep, I'm a little nervous" you know... You don't, yeah, you probably don't have to scratch very hard to find out more, but there's no space or time to find out more quite often... So then, yeah, they go, you talk through the process if they haven't been for an operation before, what you do, how you get down there, they wake up in recovery and that sort of thing. (Jill)

Jill should have been able to create an environment which supported the person to maintain the strength of their identity, a sense of well being and feelings of control in the midst of uncertainty. Jill expanded on her thoughts by telling a story about a patient who had recently received a diagnosis of cancer and was being admitted to undergo diagnostic testing.

They come back to the ward. They have to wait until the next day quite often before there's a doctor's round and even then, people don't get the answers that they need, and it's impossible to give them, you can't give, they don't know, they're only guessing. They can't tell by looking at it that those nodes are cancerous or not. You just try and do your best at the time. Cultural safety would be the first thing that goes out the window when it's busy, and that is so true. In addition, that's really awful and the onus is on us, which is fine, but you've also got to be supported. So what do I do I talk to them as much as I can to try and find out how they're feeling and it's quite nice if you've got a rapport because when they wake up in recovery and see you come and pick them up. I've had people say it's just so nice to see a familiar face, it's good you know. But there are lots of things we can't change. Like we can't change the fact that they're really scared, they're in this foreign place for a couple of days. (Jill)

On returning to the ward the person is still in a place of not knowing what is happening. They must wait for the doctor to see them but even then the doctor can only guess at what might be happening and cannot be sure until laboratory results are known. Jill's role as an autonomous nurse, using her knowledge to care and protect the patient from emotional distress, was affected by the passage of time. Jill's account illustrates that cultural safety *is* nursing and if Jill were able to nurse without structural constraints she would have been providing less restricted, culturally safe nursing care.

When asked to explore how she equates the situation of the man returning from theatre in the context of cultural safety, Jill provided an account of what she did to ensure that she provided culturally safe care. Culturally safe care in this story was about establishing a connection with the person, which would create a sense of trust. It was about building a framework of familiarity to sustain the person in times of acute stress and manage threats to his identity. It is interesting to note that she identified cultural safety as a particular practice that is sacrificed, in favour of time and efficiency, to meet the demands of the institution rather than the patient. This indicates that there is a perception that there are differences between cultural safety and nursing where the

technical functions of nursing are maintained and the caring and compassionate functions may be overlooked.

Jill's narrative illustrates Somers's (1994) construction of narrative identity and relational setting which claim that narratives are mediated through social and political institutions and practices that constitute the social world and within a context of a relational setting that influences what happens in interactions. Dukes, Conner and McEldowney (2009) note relational narratives happen when a culturally safe outcome is determined in dialogue between the nurse and the client. Sumner (2008) holds that identities of patients and nurses are defined in part by the roles they play and these are shaped by the health system, suggesting that any definition of caring should consider the needs of the nurse as well the needs of the patient. Sumner (2008) asserts that nurse-patient interaction is communicative as both are exposed and therefore vulnerable to what happens within the relationship.

Gadow (1995), in identifying levels of ethical narratives, claims that an ethical narrative is relational, a co-construction of an interpretation of an event where the outcome is in harmony with what both nurse and patient are seeking. I have established that responsibility for culturally safe care is sometimes considered to rest with the individual nurse. Jill's narrative identifies how her ability to provide such care is influenced by the physical structure of the institution and the dominant discourses which privilege medicine and administrative needs to process clients through a system. Jill's story identifies her own vulnerability in providing culturally safe care, thereby challenging the notion that culturally safe care can be achieved if a practitioner "relinquishes their position of power over the client and humbly enters into vulnerability of uncertainty with the client" (Duke et al., 2009 p.43). If the nurse experiences a vulnerability separate from that of the client, then they may not see themselves as having any power to act to manage a client's vulnerability and uncertainty. The structure of the setting means that while Jill provides adequate and safe care for her client in the context of ensuring, physical and technical safety, she feels unable at times to deliver other kinds of care. Cultural safety for Jill encompasses more than the physical and technical, and includes emotional, social and spiritual safety together with the values and philosophies of the setting. The absence of the second set of skills compromise her practice by making both her and her client vulnerable.

6.11 Ruby's story: Realising the intent of cultural safety- The recipient of care

In contrast to Jill's narrative, Ruby's story is situated within a recently established primary health care setting that has cultural safety as one of its core organising values. This setting does not carry the previously established rules, rituals and constraints of more well established structures such as the hospital. The centre is an example of a modern facility aimed at providing a health service for vulnerable youth. Approaches to service delivery are strengths-based, collaborative and relational and is informed by a youth development model guided by Te Whare Tapa Wha, derived from a Māori world view and encompassing whanau (family), tinana (physical) wairua (spiritual) and hinengaro (mental and emotional health) (Alcorn, 2007; Nelson et al., 2009).³³

Ruby's story identifies how she works within a framework of cultural safety to provide a service that meets the primary health care needs of a particular population. The focus of this story is on the way personal understandings of cultural safety are integrated into her everyday relationships. Ruby began by providing an account demonstrating how cultural safety was broader than a one-to-one relationship with a client. She felt that it also involved paying attention to interprofessional and intersectoral relationships.

...and we were talking about you know it's all inter-sectoral collaboration, but you do bring your experiences that you have with those agencies into the relationship with the client, so for my example it's working with WWCST, [a Government Department-pseudonym used] you know, like you can have really negative outcomes throughout your nursing interaction with them, and you almost start pulling back from that agency. And that might be detrimental to the client but because you're taking that into your relationship with whoever is working at WWCST or whatever, you know, like, I don't know, it's just sort of what I've been thinking about that we have it, it affects the client sort of as a third party. ...Cultural safety, is recognising your own experiences and bringing them into the relationship so that you empower the other person, but I think, you know, that that also works for the relationships that you have with nurses and doctors and agencies as well. Sometimes you're so client-focused you do that really well, and you think oh I'm being very culturally safe, you know 'I've empowered them and da de da de da' but if you really analyse it, have you?

³³ Te Whare Tapu Wha (Durie, 1994) is a Māori model of health based on Māori philosophical beliefs of wellness and holistic health. The model is underpinned by four dimensions with each representing the strength and structure of a building. The dimensions work together and a compromise in one part affects the functioning of the whole. The model offers a way to guide the development and delivery of holistic care to clients.

Because maybe you've made referrals or not made referrals with your own issues with the other agencies that you're dealing with it. (Ruby)

This account offers an interpretation of cultural safety that includes the professional relationships with agencies with which nurses work in the community. To put this in context, Ruby had experienced difficulty working with one agency when referring a client. A key element of primary health care is that of inter-sectoral collaboration and this means shared responsibility and accountability for outcomes including the horizontal management of health issues and common goals when co-ordinating, planning and implementing programmes. She reflected that if she, as the nurse, was experiencing difficulty with an agency she might unconsciously start to withdraw from engaging in ongoing communication and negotiation and the the client could be disadvantaged as a result.

Ruby observed that the personal or professional interaction between agencies might have a direct impact on the care of her client. Cultural safety meant being aware of personal responses that arose when communicating with colleagues from another discipline and recognising that her attitude toward individuals in another agency could have negative outcomes for the client. While cultural safety provided a framework whereby people using the service could judge their care as safe, Ruby suggested that this principle needed to be expanded to include colleague-to-colleague communication and to do this she had to be reflective as she carried out her everyday work. This account identified that culturally safe nursing also means respecting the views and values of different disciplines, especially where such views may differ from her own professional view. Her example identified a relationship between her own experiences and considered that while she may think that she was being culturally safe, she wondered if in reality fact she had been. She spoke about a situation where she wondered if she had at times made referrals to a particular agency based on her own personal attitudes and the quality of her relationship with people in these agencies. Francis, Chapman, Hoare & Mills (2007) observe the importance of the community nurse to not only reflecting on her own background but also being able to reflect how this background aligns with the expectation of the profession because there is always a “potential to base practice on personal rather than professional expectations” (p. 115).

Ruby continued:

I think cultural safety is about recognition of your own beliefs, your own experiences and how you feel about those. ...Or maybe you've had [negative]

experiences with WWCST, I mean we all have our own journeys and things, and it's sort of about being able to look deep into those and say 'Well maybe I'm not thinking from a nursing perspective, I'm thinking from a personal approach', you know? And that's the whole thing about cultural safety isn't it, it's sort of about being able to check yourself, you know, and recognise are you safe, and is that a safe way to practice ? (Ruby)

Ruby demonstrated a high degree of reflexivity as she examines each encounter with her client and with agencies with whom she collaborates to provide the care for her clients. Francis et al. (2007) note that to be culturally safe, community based nurses need to be able to critically reflect on their own cultural background and nursing philosophy and be able to identify how these impact on the care of people. This is consistent with the core defining principle of cultural safety that to deliver safe care requires that the nurse reflects on their practice and understands that this influences what happens in health care encounters.

An aspect of *checking yourself* in Ruby's present practise stems from her memories of how she saw others being positioned during her childhood years and later, cultural safety education. That is as different from what was considered normal or usual as in being mentally ill or of a different culture.

From the beginning of my nursing, I said I was going to be frank and honest, I'm a Pākehā, I've grown up in [place] my Mum [a nurse] has been in the mental health system and I grew up in [named] Hospital basically, so I always felt when I came to polytech [sic] that I was a very non-judgmental, that I recognised that not everyone was the same. ...And so when we first came and did the Treaty there was one camp who were like 'Oh why do we have to separate?', and I thought 'No, that's fine' you know, and I felt a lot of feelings for the Māori people, I was learning so much that I thought I already knew, then it was like 'Oh my God I don't actually know anything. ... and then I started looking at how my relationships had been and I realised that I had always tried to make up for what I felt people were lacking in the relationship, I thought that if people were mentally unwell, I'd have to pick up their a little bit of slack in the conversation. I recognised that I wasn't empowering them at all, I was empowering myself (laugh). You know I was the powerful person in the

relationship and I didn't really acknowledge anything other than they needed my help, they needed my prompts, they needed me to come in and make everything better. I was being nice to them so they should be grateful and I'd made their day. I thought that was helpful, but I don't think it was helpful when I started learning that people don't need that. They need people to be genuine and things are the way they are, and people can accept that, people are quite resilient, you know, you don't have to make up for people. (Ruby)

When learning about cultural safety, Ruby identified as a Pākehā who had grown up in a poor socio-economic area. She had close contact with people experiencing mental illness who were considered behaviourally disadvantaged and marginalised in society. She saw herself as an empowering and protecting person. Then, in an epiphany, Ruby was shaken out of her belief about herself as a non-judgmental person who recognised and understood difference. Prior to this realisation she could not really *grasp* how others could not see what she was seeing. Huygens (2007) noted that when Pākehā first come to realise that their early understandings of Te Tiriti o Waitangi do not reflect the new reality gained after learning a different history of colonisation, they can feel a sense of shock or discomfort and they may respond to this with anger or hostility, or take this new learning into a new frame of reference. Ruby realised that her childhood experiences of difference constructed her identity as a seemingly tolerant, understanding, empathetic person and this self-perception was called into question when confronted with new information. As a young person growing into adulthood this meant that Ruby would take responsibility for what she perceived as a lack of ability for a person who was unwell to act on her own behalf and confused this with her assessment of herself as an empowering person.

Ruby's next account demonstrates how her learning and understanding of cultural safety played out in her everyday nursing practice.

I think that's part of being, of working in an environment that's relatively new, very transparent, in the community and within the DHB. Without cultural safety I couldn't work with youth in primary health care, so it's one of the fundamental building blocks of it, because if you weren't culturally safe as a nurse (a) no one would come (b) you wouldn't have any practice to get any funding because the target market that you're looking for – 'market' sounds all swanky (laugh) like in an auction, but you know what I mean, - the community that I work for recognises that it's about young people, Māori and Pacific

Islanders and men, young men are at [high risk of not accessing health care], so we have to be culturally safe in our practice to encourage the people that we see at the most risk to use our service. (Ruby)

There are two elements to Ruby's narrative. She links the provision of a service driven by a market model and economic concerns with cultural safety as an analytical framework for monitoring the use of power in health relationships. Ruby's account suggests that the presence or absence of culturally safe care can be linked to economic considerations as well as to the way power is used in a situation. Cultural safety in this setting means that if the person accessing the service does not feel comfortable they will withdraw and there will be reduced funding. This is one example of Ramsden's (2002) view that the recipient of care determines what is culturally safe for them and the values and beliefs guiding the structure of the service setting will determine whether the user experiences it as safe. Some of the young people using the service include young men and men from specific cultural groups. Ruby noted that these young people were often seen as most at risk in terms of health care and high risk taking and were less likely to seek out health care, be it about health or sickness. Therefore it was imperative that the service met the needs of all young people using it.

She continues:

This service has been going for ten years, it was started initially by the young people and they brought in health professionals so there's a, way of thinking that is different from other services to begin with it, and it's pretty, it's modern, it's evidence based, it's you know, way out there. So I think cultural safety in a service shows on a planning level and on a developmental level that it's there for everybody ... If I didn't take my experiences and my beliefs into every consultation or interaction that I had with a young person it would be quite dangerous, because I am so different in every aspect, you know about how we were talking about trying to find something the same, you couldn't, I couldn't, I could search for a thousand years and never come up with anything that we had in common, so I have to recognise that and find out what page they're on. (Ruby)

The organisation of Ruby's practice setting was critical to a successful health service. This includes the total setting from the physical position (a street front entrance which is easily accessible and inviting) to the values and beliefs, both economic and attitudinal, driving the delivery of health care to this vulnerable and marginalised population.

Ruby identified how the service was consumer-initiated and consumer-run and established that health professionals were there to provide an integrated service for its users. She acknowledged that the way the service was run was different from the way other services might run. It's way out there suggests that, because it was modern and original, the values of cultural safety were more to the forefront than in older-established health services. The absence of institutional constraints meant that she was free to attend to the needs of her clients and develop relationships which were person-centred and supportive of clients through reflective, empowering communication.

Ruby continued to expand on her story, providing an explanation specific to the relational aspects of cultural safety when working with young people. She outlined the importance of being aware of her experiences and beliefs and the potential of these to impact negatively on the relationship between herself and a client. It is this awareness which enabled Ruby to work in a reflexive way and one which she established during her early cultural safety education. Reflection is a key nursing function for her and acts as a filter to ensure that her responses and interactions are appropriate and delivered in a safe manner. Her earlier talk of coming to an understanding of difference, anchors her in a culturally safe way of being with a person.

Ruby further develops her understanding of difference and how this shapes her nursing practice.

You can't assume... if I didn't take into [account] my experiences and what I didn't know, like not necessarily what I do know about myself, but what I don't know about myself, because I'm learning about new stuff all the time, so I have to be aware of that all the time. I think that you're challenged all the time, for me I'm challenged all the time thinking that from my nursing and from being sort of an adult with children and thinking of myself as quite a worldly person, to recognising how much I don't know about people and how much things still shock and affect me really deeply. There is always a sense of pulling back in myself, of jumping in or rescuing and, 'cos sometimes things panic me, you

know like if you get someone who's told you that they've been sexually abused from the age of five, you read about it in books, people tell you that it happens, but until you're actually talking to the person that it happens to, and as a new nurse, things like that happen all the time. Cultural safety just allows me to take an approach that, you know, whereas it's okay that that hasn't happened to me, do you know what I mean, and I don't know how it feels like. And a process to realise that that doesn't belong to me, you know, that's not mine, and I can't instantly think 'Oh you poor thing your life's ruined, where do we go from here?' I've realised that some people have experiences in their life that I might find would be shocking and would floor me, and I think if that happened to me I would be down for the count, but for these young people, it's their experience, their resilience and you know, what's bad for me is not bad for somebody else.

(Ruby)

This narrative demonstrates how Ruby applied cultural safety knowledge in her day-to-day nursing practice and shifted her thinking over time from taking responsibility for how others should be in relationship with her, to working in a way that supported and provided a relationship of safety and protection for young people as they negotiated difficult or ordinary life situations. She did this by weighing up what she heard and saw, being careful not to personalise her words and actions as she monitored herself from moment-to-moment. Her talk illustrated the reality and fluidity of nursing action in relationships. Central to the practice of cultural safety is the ability for the nurse to “recognise the opportunities to create change and know where to intervene” (Wepa, 2003, p.17). Ruby’s accounts provide narratives demonstrating how she frames these opportunities in her everyday practice, by working within a reflective relationship utilising her understanding of cultural safety. In this account Ruby claims the ground of relationship, power and attitude. Her earlier story of how she came to understand herself as a culturally safe nurse links directly to how she practices every day. This is evidenced by the way she positions herself as a reflective nurse who is mindful of the potential to project her own needs into a situation and mindful that her work is about listening and being able to carry people’s stories without overlaying them with her own projections about the person.

6.12 Summary

I began this chapter with a quote from Nairn (2009) who claimed that nurse-patient interaction makes little sense without an understanding of the structural location of the nurse and the patient. I have drawn on a settings approach and concepts of narrative identity and relational setting to demonstrate the way location influences and determines ways in which interaction takes place by identifying broader socio-political and historical factors influencing culturally safe care in everyday practice. The stories of participants presented in this chapter have illustrated Somers' idea that people are shaped by a limited range of narratives that are available to them in time, space and location. According to Somers, (1994), narrativity is not only epistemological, or a way of knowing about the world, but also ontological in the sense that narratives define who we are. Narrativity may be a precondition for knowing what to do, while doing creates new narratives, actions and identities. The narratives of Christina and Barbara were cogent in identifying the way that their professional identities were shaped by the limited range of narratives that they had available to them either personally, culturally or in their work environment.

Jill and Ruby both gave accounts, which afforded a contrast between providing culturally safe care within traditional and contemporary health care settings. Jill's account demonstrated how the values and structure of a traditional setting marginalise culturally safe nursing discourses by the privileging of bio-medical and managerial discourses. Her narrative identified that while culturally safe nursing is concerned with providing care and comfort for vulnerable clients, the nurse is also vulnerable within this setting in that she may feel powerless to effect change. This challenges the notion that cultural safety is about the transfer of power from the health professional to the recipient of care. I would argue that while the nurse in this setting has power to act on many different levels, the power of the institutional values, beliefs and dominant discourses can compromise this action. Ruby's narrative reflects an organisation that values the beliefs and values of a health promotion setting and identifies the interrelatedness of a personal understanding of cultural safety and the integration of this in everyday nursing relationships. This chapter offers a different way of repositioning cultural safety in the context of everyday practice by showing that each participant *does* cultural safety differently and this *doing* is shaped by the nurse-patient relationship and the settings within which the relationship takes place.

The narratives in this chapter have examined participants' stories across time and space demonstrating interrelatedness between settings and the construction of identity and culture.

Christina identified particular characteristics related to being Pākehā in a traditional Māori setting. Barbara provided an account of cultural safety within a mainstream bicultural setting. Jill demonstrated how culturally safe care was compromised by a traditional hospital setting while Ruby provided an insight into how a supportive contemporary primary health setting frees the nurse to communicate, listen and advocate for, and on behalf of, her clients in a culturally safe manner. While each setting and relationship was unique and specific, the stories identified that ethical, relational and structural factors shaped their activities by influencing their subjectivities. This included how they perceived themselves, the meaning they construed from events and the decisions they made about care in the context of the settings in which they operated.

Chapter seven examines the local contexts of cultural safety. Drawing upon Bourdieu's concepts of *habitus* and field, it will identify the micro moments and processes of relationship to show how participants construct their understandings of cultural safety in different arenas of practice and what enables or constrains their practice

Chapter seven: Cultural safety as *habitus*, field and *doxa*

People are motivated, driven from a state of indifference and moved by stimuli sent by certain fields and not others. Each field fills the empty bottle of interest with a different wine (Swartz, 1997, p. 26).

7. Introduction

Chapter six explored narratives illustrating the way the setting in which health care takes place influences the personal and professional identity of the nurse. The narratives explored the ways in which local and wider social structures act to shape nursing actions in everyday culturally safe nursing relationships. The *habitus* of cultural safety centres on relationship, difference and power in health care encounters. These characteristics provoke a rethinking of health care practice and provide opportunities to move individuals and groups from a state of indifference and acceptance of what is, to positions of being interested in, and motivated to pursue goals of what could be. This chapter draws on Bourdieu's (1972, 1984, 1990a, 1990b, 1998) concepts of *habitus*, capital and *doxa* to provide a theoretical lens through which to analyse narratives of participants in five different fields of practice. Each participant views cultural safety differently. Using a midwifery metaphor, Rose thinks of culturally safe nursing as *catching and carrying people's stories* as client's go through a process of regaining their health. For Louise *it is about getting things done* and, *doing what needs to be done*. Chris considers that cultural safety is a new way of nursing and nursing in this way means going home feeling that she has had a good day working with her clients. Debbie considers that attending to cultural needs is central to the provision of culturally safe care, suggesting that *cultural safety is a cultural thing*, while for Patricia it is about working to *prevent people from being treated as widgets*. These differing perceptions illustrate that the experience of working in a culturally safe way is shaped by personal and professional dispositions of the nurse and the context within which she works.

The work of Bourdieu (1972, 1984b, 1990a, 1990b, 1998) and Wacquant (2005) collapses distinctions between agency and structure, or objectivity and subjectivity, to construct the notion of social space and everyday action. Bourdieu's extensive research and commentary on class, culture and the constitution of difference offers an appropriate analytical template to examine how registered nurses apply cultural safety in their everyday nursing practice. While chapter six focused on cultural safety in relation to the way practice settings shape the relational and narrative identities of participants, this chapter addresses the social spaces of relation in health

care and cultural safety by examining more closely the fields of practice within which nursing takes place. Relating is central to Bourdieu's theory of practice because it is through the interactions occurring in the field that individuals and groups contest constructed differences as they occupy various positions in the field.

Conflicts over the nature and possession of capital within a field have been more fully discussed in chapter two. As a brief reminder, since the 1970s, nursing has claimed humanist concepts of care to mark out a professional and knowledgeable field of health care (Jacob, Holmes & Buus, 2008; Traynor, 2009). By claiming humanism as a principle for guiding understandings of care in nursing, a set of health care practices evolved through the construction of a humanist moral discourse, providing new forms of cultural capital from which nursing could be identified as distinct from the dominance of scientific and medical models of health (Aranda & Brown, 2006). With the advent of cultural safety in nursing, the critical paradigm from which it evolved brought the profession into conflict with its own humanistic oriented *habitus* and the *habitus* of other health disciplines. Cultural safety asserts that caring is shaped and influenced by the power of the nurse and the socio-political agendas of society. By introducing the concept of power into a caring discourse challenges and assumption that caring is an inherent and naturally occurring quality of nurses and nursing.

This chapter draws on concepts of capital, *habitus* and field outlined in chapter four which together constitute a theory of practice. Bourdieu's field is a "patterned network of objective forces" (Bourdieu & Wacquant, 2005, p.16) and a relational configuration which is imposed on all who enter it (Bourdieu & Wacquant, 2005). The field creates spaces of conflict where actors and institutions struggle to sustain or transform competing types of capital to create a particular kind of *habitus*, in order to produce and define the practices operating in the field. As a result, each *habitus* is unique because of the way the rules, processes and structures shape the dispositions of the people within a particular field. Rhynas (2004) draws on Bourdieu's ideas and applies them to a nursing context, noting that Bourdieu's work collapses distinctions between subjectivity and objectivity by constructing a theory of practice that incorporates both the practices and experiences of social groups. She claims, and I agree, that nursing has, at times, been caught between bio medical objectivity and subjective notions of care and compassion, drawing on both to construct different theoretical understandings about what constitutes nursing. It is these aspects of cultural safety that are analysed in this chapter. *Doxa* (Bourdieu, 1988) consist of the learned unconscious beliefs and values, taken as self-evident truths, which inform a person's actions and thoughts within a particular field. *Doxic* practices tend to favour the

dominant social arrangement in any field. With its emphasis on power analysis in cultural safety, the concept of *doxa* has particular relevance for this chapter as it provides for an examination of power within relationships in different fields.

7.1 The participants

The five participants in this chapter graduated between 2000 and 2005 and at the time of interview had been in practice for one to five years. All had undertaken a formal programme of cultural safety education.

Rose

Rose works in a community mental health setting. She works autonomously within a multidisciplinary team and has the power to use her clinical judgement and carry out assessments independently, being accountable to clients by providing care which is safe and appropriate to their needs and life situations.

Chris

Chris works in a forensic rehabilitation unit where she feels constrained in her ability to provide culturally safe care by the attitudes and practices of her colleagues.

Louise

Louise's narrative draws on her experience in an aged care facility where the people for whom she cares are dependent on nursing to manage most of their daily physical, emotional and social needs.

Debbie

Debbie's field of practice is a specialised unit in a public hospital. She works with people undergoing cancer treatment and palliative care and her nursing contribution is eight hours out of a twenty-four hour, seven days a week nursing cycle.

Patricia

Patricia works in a day surgery unit where her contact with clients is brief and her nursing activity is distilled into a short timeframe of up to six hours.

7.2 Rose's story: Culturally safe nursing practice is about catching and carrying stories

Rose's field of practice includes an extensive new immigrant and refugee population and this narrative examines her relationship with one client over time to illustrate how she applies cultural safety within a nursing relationship. An analysis of her story suggests that applying cultural safety knowledge is multilayered, complex, and ambiguous, requiring a conscious self reflexivity from moment to moment to guide her thoughts, feelings and actions. Rose's story identifies different fields of practice by illustrating how she uses cultural safety to initially link these fields and then later how she uses the relationship as a bridge. Her story begins following a question asking her to talk about a situation that she considered reflected cultural safety in her everyday practice.

I've been in a situation recently, the last two years now, where I'm working with an immigrant family and the father is the one who we see, the doctor and I see, and his wife and a daughter, a teenager and a toddler. He has been captured and tortured twice and he's been in a camp for quite a long time in [country named] before he came to New Zealand and when we met him and started working with him, he had just met up with his wife and then one child after being separated for five years. So I'm in a situation now where I'm working with someone and I have no idea, very little idea, understanding of their culture, very little understanding, and no understanding. I don't know what it's like to be captured and tortured, I've got no idea what it's like to live in that kind of fear, I've got no idea what it's like to be in a concentration camp, I've got no idea what it's like to fear for my life in that way or to be separated from family in that way, I've got no idea what it's like to have my mother and siblings still in [country named] and be worrying about them, you know, and the list goes on and on and on. So this is a man who has PTSD (Post Traumatic Stress Disorder) and they say he's got schizophrenia as well. So the PTSD has always interested me I'm always kind of learning about it, I think it's really interesting. However I come from a place of working with a man that I have no idea about anything or any way to work with him. There's the whole gender difference, I mean it's just all different, it is completely different, different, different, different, different, so the one thing that we do have in common is that we have feelings. (Rose)

Rose begins her account by sharing a point of commonality between herself and her client by situating him within a family context and by sharing a personal sentiment toward the toddler. She then identifies how she differs from this man, culturally and politically, by providing a context for the nursing relationship and her reason for presence in the relationship. She expands on these differences using language positioning the client within a specific frame of experience (as a refugee) and reorients the reader to the present by drawing upon a normalising theme relating to family. In the first few sentences of this account Rose positions herself and her client within a specific field of practice and identifies different *habitus* operating within her field which shape her approach to working with this man. Her client is a new immigrant, he identifies strongly with family, he brings with him the experience of political oppression and Rose alludes to a dominant medical discourse operating within the field *they say he's got schizophrenia as well*. Rose's mental health *habitus* and her client's *habitus* provide a range of perspectives and perceptions about what is happening for this man and Rose has to weave these factors into building a culturally safe nursing relationship which will deliver care protecting the man's sense of identity and cultural well being as he goes through medical treatment.

While Rose is confronted with difference between herself and her client in terms of life experience, this is not a new situation for her as she works predominantly with individuals and families who have arrived in New Zealand as refugee immigrants. According to Bourdieu's concept of *habitus*, Rose's response to this man is consistent with her experience of working in this field in that the behaviour and responses of this client are not dissimilar from her other clients. She draws on her previous understanding of working with refugee populations and brings this into her current relationship and while this understanding may help her work with this client, she does not assume that her previous knowing will apply in this situation. Accordingly she adopts a position of understanding but not knowing what this man's previous experience was like for him. By taking a position of *not knowing* and emphasising their difference, Rose conveys that she is present and open to listening to his story. By doing this she avoids projecting a position of power and control over her client when his current health situation has occurred as a result of dominant forms of cultural and political power intruding on his life. Rose is aware that she is also working in conjunction with a psychiatric medical *habitus*, which forms part of her nursing knowledge, and she has to consider this knowledge as part of her care and in developing a trusting relationship with her client. Her own passing interest in a medical diagnosis does not predetermine how she will work with this man. To be able to care safely for him she also needs to find out who he is and what his needs are as a person in the context of

his family. Through the development of a trusting relationship a deeper knowing will help her assist him in his recovery from the traumatic effects of his recent experiences of conflict and pain

Rose develops her story further.

I have been seeing him for two years now, and he sees us all as his family now. So we're at a point now that we have the relationship, where there is a trusting relationship, however you know trust alone is not enough to work with someone who does not want to talk about their torture and why would they want to, so how do you work with someone like that? So yeah this is where I have to think cultural safety, I'm aware of cultural safety, perhaps I know what not to do but how do I work with this man? You know that is my question. And I can't really go to anyone in the team because no one else who is the same nationality as this man, no one else who has been tortured you know. So we had one clinician who was from [a different country from that of the client]. She lived in [client's country] during the early stages of her life, and she has a lot of understanding of working with people, with people who have been tortured. I pulled her aside one day and spent an hour and a half with her and she was amazing, and just in terms of reminding me that the PTSD models we have are Western, reminding me that his journey had been huge, he's had a huge, huge, huge long journey to get here and remembering that. (Rose)

In this account, Rose situates her relationship with her client in a family context and suggests that, for this person, experiencing a sense of family is an important therapeutic approach in the establishment of trust. As has already been identified in this study, trust is essential in the development of a culturally safe relationship. Gordon (2006) suggests that most nursing relationships arise out of physical and technical care the nurse provides to a person; to this I would add emotional care. The purpose of the relationship is two-fold. Firstly it gives access to a person from whom information can be gathered. Secondly the relational aspect of care links Rose and her client in a humanistic relationship which addresses the needs and wellbeing of the client. While Rose recognises the importance of establishing trust over a period time, she is also aware that trust alone is not enough to be able to respond appropriately to her client as his present situation and life experience is beyond anything she can understand and it is clear he does not want to talk about his experience. I interpret her talk as wanting to find a way of staying connected to this man as a person in stress and to not create disconnection between herself and

her client by focusing on his traumatic past experiences. To some extent this is a counterintuitive response as she is working with a man who has a psychiatric medical diagnosis of posttraumatic stress disorder, where treatment centres on dealing with the trauma through processes of recall of emotions and sensations and regaining a sense of control.

In her previous narrative Rose acknowledged the presence of a psychiatric medical *habitus*. In this narrative she could logically be expected to draw on this knowledge to provide her with a sense that she was helping this man by encouraging ventilation through the sharing of painful feelings associated with his past experiences. It has taken two years to develop a trusting relationship and to create a climate of acceptance for this man and she has established that her client does not want to talk about his experience of being tortured. This is where she thinks about cultural safety in a way that does not give her an answer to her dilemma but allows her to pause and to think about what might need to happen next to move the relationship forward. She elects to seek out a colleague who has some cultural similarity with her client and who may provide her with guidance as to what to do next. Her colleague reminds Rose of the power of Western models of health care in the care of marginalised populations such as refugees. Rose's previous actions indicate that, intuitively, she may have known this but that, for her, it was useful information supporting her decision not to follow a psycho therapeutic approach utilised in the medical treatment of post traumatic stress disorder. Frank (2005) asserts that a Western approach to care requires that a person who becomes unwell requires that they surrender themselves to the doctor by handing over their autonomy. The doctor will, through the use of medical protocols, terms and technology, gain access to the person's body *or mind*, (my italics) to treat and cure him or her from illness or disease. Relinquishing autonomy is tacit through the person agreeing to follow the prescribed treatments. For Rose's client the diagnosis of post-traumatic stress disorder is clinically inscribed on his body by a medical discourse preventing him from realising his gender role in the context of his culture.

Rose's client has been subjected to violent experiences and situations over which he has had little control. The overlaying of a medical diagnosis of mental illness on these experiences has the potential to further compromise the overall safety and identity of this man and his family. A diagnosis of a mental illness limits his ability to carry out responsibilities embedded in his role as a man in his family and his culture. Having a mental illness challenges his identity as a provider and protector of his family, preventing him from carrying out his fathering responsibilities, caring for and contributing to the life of the next generation as well as being a positive influence in their

lives (Women's Commission for Refugee Women and Children, 2009). O'Brien, Hart and Hunt (2007) note that gender roles demand that men are silent and controlled about their emotional life because they will be distinguished from other men and isolated if they admit to emotional weakness. Rose establishes at the beginning of her narrative an empathy with her client's family and her subsequent accounts suggest that working with this man in the context of family, rather than ascribing a mental illness to him, is appropriate.

Rose draws on ideas within cultural safety to remind her to pause and this gives her space to reflect on how she might strengthen a trusting relationship with her client. This suggests that cultural safety knowledge operates on a number of levels. In Rose's situation it is through opening up a possibility of doing something differently from the familiar, more dominant discourses operating within the field. Rose's talk illustrates how different kinds of social, political and symbolic capital produce different health care practices. The different forms of capital came into play at various points in her relationship and she has to make decisions about how she works with different forms of medical and cultural capital. Rose has considerable professional autonomy and, apart from attending multidisciplinary team meetings, she is free to choose and act from her position in the field as a competent autonomous health professional. This account has illustrated how her confidence in her own knowing and her ability to act has enabled a course of action in keeping with the cultural safety principle of protection and maintaining the wellbeing of her client. She is strong in her own sense of how she wants and needs to be with this person. Cultural safety is characterised by relationships of difference and Rose's story identifies difference by illustrating attempts to find meaning in what is happening for her client through listening to his stories. In this way she builds a field of practise within which she works to provide this person with the care and treatment he needs to recover and return to good health.

In the following narrative Rose continues her story and provides small details to illustrate how this relationship of difference reveals itself in everyday interaction between herself, the client and her mentor.

Those are the main things actually, and it is about going little by little and I remember saying to him at some point saying "Why don't you start digging up your garden and planting vegetables?". That would be a good start. So she

[mentor] said to me it's things like that that would be alongside his beliefs because that would help him enable his status as a provider because he can't work because he's sick and while he's sick he's on medication, while he's on medication he's never going to be well, so he sees himself as being unwell while he's on medication – we need him on medication (laugh) so we need to work with a man who sees himself as unwell, yet he's not able to be a provider. So it was things like that she affirmed with me that they were they right things to do, or that was the way to go, little by little and remembering that people don't necessarily want to sit and talk. (Rose)

In this section of talk Rose demonstrates how she uses knowledge of cultural safety to transcend taken-for-granted beliefs in a field where processes of Western medical diagnosis and intervention are privileged over relational approaches the recovery of this man. Rose opts for a different approach by acknowledging the importance of this man's culture as a resource for him to maintain identity and to see himself as healthy. Her client has been dislocated from his usual *habitus* or way of being and, through listening to his stories, she is able to help him reconstruct a new way of being in an unfamiliar environment. This means constructing an identity that supports a view of himself as a healthy male able to provide for his family, while at the same time she needs to help him cope and manage the effects of his past experiences. Rose is guided by a view which affirms this man as someone who is well enough to carry out appropriate gender roles as defined by his culture. She ends this section of talk with a self reminder that time is a factor in this process and that being alongside a person can encompass other ways of relating that do not necessarily include sitting and talking. She resists working with medical or counselling models as a first priority and draws on her nursing and cultural safety knowledge to provide care for this man.

By foregrounding this man's story and his *habitus*, rather than a medical diagnosis, Rose was able to work differently and it was through her practice that she brought a process of moment-to-moment reflexivity to the fore. Without being consciously reflexive she is unable to stay in relationship in the way she chooses. Rose's story suggests that it is through the process of mediating and negotiating meaning, achieved through the exchange of information, thoughts and feelings, that identities are co-constructed and future actions decided. Rose is hearing that this man needs to be safe in his own identity in the context of his gender and she responds by adopting a person-first attitude toward her client and is guided by his thoughts, needs and desires. He trusts Rose and feels able to take part in an everyday conversation about gardening from

which an action is planned that normalises his identity. He is able to do what he would be expected to do if he were a well person.

As Rose's story comes to an end she evaluates her position in relation to her client.

I tend to come from a place of not knowing with most things. I tend to work with what I don't know, so that means I know that he's been given a diagnosis, I know where he grew up, I know that he was tortured, captured twice, I know that he was separated from his family and I know all these sort of factual things about him, they're sort of factual things. And it's everything that's not factual, I don't know about. So I can only imagine that's why, when I'm sitting there with him and perhaps talking about breathing, I'm imagining that even just sitting still is probably really difficult for him so I wouldn't sit in silence for a long, long time, you know just do things imagining the difficulty that he has with things going on in his mind, you know flashbacks and things like that, and about taking things really, really slowly and at his pace. And that comes from not knowing stuff, more than knowing. I realise that we have all this information that we have about our patients and when they tell us little bits and pieces the story is added to. As nurses our role is to carry their story. That's how I think about it, we carry their stories, and if I was a midwife – I'm not a midwife – but if I was a midwife, that's the term I'd use, they use, like catching and carrying the story. (Rose)

Rose reflects on how she positions herself in her everyday nursing practice and describes what it means for her to work in a culturally safe way. She positions herself as being open to possibilities and being prepared to act on what evolves from within her relationship with this person. She mentions that while documenting information about a person is important, the usefulness of such recording only serves to provide a structure through which treatments can be prescribed. While these facts may help her care for him, by knowing *this and that* about him, it is what she *does not know* which takes precedence in her care and guides the development of her relationship with him. Rose positioning herself as not knowing is demonstrating Munhill's (2007) concept of not knowing or *unknowing* as a form of *knowing*. By being in a place of not knowing means there is an intent from Rose to be present and open toward her client. Munhill observes that being aware of not understanding something calls for a different approach to relating. Rose has already established that her work with this man is relational first and does not

privilege medical or counselling models of care. By drawing on cultural safety knowledge she can allow herself to be open to her client's subjective experience and she does this this by listening and imagining. She knows certain things about him but cannot fully understand his experiences unless he shares them with her. Munhill (2007) notes that a person needs to be confident in what they know to be confident in what they do not know.

Even though there is some interaction between Rose and her client, Rose remains silent in order to imagine how his experience impacts his present situation. By doing this she gains a sense of what *might* have been happening for him at this time. It is as much about what is not said as about what is said. Her silence and imagining helps to remind her that she must work at his pace. She describes this process of listening and imagining as coming from a place of not knowing more than knowing. Her actions embody culturally safe care when she avoids making assumptions about this person or anticipating what might happen next in the conversation, because she *does not know*. Therefore she is able to be fully present and uses imagination as a tool, to create an empathic environment where her client can trust her and be who he is.

Frank (1995) suggests that illness represents an interrupted life and it is through the telling of story that healing can take place. Frank also suggests that while a narrative may restore order to an interrupted life, it may also identify that interruptions will continue. Mattingly and Garro (1994) frame such disruptions as healing dramas and consider that such dramas reveal lives in breach and lives that can be healed. While order may have been restored to this man's life to some extent through medical intervention, his life had been disrupted and breached on several fronts, culturally, through experience and now through a diagnosed mental illness. Rose had to find a means of working with him in a way which enabled his story to be heard. Rose's account illustrates how she used her social capital to structure a health and nursing relationship with its defined cultural capital and more significantly, a social relationship enabling networks of support and influence.

While Rose *does not know*, it is important for her to draw on her mentor's knowledge to keep herself and her client safe. She then broadens her thinking to include her nursing colleagues, acknowledging that her way is not necessarily unique and others may work in similar ways to her. In the end, for Rose cultural safety practice is summed up as *catching and carrying people's stories*. To be open to catching stories she has come from a place of unknowing. It is by positioning herself in a relational context which she names as a space of catching and carrying

stories that she can be fully present and open to possibility and action which emerges from within the relationship primarily and which is consistent with the needs of the person.

7.3 Louise's story: It's about getting things done and doing what needs to be done

In Rose's narrative, themes of working with difference within disparate fields of practice were identified, demonstrating the way she worked with cultural safety to make links between these fields. In this next section Louise's narrative focuses on practices and the institutional or objective structures within which she works, demonstrating how together these practices and structures illustrates (1972, 1998) concepts of *doxa*, and *habitus* in relation to everyday nursing practice. *Doxic* attitudes work to produce certain courses of action operating as a regulating principle that is produced by the *habitus* within which practice takes place. *Doxa* represents a set of core values and discourses arbitrarily produced and presented as objective truth to maintain the durability of *doxic* practices in which the people in the field have invested. *Doxa* creates fields of routines, rules and behaviours which primarily work to regulate and reproduce practices and guide the behaviours of the people within the field to create a particular kind of *habitus* (Bourdieu, 1972; Bourdieu & Wacquant, 2005; Webb, Schirato & Danaher, 2002). Bourdieu (1984b) states that "*doxa* is a particular point of view, the point of view of the dominant, which presents and imposes itself as a universal point of view" p.57). As Louise enters a new field of practice she encounters *doxic* attitudes and practices among her colleagues. In both the community house and the rest home where Louise worked, the effects of *doxa* are unconscious and defended as common sense. It is through these unconscious routines that patients and staff have become complicit in their own domination by accepting the *habitus* of the field as normal (Bourdieu, 1988). Louise's narratives demonstrate how different forms of capital, *doxa* and symbolic violence work to create an environment of self-evident truths which to Louise, as a new graduate, are contradictory and at odds with her understanding of culturally safe nursing.

Louise had been talking about how difficult it had been for her, as a new graduate, to transfer her cultural safety learning from the classroom into her new practice environment. The following account is situated within a community mental health facility.

I had a lot of resistance from staff I worked with especially people who had been in that particular field for some time. A lot of people had come from [place

named] and had been in a structured environment. I remember I had a particular patient and I was his key worker, he was diagnosed with diabetes so I was there to help him. ... We identified that cups of tea were being made in a big pot and the milk and sugar was put in there. They all got cups of tea like that. And then this man wanted to have porridge for breakfast and of course this was about February. They said we make porridge in the winter for all the residents so because it was summer he couldn't have porridge and they weren't going to treat him any differently from anybody else. So I had to be careful how I handled that so the team leader agreed we shouldn't make cups of tea like that because that didn't allow for the individuality. That was good. The one with the porridge I just had to have that as a personal goal for the person –a personal need and because it was backed by his family, because one of his sisters was a dietician she was going from low GI perspective and she said he likes porridge so I put down “he will request porridge when he would like to have it” and so in that way it came from his perspective not me telling the staff what to do.

(Louise)

Louise struggled over the forms of capital that she encountered operating within the field of mental health residential care. These forms of capital were established within the old psychiatric institutions and have not disappeared with the disestablishment of institutionalised care. Instead these have devolved to the community setting where Louise identifies such practices as culturally unsafe. The durability of the institutionalised capital that operated within the setting of the psychiatric hospital institution is symbolically represented by the way the tea is made - in which little room is given for individual preferences. *Doxa* relies on repetition and ritual to survive and Louise's talk is an example of the way that ritual works to sustain the status quo, even though to Louise these practices lack respect for the worth of the individual.

Webb et al. (2002) observe that *doxa* constructs regimes of truth that are designed to reproduce the existing social order through the acceptance of certain values which are constructed as natural and legitimate. Bourdieu (1972) maintains that such truths can only be sustained through a process of misrecognition or a form of forgetting. In this case Louise's more senior peers misrecognise the way in which the old institutionalised practices, which do not take into account the needs of individuals, are inappropriate in a contemporary mental health community setting. Because the staff have been engaging in practices and within structures that did not treat people

any differently from anybody else for so long, it had become second nature and thus they were resistant to her attempts to change the way that things were done. Louise's narrative illustrates an important point - that as people travel across different fields of practice they bring the forms of capital that operate within those fields with them. When the field of institutionalised psychiatric care was disestablished, staff moved from institutions to community settings, re-establishing some of the routines and practices of the old institutional field in this new locale.

The process of closing down large psychiatric institutions during the 1970s and 1980s meant that people who had been diagnosed with a long-term mental illness and who were not able to live independently, were relocated to small community houses where they could enjoy everyday living and life within the wider community. Louise's talk suggests that a shift toward a more person centred, normalising social environment for people with mental illness did not eradicate some dehumanising practices prevalent within larger psychiatric institutions. *Habitus* is concerned with the way people become who they are in nursing. Students' attitudes and dispositions are influenced by the external structures, values and knowledge (or forms of capital) which shape nursing practice. As a structure imposes domination on an individual's disposition, it does so in such a way that a person is not aware of their internalised domination. As a result, an individual may be unconscious of the impact of their behaviour on the care of others, leading to the enactment of '*symbolic violence*' (Bourdieu, 1998). In Louise's narrative, symbolic violence is evidenced by reliance on historical institutionalised practices, which have been directly imported from one field into another field, the community, and one which was purposefully designed to eliminate such practices as Louise identifies. According to Louise, the practice of mixing tea, sugar and milk together as denotes a lack of concern for individual preference, dignity and the health issues related to the man's diabetes. Her challenge to this practice has uncovered a form of symbolic violence captured in words *they weren't going to treat him any differently from anybody else*. For practices to be reproduced through *doxa*, challenges to established truths have to be limited and this is achieved through the use of language and practices within the field that exclude different points of view (Webb et al., 2002).

Since Florence Nightingale's original claim that nurses treat every person the same *regardless* of difference, generations of nurses have used this as a mantra which has come to define practice (Raile Alligood & Marriner Tomey, 2010). Ramsden (2002) highlights Nightingale's claim and considers that cultural safety offers nurses an alternative perspective that nurses care for people *regardful* of difference. Benhabib (2002) suggests that when the dominant group replaces

difference with a discourse of sameness, then this constitutes a form of erasure and can enact a violence, or in Louise's account, a form of symbolic violence against an individual. Symbolic violence in this narrative is made visible through the act of silencing Louise's opposition to the current practice, providing her with limited ability to change this practice on her own. Bourdieu (2000) describes symbolic violence as an entity experienced symbolically rather than by direct physical force and works on an individual through relationships and mechanisms of domination and power. Silencing according to Morgan and Bjorkat (2006) is an act of symbolic violence because the process goes unnoticed by the silencer but is experienced as domination by the recipient and it is the action of silencing that maintains and reproduces relations of domination. As a new graduate Louise had not yet been influenced by the power of the *doxic* attitude permeating the field and therefore not complicit in perpetuating what she considered to be inappropriate practices.

Louise's experience of learning about cultural safety as a student provided her with the capital that enabled her to enact nursing care which took difference into account. In transferring this capital into a practice field she became aware that cultural safety knowledge was marginalised, as her peers had greater capital because of the power of their unconscious misrecognition supporting the collective belief that this is how *things were done around here*. Her position in this field was determined by the amount and weight of the capital that she had to challenge these discursive practices. Louise's colleagues controlled the environment through silencing opposition by suggesting that personal choice and individualised preferences were not an option in this setting and to think otherwise would be *breaking the rules of the game*.

Louise's account identifies the difficulty associated with bringing cultural safety knowledge into an already established field. She resisted the rules of the *habitus* by trying to maintain respect for her clients through attempts to change demeaning practices. At the same time Louise was aware that she could jeopardise her attempts to change actions that were embedded within the culture of the field but which her colleagues did not recognise as demeaning. By asserting herself she risked alienation from her new colleagues which could have compromised the care of her clients. Her colleagues did not share her concerns because they were not aware that there was a problem. In this setting ritual and routine was the common-sense way of working in a mental health environment where control was more important than responding to individual needs and building effective relationships with clients.

Habitus is created by and through *doxa*. However when an individual holds values and beliefs that are different to the prevailing *doxa* they may become aware of the restricted options that are available to actors within that setting (Webb et al., 2002). Bourdieu (1972) notes that the consistency and uniformity of *habitus* causes practices to be immediately intelligible and foreseeable, and therefore taken for granted. This practical comprehension obviates the need to take notice of, or respond to, an inquiry about the appropriateness of a practice and less so of a person who has less capital than the majority. When Louise initially encountered opposition to her suggestions for individualised care, she was intuitively aware that this resistance resulted from the long established attitudes that operated in this setting and the social practices that made them legitimate. In order to achieve her goal of individualised care she needed to find another approach, so she strategically enlisted the help of family by framing her request for change to staff in relation to the wider context of family support and care. Louise was aware that her actions had to be presented in a way that would be favourable to the thinking of her colleagues.

When *habitus* interacts with the social world that produced it there is a sense of comfort or sense that all is well. Reay (2004) suggests that when the *habitus* encounters an unfamiliar world it can change or transform it. Louise's personal and professional values motivated her to continue with her attempts to change the situation and she called on the cultural capital of a family member to reinforce her own capital to help achieve her ends. In this narrative, Louise could not act fully on her own behalf and nor was she prepared to deviate from her course of action. By enlisting the help of a relative she did go some way to ensuring her commitment to working in a culturally safe way to overcome the potential negative effects of the taken for granted, unexamined practices of her colleagues. Mol (2008) notes that a logic of care involves recognising that the patient cannot be separated from "his or her collective" or this case his family, as all help make care work. Louise sought the involvement of her client's family and thereby created a climate for co-operation rather than resistance.

Bourdieu suggests that *doxa* works to distinguish the *thinkable* from the *unthinkable* so that certain courses of action which challenge established social relations become unthinkable (Bourdieu, 1972; Webb et al., 2002). At the beginning of her story Louise was confronted with the unthinkable and was not prepared to support this, resulting in conflict and struggle between herself, her colleagues and the institution. She chose to go with what was thinkable and therefore possible - that is, to pursue the best and most appropriate care for her client, and actively worked against the rules and routines of the *habitus* in order to achieve her desired outcomes. As a new graduate Louise may not have had capital in terms of time in the field.

However her own social capital and personal dispositions gave her the power to act in ways that produced favourable outcomes for her client.

Several years later, Louise worked in an aged care setting and again was faced with doing what is right, walking a fine line between alienating herself from her colleagues and providing individualised care for a client. She had been talking about the need to get to know people and their likes and dislikes so that she could provide culturally safe care. In order to demonstrate how she practices in a culturally safe way, she tells another story which illustrates how *doxa* operates in a rest home setting to produce routines which are inconsistent with culturally safe care.

We had a lady just recently who was in our care, not because she was ill but because her caregiver was unwell so she had to come into care, she was reluctant to have a shower at all. And staff were saying "You know, she's terrible she won't have a shower" and everything you know, and for four days had not had a shower, so I went into her and I said to her "I'm just wondering when it would be a suitable time for you to have a shower?" She looked at me and she said "Just before I go to bed." All right. Fine. So I went back to the girls and I said "This lady would like to have a shower in the evening before she goes to bed". They said, "We can't do showers, the afternoon staff are going to hate you for that." And I said, "Well that's how we get that lady showered." But I got resistance. Came in the next day, no she wasn't showered. (Louise)

Louise attempted to negotiate a different outcome for her client with her colleagues but to no avail. Bourdieu asserts that *doxa* is the point of view of dominant actors in a field presented as self evident truths. These truths are produced over time and are constructed in a way that makes challenge difficult due because they are construed as common sense (1972, 1994). In this account Louise stayed with her sense of self and what was appropriate and safe for her client's dignity and sense of self worth. She was not swayed to agree with her colleagues and unlike her earlier experience as a new graduate she used her own capital to challenge the rules of the field. Again Louise worked from a person-first approach, framing her request for an evening shower through the wishes of her client. Her initial attempts to negotiate to work within the already established routines of the field failed, even though she was assertive in her statement that this was going to be, rather than how it was. According to Bourdieu, *habitus* is internalised as the qualities of the external structures that individuals are exposed to and acquire as dispositions

throughout their lifetime. By internalising the objective qualities of the social structure, subjective dispositions, rendered as thoughts and actions, are produced which are then projected outwards to structure an individual's social world. Bourdieu states that the more stable the objective structure of the field, the more fully it is reproduced or reflected in a person's disposition and way of being in the world. The greater the extent of the field through which practices are reproduced and taken for granted, the more likely they are to go unquestioned (Bourdieu, 1972).

The field of aged care has traditionally been considered to be hard physical work carried out by a mainly unregulated workforce. Until recently this field has been vulnerable to the development of practices which have relied on routine, ritual and repetition to complete the work of caring for people who are elderly and in residential care. It is only when practices are challenged through the presence of competing discourses, in Louise's situation through her desire to provide culturally safe care, that Bourdieu says the "truth of the *doxa* is fully revealed" (p.16). While Louise challenges the practice it is too entrenched in the objective structures of the field, routines and the subjective dispositions and relationships of her colleagues to effect or develop a new practice more in keeping with protecting the integrity and self-worth of the patient.

The next day she anticipated that the situation might not have changed and she commented:

So I had to go to Plan B, so I thought "Right." So I just actually then had to say to her "Would you like to think about when you might like to have a shower while I'm here, 'cause" I said "I can actually assist." She didn't actually need to be showered but you had to set the shower up and I said "I tell you what" I said, "it's nice and quiet between such and such a time" because actually if she was to have a shower early in the morning, hurry up, hurry up, hurry up, so I said to her "What say somewhere between this time and that time, because it's lovely and quiet. Nobody else is needing the shower and you can take as long as you like, no interruptions." "Oh hmm" she said, "That's all right." So then I just sort of came along and reminded her. ... That's about getting things done. And of course at that point I thought the time I try to take convincing other people to get her showered at the afternoon, when the most important thing was to get her showered for her sake, but not so much for that but for the people she was around, for everybody. So I did it, and of course it meant that I got a bit behind with stuff because I'm supposed to do a million and one things just

before lunchtime, but I just thought well it's got to be done. Yeah, you know, that sort of thing. You see we get so tied up in our routines, I just find that, and I know we have to when we've got so many people to get lunch for and stuff like that, but sometimes we just have to think outside the square a little bit. (Louise)

Louise was pragmatic, she was not deterred by the power of institutional routines and while she was unable to offer exactly what this woman would like, she was able to find a middle position by thinking outside the square. This account is as much about providing individualised care as it is about engaging in a relationship where the dignity of the person is held and maintained within the limitations of an established field. While Louise was unable to reduce the potentially dehumanising effects of ritualised routines, she was able to change the rules of the field through changing her own routines. This story illustrates the struggle involved in trying to work in a culturally safe way while engaging in fields which produce entrenched practices over time that are difficult to shift. Louise's accounts have illustrated how Bourdieu's concepts of field and *doxa* conform to, or resist, attempts to change routinised or 'common sense' practices. The accounts demonstrate the way Louise used her own capital to accumulate power and resist conforming to the rules of the *habitus* within the two settings in which she worked. The cultural safety features of this story are evident in Louise's efforts to reduce the potentially harmful effects on this woman's dignity and identity by resisting the rules and opening up the possibility of new action. In doing this she risked alienation from her peers. While she was not wholly successful in her endeavours, she did act to maintain the dignity of the woman. It was more important for her to enable the woman to feel she had some control over her care than it was to try and convince her colleagues to change their routine. Louise committed to a course of action even though she knew that this meant changing her own routine and reprioritising her work. For a short while, her client was able to feel valued and respected for the choices she made. For Louise, although changing routines was problematic, it was not impossible and it took a problem-solving approach to reach an outcome.

In summarising her talk about applying cultural safety in practice Louise said:

Because this is my actual belief, and that's probably a personal belief so it's quite strong, that nursing is about a partnership between the nurse and the patient and that things that come in between that and prevent you from giving quality care and undermine that and so then if I wasn't able to do that I would

start questioning whether I should be in that job. And there have been a couple of times I've felt that perhaps I shouldn't be in this job. (Louise)

Louise exerted considerable energy in resisting unacceptable practices and she wondered if it was worth it. Her comment is not unusual from nurses who strive to be vigilant and resist approaches to care which have the potential to harm or diminish the integrity of a client. As Louise has demonstrated, the field and the people within in the field have a powerful influence over what happens, particularly when the power of the group is greater than the power of the individual. For Louise, being true to her beliefs may be too costly for her in terms of energy and the struggle that it takes to provide quality, person-focused care.

Louise was not the only nurse interviewed for this project who encountered *doxic* practices. Analysis of Chris's story in the following section demonstrates how particular investments in the field operate to maintain the status quo. A constraining factor for Chris in working with culturally safe knowledge is her relationship with older colleagues who have had many years of practice. These constraints are made visible through language, attitude and behaviour. Chris's story recalls her experience as a new graduate in a long-term mental health facility.

They say things and I don't know whether it's from old nursing or whether it's just something that they picked up along the way, a lot of the slang I have a problem with. A lifer, someone who's just there and he's just there, I mean we're a rehabilitation unit you know, we need to be rehabilitating these people for the next level, whether it's going back into society, or go to a rest home or in terms of their family, it's not just to be sat in that room and you sit in a room until you die, that's not right [She uses the word bin]. This is slang, that when I was studying, I didn't know what the hell a bin was, I thought it was that thing there in the corner you put your rubbish in it, is that the term used for the way I work, I'm in a bin and the rubbish is the people that I care for and you know basically my problem is, but at the end of the day I can come home and say I did a bloody good day's work even if I was in a bin. I hear it by our nurses who've been there 100 years. And maybe that's how they used to nurse and I tell you there's a lot of times when they start using, 'oh back in the old days we could', and I used to say to them, 'we're not back in the old days and if you want to go back there it's probably time you moved on'.

The guys that work at the hospital they have their own little culture and they work it that way and they like it that way and they don't want to change, they don't want to bloody change and for those of us coming out from the polytech, coming out from all this book thing, you can ask who am I but our belief system, you know that the old man, we helped him, you know, we don't just keep quiet and keep walking, we say hello and we help them, you ask him how he is, but they don't, it's like oh yeah he's there, and he's in room blah blah. If you were to ask him, "How is your daughter? How old is she now?" he will tell you. They don't even know he's got a daughter who's 27. They have all this knowledge but they don't put it to use. When I first started in this ward I did not say things sometimes because I did not know much but as soon as I got the RNI [Postgraduate Certificate in Mental Health Nursing] I could say I'm on your level brother and I don't care if you have been here for 100 years. My patient says "Oh, I don't like that", I'm going to tell you. (Chris)

For Chris, derogatory and labelling language is not only confined to the way her colleagues talk about clients but also about their workplace. She judges her colleagues' attitudes towards the people for whom they provide care in relation to how this language positions the clients *as rubbish*. The use of the word *bin* to describe a place of care belongs to a time when people were constrained in institutions in order to monitor their behaviour through surveillance techniques such as observation, ritual and separation from normal society. Forms of surveillance, originally developed in large institutional contexts, reflected the values of the wider society, in which people who transgressed against societal norms were removed and made invisible. This gave rise to a local culture in which potentially beneficial social interactions with clients were ignored. People with mental illness were no longer subject to the kinds of physical punishment associated with psychiatric institutions such as constraint. Disciplinary techniques were effected through other means such as observation, language, ritual and collective routine (Johnson, 2004). The outcome of such practices produced a docile, compliant patient and also impacted on the persona of the caregiver. Both patients and psychiatric nurses were incarcerated away from the world.

Othering patients meant that both groups were seen as less than worthy of the right to dignity and respect. Isolation also meant that different practices and attitudes evolved which reflected alienation from society and the harshness of the environment. These dispositions and practices gained the status of *doxa* and were subsequently transferred from large institutions to community settings by the hospital-trained nurses. Bourdieu (1972) asserts that *habitus* is central to the

generation and regulation of practices that make up social life and a person will learn to want what is available to them in the field rather than create conditions making other actions possible. Chris, a newly registered nurse, had been prepared for nursing outside in a different kind of *habitus*, an educational context where she learned to understand the importance of the dignity of a person and the importance of developing a trusting relationship. She struggled with colleagues who had *their own little culture* and who invested in expending time and energy ensuring that *they work it that way and didn't want to change*.

Chris was aware that her novice, polytechnic-trained status ensured that she had little cultural capital among her older colleagues. The propositional knowledge that she had gained from a tertiary education was dismissed by the hospital-trained colleagues who privileged *the old days* and practical knowledge gained through experience. She recognised that she needed the practical knowledge of peers but was disappointed in the way they talked about clients, suggesting that this workplace would not extend or consolidate her practice. Chris emphasised this disappointment by swearing which showed the level of frustration she had with not being able to develop collegial relationships with her colleagues whereby they could work collectively to provide culturally safe care for her clients.

Perron and Holmes (2006) note that nurses are agents of care, agents of the state, straddle different discourses and have the power to protect and the power to control. They occupy ambiguous positions within institutions of health care. Chris's narratives demonstrate that culturally safe care goes beyond what happens between the client and the nurse and permeates every point of interaction, affecting what can and cannot happen. Chris can see how attitude and language translate into a pattern of relationships and care that are antithetical to cultural safety. Chris concludes her narrative with a statement which suggests she is now able to act from a position of confidence and self knowledge. With the attainment of a postgraduate qualification, Chris now has the mechanism and the means of visible authority which will enable her to draw upon her educational knowledge, within the environment, in order to act as a strong advocate for her clients.

7.4 Debbie's story: It's a cultural thing

Debbie works in a specialised oncology unit in a large metropolitan hospital. Analysis of Debbie's narrative focuses on Bourdieu's concepts of cultural, social and symbolic capital, including the notion of interest (1998). It examines nursing care in an identified field of practice to show how Debbie works to provide culturally safe care. Debbie's everyday practice environment is structured by a set of values and beliefs that melds nursing, medicine, science and technology into an integrated *habitus* called oncology. Within this *habitus*, each person works in a multidisciplinary field to independently and interdependently diagnose, treat, monitor, survey, provide comfort and be compassionate. Fields develop specific characteristics and involve many different kinds of relationships. Collectively health professionals in this field work with patients and families to alleviate pain and suffering and to provide support as patients and their families move through experiences associated with loss and grief. For Debbie, this field provides a place where she can invest her interest in providing compassionate care in an autonomous way through the development of trusting and caring relationships with people when they are at their most vulnerable, and at the same time be part of highly technical and bio medical *habitus*. Boride's (1977, 1988) concept of capital relates to the power of a person, which can be changed or used to improve their position in the field. In Debbie's narratives the interplay between cultural, symbolic and social capital will be considered in relation to the field of nursing.

Debbie begins by commenting on how cultural safety informs her practice.

It's [cultural safety] made me think not only about my culture but more about other people's cultures and I feel more sensitive to how they are when they come into hospital, the environment they're in, perhaps what I need to do for them and how I need to respect certain things they might want to do. I'm quite aware that people need to have their family around them, perhaps people need to have time for their prayers if they do prayers, I am aware of where I place things in the room when I go into the room, perhaps I might not place their food on the bed, there's just certain things that I might not do until.... I might ask them "Where would you like me to put this?" until I know specifically what they want me to do with it. Sometimes I'll ask them if it's appropriate if I do certain things to them you know, especially when it's some of the men, it's not appropriate for me to do certain things, so I'll ask them first and if it's not I'll

find someone that's more appropriate to do it. That's what I learned from cultural safety. (Debbie)

Debbie's knowledge of cultural safety has made her more aware that culture is important and will affect the way a person experiences hospital care. Her account identifies that she uses this awareness to seek information from the client as to what their everyday needs are in the context of the hospital environment. Attention to detail and personal preference about the placing of objects is considered by Debbie to be important for her client. During the process of eliciting this information she is also assessing how the person is responding to her as an appropriate person to be providing care, setting the groundwork for the development of a trusting relationship through a mutual sharing of information. Debbie's actions are the first steps in applying, assessing, appraising and using clinical judgement specifically to begin to establish a culturally safe field of nursing. She does this by not making assumptions about what she can or cannot do, conveying an attitude that enables the person to construct their own *habitus* and to shape their environment according to their needs within a hospital setting. Through this process of negotiation and enabling Debbie is able to learn about her client's everyday preferences and accommodate these preferences within a hospital environment.

Bourdieu (1994) identifies the structures of a field, such as the culture and practices within a hospital, as being the material conditions that constitute a particular kind of environment, producing the *habitus* from which practices are generated. Practices are generally considered to exist within the routines of various disciplines within the field. Debbie's account identifies the way in which the everyday routines and rituals of the patient also operate alongside other practices within the field. Debbie is mindful of the influence of the hospital structure on care (referred to as *the environment that they're in*) and she sets the scene for evolving her relationship with her client in the context of this structure. However, knowing the rules of the field, and how relationships work in the setting of an oncology ward, does not mean that the care Debbie provides is without tension or complexity. To be able to fulfil her promise of culturally safe care she has to be vigilant and ready to act.

We had been talking about specific instances of where she felt there were differences between cultural safety and nursing.

I've watched people actually. I've watched people who are Māori come in and they would draw into themselves, you know. I've seen things that are done, for

instance someone might go in and drop their meal off onto a chair and walk out, and I'll go and grab it and quickly put it somewhere that is more appropriate for them. Or someone is getting washed, if they're having to be washed because of incontinence or something like that, and they see the nurse using the flannel for down there [gestures toward lower body area] and then using the flannel for their face, you know, there's just so much that goes on that people don't realise, and I see people withdraw, they'll get quieter and quieter, they won't necessarily ask for things. And some relatives have even said to me 'Oh dear can you please make sure the nurses don't do this when they come in and put Dad's blah blah.' and I'll go 'Yeah.' In one instance this family just started to cry when I walked into the room because their family member had just died, and they went 'Oh thank God, a Māori nurse, someone who can take care of our Mum in the right way' They just expected that I would be different in some way. They'd had someone from an agency who was from [another country, not New Zealand] who was quite abrupt and in their face during the time their family member was dying, so when I went onto the shift I was coming on just as they had died so I was taking over the after care. Then they started to cry. In addition, they said, 'It's just been terrible and all these things have been going wrong, and, you know, it's not how Mum would have wanted it'. In other situations other family members might say to me 'Oh it's so nice dear that you don't put my food on a chair'. You know, they'll say to me 'I haven't eaten my meal for the last three days because it's been on the chair and we've been handed poor appetite. You know. They [the patient] might say, 'Once it goes on the chair I can't eat it'. They've said things like that. Or the family will come and they'll just say 'Thank you for looking after....' and they'll give you an example that, you know. (Debbie)

Debbie identifies practices which contradict the intentions she laid out in the previous narrative. She maintains a vigilance regarding the practices of her colleagues but is unable to act in any other way than by intervening to ensure cultural boundaries are not violated and to avoid possible distress and unease for the client if it were to remain that way. She acts to maintain the cultural integrity of the person but she does so as an individual and almost in a 'damage control' manner. Debbie then elaborates on this by giving a specific example describing how one family perceived the care of a nurse who was not familiar with the cultural environment and therefore not able to meet the needs of their family member. Debbie's cultural appearance is an instant pacifier or a

protecting influence for the distressed family, providing some sense of emotional and cultural safety for them. This account confirms the reason why cultural safety was introduced into health care and demonstrates that, while guidelines for cultural safety are embodied within District Health Board cultural best practice guidelines, the application of these in practice is variable depending on *habitus* operating in the field.

Debbie draws on specific cultural knowledge to guide her in her care and this arises from her own cultural orientation and is consistent with Tikanga Best Practice Principles.³⁴ Generally Tikanga Best Practise guidelines outline principles for applying key principles of Tikanga.³⁵ Such guidelines can be aligned with cultural safety principles and set the boundaries for improved communication, engagement and cultural safety for patients and staff (Lakes District Health Board, 2008). Tikanga principles, or best practice guidelines arise out of Māori health care needs and they are both specific to Māori and can be generalised to a wider population. Enacting these principles not only requires knowledge about specific cultural practices but also requires an attitude of openness and willingness to respond to difference within the nursing relationship. Tikanga best practice ensures the taha wairua (spiritual), taha hinengaro, (psychological) and taha tinana (physical) wellbeing of the patient and their whānau (family). All these dimensions are central to the healing and recovery of Māori clients and all staff need to be aware of these dimensions of care. Debbie reflects on how her own Māori identity acts as a resource for a patient's whanau. Debbie's narrative suggests that she is a touchstone for this family as they feel that their family member will be well cared for and that they will have someone on their side protecting their loved one from potential cultural harm. In the previous section of talk, Debbie identifies a typical situation in which tikanga principles are not followed. Placing the food where people sit means that the food is then unclean or tapu and therefore cannot be eaten. Debbie notes that this reluctance to eat is interpreted in a clinical context as poor appetite. Debbie's account suggests that disclosures of unsafe practices to her by whānau are not uncommon occurrences, illustrating difficulties in how Māori patients convey judgements about unsafe care to caregivers.

A critique by Nelson (2006) of nurse theorist Patricia Benner's notion of what constitutes a *good nurse* offers insight into Debbie's account and illustrates Bourdieu's concept of capital arising from within the *habitus* of nursing. According to Benner (1984) nursing expertise is a moral practice that develops over time and is an accrued capacity which enables the nurse to navigate

³⁴ There are a number of District Health Boards who have Tikanga Best Practice Policies to guide staff in providing care which is culturally appropriate for a client or patient. These include Auckland District Health Board, Capital and Coast District Health Board, Lakes District Health Board, Otago District Health Board, Waitemata District Health Board, Waikato District Health Board and Tairāwhiti District Health Board. See for example....

³⁵ Tikanga – Māori term for customs, which in a hospital setting includes obligations, meanings and conditions determining the delivery of care.

complex clinical situations and to express an intuitive grasp of events which do not always rely on rules. Benner describes nursing as being underpinned by an ethic of care informed by humanist notions of justice, courage, and truthfulness and therefore claims the moral high ground in health care by constructing nursing as a moral endeavour. Benner's work is situated in a humanist discourse and Nelson (2006) argues that Benner's conceptualisation "sets up nursing as an essentially ethical form of conduct and clinical skill and expertise reconstituted as an expression of exemplary ethical understanding and a moral agency that is free from theoretical or structural determinants" (Nelson, p.76).

Debbie's account provides a counterpoint to Benner and illustrates the way ethical conduct, clinical skill and expertise are not necessarily expressions of moral agency free from theoretical or structural determinants. Bourdieu (1998) suggests that subjectivity, which I take to include moral and ethical behaviour, cannot be considered in isolation from the structures within which care takes place. Debbie's narrative identifies omissions of caring relating to cultural considerations by her colleagues who fail to recognise cultural and structural influences shaping care. Her colleagues are seemingly unaware of these oversights and Debbie is the person to whom relatives turn to allay their own moral distress about the way their family member has been cared for. Bishop and Scudder (1997) describe nursing as a practice in which care fosters patient wellbeing through a direct personal and professional relationship between nurse and patient. Liaschenko and Peter (2004) argue that relationships between the individual and the larger group go beyond the singular nurse-person construction and are mediated by the division of labour and culture within institutions. Cultural safety provides a lens through which to apply the view of Bishop and Scudder (1997) and Liaschenko and Peter (2004) together thus aligning agency and structure into the construction of a moral nurse.

Nelson (2006) notes Benner's work has been influential in forming the foundation of competency frameworks. It has been widely adopted by nursing and health care organisations internationally to organise care, identify competency levels, nursing roles, salaries and career pathway and "continues to define nursing practice and clinical expertise and explain how knowledge and skill are developed" (Nelson, 2006. p.71). Benner asserts that, once an expert nurse, there is no longer a need to rely on an analytic principle, rule, guideline or maxim to connect an understanding of a situation to an appropriate action. The expert nurse with her background of experience has an "intuitive grasp on a situation and can zero in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions" (Benner, 1984, p.31).

Nelson points out that the impetus for Benner's work emerged partially as a defence against the dominance of the scientific rational approach in health care and my reading of Benner's work and Nelson's critique suggests that Benner's work was initially useful in framing an approach to nursing practice. However, within a cultural safety context, Benner's work embodies and reflects the values of the power structures she set out to distance nursing from; that is she tends to privilege the techno rational in health care over the relational. Ramsden (2002) foregrounds nursing as a subjective experience between two primary people, the nurse and the client, and other members of the health care team, suggesting that within this experience there are grey areas of care where professional distance is minimised and intangible skills are employed and these may become critical turning points in care. According to Ramsden (2002) such skills improve the quality of human and emotional interaction and break down barriers to service, as people feel safer. While Benner identified clinical expertise as pivotal to nursing practice, Ramsden identified such expert practice as evolving from the quality of the emotional and spiritual interaction which will more likely break down barriers to service. No amount of technical skill and experience will be of use to people using health services if they do not feel emotionally safe in approaching the service.

Debbie's section of talk relating to the care of the agency nurse is significant and illustrates Bourdieu's notion of interested and disinterested acts. Bourdieu (1988) claims that if an actor is not aware of the way of doing things in the field then they are more likely to be disinterested and lack investment in the *habitus*. If, on the other hand, a person's mind is attuned, as was Debbie's, to the structures that influence the *habitus*, then the way things happen will seem obvious and worth investing in. Using the metaphor of a game, Bourdieu suggests that an indifferent or disinterested person may still play the game but does not see why they are playing. Therefore one game is played the same as any other game as there is no distinction between them. In other words, a disinterested person treats all clients the same regardless of difference. This does not mean that the agency nurse did not provide care. What it does mean is that the quality of this care, by failing to recognise the cultural requirements and rules accompanying the dying of a person who is Māori, did not meet the needs of the family at a particular time.

Another element of Debbie's narrative demonstrates Bourdieu's concept of struggle and tension between different forms of capital and *habitus* within the hospital field. Bourdieu (1988) states that entry to any field requires that actors have a relationship with that field. Debbie provides a detailed account about how she brings her client into the oncology nursing field, making her investment in the field clear. This is further emphasised when she comments about the family

seeking her out as a nurse who is Māori. Rhynas (2004) positions Bourdieu's concept of capital within a nursing context suggesting that cultural and symbolic or social capital are made visible in the field, affecting decision-making abilities which in turn influence practice. Debbie has cultural capital as a nurse because she acts like a nurse, and is identified by others as having nursing knowledge and the credentials to apply that knowledge to their whanau member's care. Webb et al. (2002) describe symbolic capital as a form of capital that may not be consciously recognised and depends on people believing that someone possesses particular qualities. Clients and their families draw on Debbie's symbolic capital by positioning her as Māori, like them, and therefore able to influence the way that nursing care, which sustains the cultural integrity of the person, is provided.

As in Louise's story Debbie is philosophical about what she can and cannot do. I asked her how she felt about being in a situation where she has to hear information about a patient's progress in relation to whether information shared is interpreted within a narrow framework of clinical outcomes and medical conditions, rather than within a broader context of culture and the daily experience of the person.

Debbie said:

People are in the system that's all there is to it. I'm only there for eight hours and during that eight hours I do my thing, and if it's important, like people putting their food down on the commode chair I'd definitely say something now, I'll say 'Jack hasn't eaten today because they've been putting his food on the commode chair. I'm not sure I'd like that either'. Then the nurse will go 'Eew Yuk' Yeah then they'll see it from their [the patient's] point of view. (Debbie)

Debbie recognises her boundaries and limitations around what she can and cannot do in relation to her own practice and the practice of her colleagues. Rhynas (2004) notes that the individual *habitus* interacts directly with different forms of capital that are at the same time internally regulated by the *habitus of the field*. Debbie's accounts of practice have demonstrated how her own cultural and symbolic capital works to produce culturally safe care. At the same time she is also aware of the constraints that the health care system imposes on her practice. *Habitus* may provide a place for finding meaning in the context within which action takes place (Rhynas, 2004). Over time, Debbie has learned strategies that enable her to use her cultural and symbolic capital to provide care that she considers important to the wellbeing of Māori clients. She uses

explanation and self-reference to ensure a message is heard, being careful not to alienate or rebuke her colleagues. Debbie's story identifies the personal accountability of the individual nurse to ensure safe care is upheld in everyday nursing practices within the context of institutional cultures or everyday practices that may work against this process.

Debbie's work focuses on high acuity treatment and intervention for long-term illness. There is an emphasis on technology, life prolonging intervention, clinical outcomes and prognosis and in this story less attention to cultural needs. Debbie explained:

Unless someone writes something in handover and specifically points it out [nobody will take any notice] I say to my colleagues that while Jack's having his food the commode chair needs to be outside the room, it's a cultural thing, and they're like 'Oh yeah, okay'. ... as soon as I say those two, or three magic words, or four – 'it's a cultural thing'... They're the magic words. That is the line, they know. Oh, 'it's a cultural thing for them'... at the end of the day nurses want to do what's best for their patients. (Debbie)

Debbie's commitment to culturally safe practice means that she constantly scans her field to assess and interpret what might be happening for a client in the context of their illness, treatment, daily experience and their culture. She has to be vigilant to breaches of cultural protocols and to manage the potentially negative effects of disinterested personal care. She does this by personalising practices that she considers unsafe for her clients. Debbie understands that her colleagues want to do the best for patients so she has developed a strategy which will help them save face in relation to their lack of awareness of cultural safety practice by offering them a way to be mindful.

The theme of Debbie's story is about aligning tikanga best practice principles with cultural safety and nursing. She demonstrates how her particular *habitus* and capital work in her relationships with her clients, clients' families, and colleagues to maintain the cultural integrity of all.

7.5 Patricia's story: Processing widgets

Patricia's story provides an account of how she applies cultural safety in a day surgical unit. An analysis of her story will show how she works with the tensions between taking time and getting things done when negotiating her way through three fields of care that impact on her practice.

Patricia works in an environment in which she is objectively and subjectively positioned in an in-between space where she operates as a nurse in a surgical setting, brings a primary health care orientation to her work and has to struggle to make her nursing visible and legitimate in a dominant medical field. A day surgical unit provides for rapid assessment, diagnosis and treatment of illness and disease within which she has a short time to establish trust with her clients. Patricia has a strong working-class identity with a background in unionism and is an advocate for social justice including access to affordable, user-friendly and appropriate health care. She brings this consciousness to her nursing and is mindful that people may come through the unit with various other health concerns with which she may be able to help. In the following narrative Patricia describes what it is like for her working in this environment on days when her commitment to social justice, enacted through a primary health care orientation, may not be possible:

Having too many people, coming to stay, when we're processing people like widgets on a conveyor belt and you know [she indicated that there are times when she could do more than processing people] ...tomorrow I may be able to do more, whereas today we're just processing widgets.(Patricia)

Patricia identified times when she felt that she was not able to provide good nursing care. Issues of homogeneity with medicine and heterogeneity with nursing were alluded to in this short section of narrative. Patricia disliked days in which time constraints forced her to treat all her clients the same, or to be, in Bourdieu's terms, a disinterested actor. She equates good nursing care with treating people as individuals through investing in *doing more* with her clients. For Patricia cultural safety is about taking time and building relationships, principles that she associates with a primary health care approach to nursing. She uses an industrial factory metaphor to describe her sense of what it is like working with clients in a high turnover day clinic. Patricia's use of the term widget means that people are likened to objects passing before her like gadgets on a conveyer belt. She has little time to attend to them in any detailed way before they move onto the next part of the production process, this being medical assessment, diagnosis and treatment. On busy days Patricia struggles with providing an effective nursing service that goes beyond serving the needs of the biomedical *habitus* which is dominant in this field of practice. Lupton's (2003) identification of mechanical metaphors to conceptualise the way a person is viewed within the medical field resonates with Patricia's widget metaphor. A mechanical construction views the body as consisting of different parts which, like a machine, may stop working, fail, or need replacing. Thus the focus of medical care is on techniques and

practices designed to locate the non-functioning part in order to treat or repair only that part. Lupton (2003) argues that the mechanical view of the body does not take account of the spiritual nature of the person, or of healing relationships, intimate personal contact through relating and the need to develop a deeper trust with the health care provider.

A mechanical model identifies the functionalist role of medicine as a powerful determinant of health care delivery. A functional model assumes illness is an unnatural state for the human body, which causes both physical and social dysfunction, and therefore it is a “state which must be alleviated as soon as possible” (Lupton, 2003, p.7). The functional model is maintained by people’s occupying defined roles and performing certain functions in their everyday work. This means that, for Patricia, her role is to provide nursing activities supporting the function of medicine to assess, diagnose and confirm dysfunction and for the patient to be a passive recipient or widget in this process of diagnosis confirmation and treatment.

Patricia’s next account describes in detail what she means by *doing more*.

I can think of one actually and that was an elderly Māori woman that came in for a, oh I can’t remember, a minor op, as a day patient with her daughter, and she was one of the ones who stayed in one night till midnight she still had her medication with her and she had asked the doctor you know, what the different ones were for and he said “If you take them all at once it doesn’t matter, just take them in the morning, you don’t need to worry about that”, so she really didn’t have a handle on those things, she’d worked out from looking in a book that prozac was for depression, so she’d just taken them the day she felt down. ...so she hadn’t been very well and she thought that with her diabetes if she just didn’t have chocolate she’d be ok so her blood sugar had been up and it was all over the place 33 down to you know 3 or something so she was one that was a favourite. I did have time to do a lot of stuff with her, so I did get a Benefit Rights person to tell her what she was entitled to get, but the daughter felt really terrible she hadn’t been able to find out. The diabetes nurse came over and from the outpatient clinic and spent time with her, so that was a day that I thought was quite good. I thought I was making stuff available with her and her teeth and there are so many people that don’t have teeth and terrible self image and the people can’t afford dentist and get upset. (Patricia)

Patricia's commitment to social justice and a primary health care approach to nursing are illustrated in this narrative. She contacts the benefit person to make sure that her client is receiving all of the welfare entitlements for which she is eligible. She stays with her client until midnight, taking time to listen and establish trust illustrated through Patricia's reporting of her client's disclosures to her about concerns relating to her medicines, diet, teeth and appearance. Bourdieu's metaphor of the game has relevance to Patricia's story and identifies struggles over the forms of capital and resources that are available to people within a particular social field (Bourdieu & Wacquant, 2005). It is in the spaces within the field where competition between different forms of capital is played out. The spaces are hierarchical in nature and each actor struggles to occupy dominant positions in the field. Patricia has cultural capital; as a nurse she uses her specialised knowledge and position within the field of health care to access resources for her client. This had been a good day for Patricia; she had time to attend to the person and to follow up on other health care issues and concerns that were impacting upon the woman's self esteem. She was able to supply information and enlist the help of colleagues to provide specialised and appropriate care. She could take time to talk with the woman and her daughter and make her feel valued as a person. For Patricia, a good day was being able to practice in a way she considered to be good nursing and culturally safe care. She created a space which provided physical safety and protected the woman's self integrity by recognising gaps in care and putting resources in place to address the woman's health needs beyond those for which she was attending at the clinic. She engaged and showed interest in her as a person needing a range of services beyond the narrow focus of a minor op in the unit where she worked.

Patricia's narrative illustrates how Bourdieu's (1998) concept of field parallels that of the way a game is played. By giving attention to and investing in time to address needs of the client considered as being outside the rules of setting, she has in some way changed the rules of game. Patricia's narrative, is links her practice to fields of cultural safety and the principles of care that associated with primary health care nursing beyond the medical agenda. Constrained by the field and empowered by time, Patricia was able to focus on establishing a brief working and productive relationship with her client. The *habitus* of her practice was characterised by a high turnover of clients attending the unit for a specific procedure and at the same time arriving at the unit with complex health needs. For Patricia her personal and professional habitus, driven by an internalised class consciousness and respect for human dignity, provides her with a space to deliver effective nursing in a highly medicalised field of practice. She is also aware that this degree of care is partial and determined by the Biomedical and technological demands of the service.

Patricia's account suggests that by working within a strong nursing framework, political action is possible. Her nursing intent is grounded in a primary health care approach combined with a strong sense of social justice and as such she has an appreciation of the effects of disadvantage on the wellbeing of people for whom she cares. Patricia understands, for example, the inverse care law in which people from disadvantaged groups are less likely to access health care and more likely to need it (Dew & Kirkman, 2002). She takes advantage of their time in the unit to do a full nursing assessment and care plan. In a surgical unit it is easy to prioritise the biomedical and technological demands of care and to see technological competence and efficiency as exemplars of good nursing. For Patricia nursing is about treating people as individuals and not *widgits*, her politicised, relational and holistic approach *is* culturally safe nursing care.

Patricia's narrative has identified how different fields of practice interact and how one maintains dominance over another. Everyday culturally safe nursing is embedded within the nursing relationship and has to compete for legitimacy in settings dominated by medical discourses and practices. The socio-political orientation of cultural safety means that it also has to compete with humanist nursing discourses in order to be visible and effective. The nurse has to be committed to striving to work in a safe manner, as safety is a defining characteristic of all health care. Cultural safety provides a medium for a nurse to maintain and address the complexity of nursing practice which involves all aspects of physical, social, emotional, spiritual and political concerns of the person with whom she works and is central to the practice of nursing. Larsen (2003) asserts that the medical field is a socially prestigious and symbolic system because of its specialised concepts and classifications. Larsen claims medicine is a male oriented profession directed toward maintaining and raising the profession's social position and healing patients based on a background of medical examination and diagnosis. Nursing on the other hand draws from a multiplicity of paradigms, some of which have parallels with medicine and some which do not. Larsen (2003) notes that while the production of nursing research knowledge and the development of an independent nursing science may be considered in relation to medicine, he observes that nursing is seen as subordinate to medicine. He proffers a view as to why this may be so, and argues that:

The experience of practitioners, management and organisational specialists within nursing, the experience of being constrained in their efforts to gain autonomy, reflects that fact that they indeed are constrained and that this constraining process is taking place in an unnoticed way, e.g., in that which has not yet been articulated as 'something', in the natural and in the self evident. (Larsen, 2003, p.276)

Larsen's comment reflects a Nordic view and in New Zealand in some settings this claim could be disputed due to the critical consciousness developed through cultural safety education. However in different health care fields Larsen's comment has relevance as evidenced in Patricia's intent of providing complex care for her client in a climate of time constraints and medical efficacy. This means that fundamentally there is a clash of interests between medicine and nursing in Patricia's account. Patricia is driven to care for the whole person by putting the patient at the centre of care while the field demands that the medical staff are the centre of attention because the value of medical skill and practice is privileged and shored up by the attendant and supportive tasks of Patricia. In this situation Patricia has to work keep the client at the centre of the project but she can only do this on an ad hoc basis and only when time and space allows for attention to complexity.

Patricia comes to nursing with a strong social consciousness and an understanding of inequality and justice. Her account demonstrates how she personally struggles to legitimate her cultural safety and nursing actions in order to keep her patient at the centre rather than at the margins of her care. Patricia's account suggests that, because of her personal and professional way of being in the world, what happens in this setting is solely within in the domain of her nursing responsibility. Patricia's concerns go beyond the personal and are embedded within the *habitus* and cultural capital of the field. People using this day surgery service are there for diagnosis and treatment. Other health or social needs are separate to this and therefore people are sorted and assigned positions according to the cost of medical time and the efficient use of facilities. In this setting it is time and efficiency that tend to be valued and not the complexities of other health and social needs that patients may have.

7.6 Summary

This chapter has examined five narratives of cultural safety against the background of Bourdieu's concepts of *habitus*, capital and *doxa* to demonstrate the way cultural safety interacts with four different fields of health care. Each field identified specific practices demonstrating the way in which the nurse's autonomy was either constrained by forms of symbolic capital and *doxic* attitudes, or enabled by their personal, cultural and professional dispositions. The chapter has demonstrated the way everyday symbolic power, embodied within hierarchies, relationships, practices and rules, shapes the way the nurse mediates conflict and tension inherent within different fields of practice. By making visible the qualities of cultural safety through challenge, reflection and communication, the participants had to not only manage their subjective

relationships with other people in the workplace setting but also the power of the structural symbols guiding everyday practice.

Cultural safety is a body of knowledge which has an examination and awareness of power as its driving force. However the concept is not legitimated in some practice settings and is actively discouraged through the development of *doxa* and symbolic capital. This results in the prevailing values and beliefs of the field being recognised as interest in the field but which in reality disguises power which enables individuals and groups to maintain their positions of dominance and influence. This has implications for new graduates and experienced nurses in relation to cultural safety practice and for each group there are different consequences. New graduates entering a practice field for the first time have to know how to resist the attempts within the field to make them think differently or 'forget' their cultural safety knowledge and adopt practices compromising the identity, well being and worth of the individual.

I have identified in this chapter that the more autonomous the nurse is in her practice, the more cultural and symbolic capital she has to determine how culturally safe care will be delivered. The less autonomy she has the more vulnerable she is to being constrained by the symbolic effects of power which may not always work in her interests or the interests of the people for whom she cares. As a result the nurse may not be aware that she is subject to this power and may become complicit in the exercising of power through the very forms of symbolic violence that she resisted. Rationalising unsafe nursing actions as resulting from a legitimate and sanctioned power enables the nurse to gain symbolic capital. This form of power is not perceived as such but as the legitimacy of, and the demand for, recognition, deference and obedience.

I contend that cultural safety is a practice which has the potential to guide nurses in monitoring and recognising symbolic power and its effect on the health and wellbeing of a patient. Cultural safety education enables nurses to develop skills and strategies to gain nursing capital which can be brought to bear on the field to provide care which consistently reflects values of worth and respect and puts the patient at the centre of care. This means having an understanding of the way capital works to maintain the status quo and understanding their position within the field. I argue that acting on this understanding is difficult but not impossible because awareness brings with it a motivation to act and this I not always possible. On the other hand to act can leave the nurse exposed and vulnerable Within an integrated field of practice, any voice taking an opposing view to what is considered the usual or normal in the field is subject to the very practices that they are trying to identify as comprising quality nursing care. For this reason, cultural safety is vulnerable

to being marginalised in some fields of practice and for it to be the driving force of care in other fields.

An analysis of participant narratives drawing on Bourdieu's concepts of *habitus*, capital, *doxa*, and field suggests that cultural safety may be viewed as both a body of knowledge and a framework for working with different forms of capital in everyday nursing practice. At the same time the potential for the perpetuation of unsafe practice through the indifference and disinterest generated by *doxa* and the accumulation of symbolic power by individuals within the field may also be identified. Incorporating the theories of Bourdieu into understandings about cultural safety draws attention to these tensions and possibilities. Cultural safety is a field that engenders interest, indifference, resistance and possibility for change and is more likely to engender indifference amidst other fields which have accumulated more cultural and symbolic capital because of their longevity and prestige within the health care system.

Cultural safety is a conceptual framework focusing on power, attitude and relationships between individuals and groups. This chapter has demonstrated how, in practice, these concepts are played out in everyday nursing and identifies that the theory and practice of cultural safety cannot be separated. Each concept of cultural safety was analysed as a practical expression of Bourdieu's theory of practice, demonstrating how the field of cultural safety struggles to gain symbolic and material power to effect change and reverse the established *doxa* within different health care domains. The nurses' narratives have identified that nurses work with different symbols, subjects and objects of power in diverse fields of practice and these factors shape how their actions are constrained or enabled in the pursuit of providing culturally safe care in everyday practice.

The next chapter draws on themes from the previous chapters to illustrate how the goals of the research have been met. Limitations of the study are discussed. Directions for further study arising from the research are identified and the chapter ends with a reflection on the research process and concluding thoughts.

Chapter eight: Discussion of findings

8. Introduction

This study extends Ramsden's (2002) work on cultural safety by examining how *habitus*, *doxa* and forms of capital operating in different fields of health care influence cultural safety in nursing practice. The thesis has provided an examination of how the resources that are available to nurses, within different fields, open up or close down possibilities to create conditions for culturally safe care. The use of an abductive approach (Blaikie, 2002), Somers' (1994) concepts of identity and narrativity and a Bourdieusian analytical lens enabled me to turn participants' stories into technical descriptions of cultural safety in everyday nursing practice. The initial focus of this research was to provide an analytical explanation of how registered nurses work with cultural safety knowledge in their everyday nursing practice. However, at the conclusion, the study has identified that an understanding of cultural safety knowledge in practice is incomplete without a consideration of cultural safety education, as both are inextricably linked.

This final chapter reviews key findings of the study and integrates the findings with the literature. Blaikie (2010) suggests that a shift in theoretical perspective can change the shape of the social world. Bourdieu's theory of practice as applied in this study is discussed and ideas about the way Bourdieu's work might open up possibilities for culturally safe practice are introduced. Limitations of the study are identified and the contribution of the methodology to research is briefly examined. Consideration is given to the implications of the findings for nursing education and practice. The chapter concludes with reflections on the research process.

8.1 Review of the findings

8.1.1 *Learning about cultural safety and meanings of cultural safety.*

Chapter five explored accounts of learning about cultural safety and different meanings the concept held for participants. Cultural safety, like many other aspects of nursing practice is taught to people with different personal pasts and positioning and this influences how they hear and understand cultural safety, including what is at stake in applying it in practice. This personal positioning therefore shapes the level and type of uptake of cultural safety knowledge and an individual's intent or ability to acknowledge or use what they have been taught.

The participants reflected back what and how they had learnt about cultural safety and how they applied it in practice. Some had come to know about cultural safety through many years of nursing practice. Others came to nursing as new graduates knowing about cultural safety and having to adjust and adapt to practice environments that may or may not have been compatible with culturally safe practice. Culturally safe nursing was not always explicit in nursing actions and became a visible entity only if a participant was asked to share a story about cultural safety or in practice when she needed to assert herself by taking a particular course of action consistent with cultural safety, for example resisting the dominant discourse in the interest of the patient. Meanings of cultural safety were shaped and influenced by early educational experiences as well as the personal and social dispositions of the nurse. The participants' learning, and the learning of colleagues during cultural safety education, at times moderated the application of cultural safety in different practice settings. Tensions identified between cultural safety education and practice suggest there is a dissonance between what is learned in cultural safety education and what is possible in practice thus resulting in different levels of uptake of the concept in practice.

The NCNZ (2005/2009) states that cultural safety is:

The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socio-economic status; ethnic origin or migrant experience; religious or spiritual belief; and disability. The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well being of an individual. (p.5)

A reading of this definition suggests that responsibility for providing culturally safe practice lies with the personal and professional capability of the nurse and does not take account of the setting or the structures within which health care takes place. This thesis moves cultural safety away from a focus on the individual nurse and individualised relationships between nurse and patient and draws attention to a focus on the field, *doxa* and *habitus* of the settings within which nursing takes place. This could be interpreted as absolving the nurse from individual responsibility to provide culturally safe care and to 'blame' the setting. Such an interpretation falls within a dichotomous argument of either/or. A key feature of Bourdieu's theory of practice is the collapsing of distinction between the subjective and objective. Therefore including a focus on the context within which nursing takes place can assist in strengthening the personal and professional capability of the nurse. With a practical understanding of the way relationships

operate in, and are influenced by, fields of practice, the nurse is better equipped to act in the best interests of people for whom she cares.

8.1.2 Settings and identity: Structure and agency - towards a setting approach

Participants' stories in this study have illustrated how culturally safe care nursing is enabled or constrained by the uptake of cultural safety in different settings. Chapter six explored a settings approach and demonstrated that the provision of culturally safe care is not a generic concept where what is appropriate in one setting will automatically be so in another. A settings approach identified sets of values, beliefs and relationships guiding what happened in different settings. The participants recognised that cultural safety and the quality of nursing were closely intertwined and shaped by the setting, and they worked to try and moderate the environment to increase the potential for culturally safe care. Conversely, stories identified that some participants' colleagues found advocating for conditions that enable the provision of culturally safe care was too hard and this resulted in the nurse feeling silenced by the dominant values of the practice context. Being silenced in some cases was a source of moral distress. Such silencing supported the continuation of *doxic* practices in contradiction to culturally safe care.

The study identified that different practice settings supported the need for cultural safety in a very arbitrary way; a little in some places and not at all in others. It was evident that the greater personal and professional autonomy the nurse had in determining her own practice, the less she felt bound by the rules and practices of the field and the more she was able to nurse in a way that she considered culturally safe. Participants who were constrained by the structure and practices of the field had less opportunity to make culturally safe care visible in their practice.

The purpose of cultural safety is to provide an effective health service to meet the health care needs in a way which maintains the personal, social and cultural integrity of the person using health services. I have argued in this thesis that identity and a sense of wellbeing, independent of the health concern, are important factors in determining health care outcomes for all people using health care services. Just as identity can be considered a resource that a person can draw on to maintain wellbeing and social connectedness during times of illness, stress and change, so too is an awareness by the nurse of her or his own identity critical in determining the quality of health care outcome for a patient. Experiencing a sense that they matter to the nurse providing care can mean that a patient feels valued as a person and more able to trust, feel safe and participate in

their own care. Similarly an awareness of her own identity can enable the nurse to feel more able to engage with a patient and feel confident in developing a trusting relationship.

An enduring feature of current understandings of how cultural safety is assessed lies in the power and ability of the recipient of care to do so. The statement *culturally safe care is determined by the recipient of care*, has almost become the gold standard as to whether culturally safe care has occurred or not. There is an inference that culturally safe care is what a person says it is, thus it has become a *doxic* statement in that what this means has not been adequately critiqued and stands as a taken for granted understanding in assessing culturally safe care. While in a research context recipients of care may feel able to comment, this study identified that patients who feel vulnerable and disempowered during a health care encounter may not feel so able. It is the personal and professional disposition and intent of the nurse which enables the creation of a safe place for patients to give feedback on the quality of their care.

Cultural safety draws attention to the ability of the nurse to reflect on attitude and the impact of an individual nurse's culture on that of the patient or client. Participants' stories in this study contributed a wider understanding of the way reflection determines action and plays out in everyday practice. In this study action arising from reflection was at times moderated by the structures and values of the practice settings as well as by the personal and professional identity of the nurse.

This research has shown that the *doxic* practices at work in different health care settings determine the degree to which any of the above can happen. This study has identified that the greater the resonance between the values and beliefs of the setting, the nurse's personal and professional positioning and the values of the person receiving care, the greater autonomy the nurse has to determine the approach to nursing practice. This means that it is more likely that nursing can happen in a way which contributes to, or initiates, change in relationships with clients as well as within relational power networks operating within the nurses' everyday practice.

8.1.3 Cultural Safety: Habitus, capital, doxa and field

Chapter seven explored narratives of cultural safety set against a background of Bourdieu's concepts of *habitus*, capital, *doxa* and field (Bourdieu & Wacquant, 2005). Participant narratives demonstrated the way cultural safety interacts in different fields of health care. The degree to

which the participants could act was in part dependent on the amount of cultural and symbolic capital they had to effect change and deliver care they considered culturally safe.

Bourdieu's concepts of *habitus*, field, capital and *doxa* provided a framework to explore narratives about the way power operates within different fields of practice. Opportunities for nurses to provide culturally safe care had the potential to constantly shift and change, depending on the forms of capital that were valued, the resources that were available to nurses and the relational practices that operated within the particular fields in which they worked. This chapter demonstrated that an analysis of the structuring of power created an awareness of how forms of dominance operate in health care relationships.

8.2 Integration of findings with the literature

An examination of the literature related to cultural safety centred on the scholarly application of the concept within education and national and international contexts. There was minimal literature examining cultural safety nursing practice and even less from the perspective of the person receiving health care. More importantly, the literature identified issues of theoretical interpretation in different cultural contexts. National literature on cultural safety was situated in an historical, socio-political context and drew on Te Tiriti o Waitangi to explain cultural safety (Fitzpatrick, 1998; Richardson, 2000; Wepa, 2003). Although the international literature addressed the importance of a critical, post colonial or feminist theory as a way of providing an analysis of power and marginalisation (Anderson et al., 2008; Browne, 2007; Browne et al., 2009; Perry et al., 2003), conclusions tended to limit cultural safety to an indigenous or ethnic orientation, giving rise to tensions between cultural safety, transcultural care and culture specific models of care. The literature tended to privilege transcultural care or cultural competency, focusing on ethnic or cultural difference from the perspective of the provider. It identified that cultural safety was beginning to be subsumed within the growing cultural competency literature with its preference for addressing difference from a cultural perspective (de Souza, 2008). Attention to culturally competent care risks masking the reality of the patient experience by focusing solely on the provider of care. This creates a false sense of security, or a misreading that the provider of care has performed and met the criteria for competence against a pre-determined set of standards which may or may not actively and sincerely consider the patient's view. The extent to which processes are accessible in health care settings for patients to comment on their care is dependent on their ability to understand complex and unfamiliar systems and to participate

in complaints or feedback-procedures that may be long and drawn out, as well as on the degree of support available to assist them in this process.

A significant point of difference between national and international literature was that New Zealand literature was embedded in the political origins and development of the concept of cultural safety and invariably made links between Te Tiriti o Waitangi and health care delivery. International literature acknowledged Te Tiriti o Waitangi as being significant but could not always fully critique the centrality and significance of this in health care delivery. Te Tiriti o Waitangi is a defining quality of cultural safety in the context of New Zealand nursing and health care because it brings a colonising/colonised power relationship into sharp focus. In this study, participants invariably made links between their practice and the history and development of cultural safety. Either directly or indirectly being a nurse in New Zealand privileged their knowledge of cultural safety at different points in time and influenced their understanding and meaning. This raises issues for how cultural safety is interpreted and applied in international contexts where transcultural and multicultural perspectives are the more common frameworks for guiding health care.

A critique of cultural safety, by contrasting it with transcultural care (Anderson et al., 2003; Anderson et al., 2008; Browne, 2007; Browne et al., 2009; Cully, 2006; Gray & Thomas, 2006; Gustafson, 2005) identified paradigmatic differences between the two. This suggests that while the uniqueness of the concept is embedded in the history of Aotearoa New Zealand, this does not exclude theoretical development of the concept in international settings. It could be argued that, as in the dialogue between Cooney (1994), Coup (1996), Smith (1996) and Leininger (1996) (see chapter 3), national and international interpretations of cultural safety have the potential to provide an engaged exchange of scholarly ideas and thinking as to what constitutes culturally safe care from the recipient's perspective. Such engagement needs to be able to explore the practical implications of the effect of power on the well being of any person coming in contact with health care services. An analysis of cultural safety without an analysis of power misrepresents the original intent of cultural safety. The focus on the recipient of care is central to understanding cultural safety and shifts the focus of power away from the provider of care. This calls for a change in the power structures and a need to draw on theory to assist in providing an explanation of the power structures shaping the delivery of cultural safety in the practice of nursing.

8.3 Towards a Bourdieusian theorisation of cultural safety

Cultural safety is informed by critical theory in which conflicts and tensions underlying social structures are deconstructed and reconstructed in a way which offers a different perspective on why things are the way they are and why things happen the way they do.

Knowledge evolves from the experience of everyday living and the relationships that structure these experiences. Blaikie (2010) notes that the role of research is to promote a critical consciousness by breaking down institutional structures that produce oppressive and social inequalities, shift the balance of power through increasing critical consciousness.

In this study I drew on theorists Somers (1994), Bourdieu (1972, 1984, 1990, 1998) and Bourdieu and Wacquant (2005) who developed theories about identity and spaces to extend understandings of agency and structure. Somers' work guided the research by challenging identity as a relatively stable category through linking subjectivity with narrative. This linking introduced the idea that identity is dynamic and is affected by what happens when people exchange thoughts, feelings and ideas in relationship. This thesis has shifted thinking away from an artificial separation between individual agency and social structure to produce new understandings of identity within networks of power relationships that are simultaneously personal, local and global.

Bourdieu emphasises the importance of the person within the social world (Bourdieu, 1972, 1984, 1990, 1998; Bourdieu & Wacquant, 2005). By collapsing separations between agency and structure removes the potential for 'blame' to be ascribed to the person or the structure by emphasising the interconnectedness between both. To suggest that the focus on settings and structure presented in this thesis absolves individual nurses from responsibility for providing culturally safe care is in my view a serious misreading of the arguments presented in thesis. Instead I argue for an educational environment that nurtures the development of critically engaged nurses who are prepared to take responsibility for the practices and organisational structures within the settings within which they operate and who work toward facilitating changes that support and/or enhance culturally safe care.

The substantive findings of this research derived from participant narratives have illustrated tensions associated with the coming together of humanist, positivist and critical paradigms relating to nursing education and practice. The stories drew out personal meanings of cultural safety and highlighted how early experiences of learning about the concept either directly or indirectly influenced current culturally safe practice. A second set of narratives illustrated how

culturally safe care is expressed in everyday practice in conjunction with the influence that personal and professional identities had on shaping care in the context of differing health care settings. Why and how identity, relationship, *doxa*, *habitus* and different forms of power work to produce practices in fields of health care examined another set of concerns within stories of practice.

A significant outcome of this research is the adoption of a Bourdieusian approach to explain cultural safety as it has been presented and articulated by the participants in this study. Such an approach has implications for the ongoing development of cultural safety education and nursing practice. Theorising cultural safety within a Bourdieusian framework of practical action, with a focus on *habitus*, offers nursing a structure to assist in reconciling differences between the health care structures within which the nurse works and her/his subjective experience of that structure. Fields, or spaces of practice are hierarchal in nature and the dynamics of relationships in any field arise out of the struggles people engage in as they try to occupy different positions in the field. Bourdieu's *habitus* or dispositions acquired through perceptions, thought and action, are developed in response to the conditions a person encounters. The *habitus* is a key determiner of behaviour in any setting and generates and regulates the practices that make up the life of the field.

The *habitus* of cultural safety education shapes what students learn about cultural safety and regulates how this knowledge will be applied in practice. Preparation for transferring cultural safety from an educational to a practice field is not always considered as new graduates prepare for practice in different settings. It is not until they enter practice that they have to learn a new set of dispositions and behaviours which will make working in that field possible.

Knowledge and practices consistent with the fields of practice new graduates are entering need to be compatible with the aims of the practice setting. Cultural safety knowledge, with its focus on power and the behaviour of the care provider, is less likely to conform to some practice settings, bringing the nurse into conflict with what she/he knows about cultural safety. The nurse may be subject to practices which have the potential to silence her/him to enable them to fit in to, and participate, in the relationships and practices structuring the field in which they work. Bourdieu's concept of *doxa* offers nursing a practical understanding of the order of things while narratives in this study have demonstrated how this order is played out in practice. To summarise, *doxa* is a mechanism of learned, unconscious beliefs that inform actions and thought within a particular field. *Doxa* tends to favour the group with the most capital in the social hierarchy and therefore

privileges the dominant values and beliefs of the field. The nurse who understands and works in a culturally safe way may risk resistance from others in the field through actions identified in this thesis as forms of symbolic violence. According to Bourdieu, (Bourdieu & Wacquant, 2005), it is the self interested capacity for the arbitrary or taken for granted nature of the field to either ignore or take as natural, existing practices and ideas and by so doing perpetuates the continuation of such practices. Cultural safety education equips nurses with skills of analysis to critically deconstruct practices which oppress and marginalise people using health care services applying these skills requires a practical understanding of the relationship between agency and social structure.

As has been identified in this thesis, the field and *habitus* within which the nurse works enables the delivery of culturally safe care or silences the nursing voice - which perpetuates nursing's history of silence in the face of unacceptable practices and attitudes encountered on a daily basis. While such silence (which only serves to perpetuate the conditions of power operating in any field) cannot be solved within this thesis, the research has made it clear that conditions which maintain silence cannot continue. Bourdieu's concepts offer a way of addressing the gap between the *habitus* of cultural safety education and the *habitus* of everyday nursing practice. To suggest that when cultural safety is seen as operating within Bourdieusian fields and the conditions of possibility created by those fields is made visible, then the rights or wrongs of transcultural care or cultural competency are no longer tenable or necessary. Attention can then be turned to how nurses can work effectively within fields of practice which draw on cultural safety knowledge to better meet the needs of patient and clients.

The findings in this thesis have extended understanding of cultural safety by looking at how power operates at every level of the health system to create conditions of vulnerability for *both* nurses *and* patients. As a result I have identified that a critical understanding of individual, socio-political and historical influences on health care and health outcomes does not automatically ensure the delivery of care into practice. However, a practical understanding of the operation of fields, *doxa*, *habitus* and different kinds of capital within nursing will increase the potential for nurses to develop or protect conditions required for healing and recovery from illness or changes in health among patients. Such an understanding involves the development of skills in recognising how these concepts work to produce everyday health care practices that enable or constrain the maintenance of identity and the well being of a person using health services. The analysis of power offered in this thesis provides a theoretical understanding relating to how

different forms of hegemony and ideas operate which nurses can utilise when working within contradictory and complex health care environments.

8.4 Contribution of the methodology to research

I undertook this research to provide an analytical explanation of how registered nurses apply cultural safety in everyday nursing practice. Since its inception very little theoretical development had been undertaken in advancing understanding of cultural safety in contemporary health care, especially in nursing practice. After twenty years in the nursing education curriculum, the impact of cultural safety education on everyday practice has been uneven or overlooked.

The methodology used in this thesis emerged from the complex field of investigation and dense data arising from the stories of the participants. Existing linear, thematic approaches to analysis were insufficient for dealing with the complexities that arose from the narrative data. A narrative method provided a way for me to hear stories and identify concepts participants used to structure their descriptions and meanings of cultural safety education and subsequent nursing practice. Extrapolating from the narratives, abductive analysis provided a structure whereby I could apply a particular theoretical lens through which to explain why things were the way they were and how they could be otherwise.

Patton (2002) observes that qualitative research generally is fraught with ambiguities and requires methodological strategies rather than methodological rules. Therefore qualitative research requires a tolerance for ambiguity and the methodological design needs to be flexible. Early in the research I realised that my assumptions going into the research, obtaining stories and analysing them according to a set of specific narrative analyses guidelines, were redundant. My assumptions were based on what I knew at the time. As the analysis deepened, my understanding of narrative shifted because of my engagement with the participant's individual stories. My discovery of the abductive research strategy brought another dimension to the study which eventually led me into making links between the ontological and epistemological elements of the study. Holloway and Freshwater (2007) note that narrative research is perceived as not being '*scientific*' or evidence-based and therefore lacks credibility. I argue that before making this claim there needs to be clarity about deductive, inductive and abductive approaches as each is useful depending on the kind of question that is being asked. An abductive approach was appropriate because I was investigating an area of practice about which little was known.

Another aspect of innovation used in this study was that the researcher had to trust the participants' narrative perspective rather than *make* the story believable by applying methodological rules (see Riessman, 1993 and Labov & Waletzky, 1997 for examples of this approach within narrative research). This thesis gives centrality to the voices of the participants and thus to the trust the participants have in the researcher. Abductive research requires the researcher to commit to being open to challenging herself and her own vulnerabilities regarding intentions, biases and the potential to manipulate the process. While the approach is innovative, it adheres to orthodox research methodology by being conducted within the mainstream academic environment. The findings are open to the scrutiny of the academic community through publication. Auditing procedures and ethical rules for conducting the research were outlined in chapter four.

A methodology incorporating narrative, abductive analysis and a Bourdieusian theoretical analysis avoids a single view approach and demands a wider consideration of factors influencing nursing work. An abductive approach, for example, enables a set of practices to be brought together with ontological and theoretical considerations into a collective whole, to produce a framework of practical action or praxis that makes cultural safety visible in everyday practice.

The methodology developed in this research is complex and therefore appropriate for researching ambiguous issues in nursing education and health care. It puts a marker in the ground by articulating the complex nature of, in this case, cultural safety and nursing practice, thereby demonstrating a shift away from descriptive research to a nursing research approach in which the data determines the shape and content of the analysis and the development of nursing theory. This has implications for future nursing research and scholarship, by taking the development of knowledge beyond what is known to finding different answers about what is known.

8.5 Limitations of the study

Narrative analysis is an appropriate methodology for oral, first person accounts of experience and not so useful for large studies. It requires attention to multiple factors including nuances of meaning and speech, social discourses, what is said and what is not said (Riessman, 1993). In narrative analysis, sample sizes are small and there is a focus on depth of description rather than breadth of description, meaning that the results of this study cannot be generalised to other similar situations. An important element of narrative research is to ensure that the participants'

contributions are valued and included in the analysis. In this research some participants' stories were longer than others and as a result, not all participants had equal voice.

The participants in this study were self-selected and therefore not representative of the general nursing population. It may be assumed that participants volunteered because they felt that they brought to the study a set of ideas, thoughts and feelings that they considered would meet the criteria as well as a willingness to articulate their understandings of cultural safety in nursing practice.

The number of sites accessed for participants was smaller than intended. A greater geographical representation could have brought forth more diverse experiences of cultural safety. However, the absence of geographical spread shifted the focus of the study where it evolved into a settings approach, enabling a different kind of theoretical analysis.

A semi structured questionnaire in hindsight may not have been the most effective method of gaining data and a more open ended conversation may have more in keeping with a narrative methodology. This brings me to a final limitation, my own researcher, practitioner role. I felt I did not adequately resolve tensions between researcher and participant and have come to the conclusion that may not be something to resolve but rather a tension to be mindful of in future research. Although this may have been a limitation, experiencing the tension enabled me to examine the place of reflection in research more thoroughly.

8.6 Issues for further investigation in the development of cultural safety knowledge

What then are the implications and applications of the findings for the ongoing development of cultural safety knowledge in nursing education, nursing practice and the wider health care context? The struggle for cultural safety to gain legitimacy as a framework for analysing and deconstructing the way power works to produce particular kinds of practices in health care continues. The findings in this research have implications at all levels of the health care system and further research possibilities are outlined below.

8.7 Relevance of the findings of this thesis for Māori and nurse educators

It is hoped that the findings in this research will move understandings of cultural safety beyond old controversies associated with ethnicity to an investigation of settings and structures in which culturally safe nursing takes place. A challenge arising from arguments about cultural safety in this thesis is how to maintain a focus on Māori inequalities and access to health care as patients and providers, without continuing to essentialise groups and individuals by targeting social characteristics and identity traits based on colour, age and gender. Reid et al. (2002) address this where they identify common myths associated with health inequalities and structural barriers discussed previously in this thesis. The integration of ideas about settings, fields, power, identity and difference within this thesis adds to the work of Reid et al. (2002) and calls for further evaluation of these ideas in relation to both Māori patients and practitioners. I leave the discursive space open to this possibility.

8.8 Cultural safety in nursing education

This research has identified links between cultural safety education and practice and has established that learning about cultural safety continues to influence the application of the concept in practice. The study has several implications for practice, a key one being the nursing education curriculum. Current curricula are the result of, and mirror the development of, nursing knowledge and health care issues and trends throughout the twentieth century. An abiding, underlying presence guiding the development of nursing knowledge continues to be the biomedical model which enables or constrains culturally safe practice in different settings. In the first decade of the twenty-first century it is time for nursing education to deliver a curriculum in which it professes to believe, that is, person centred care. To do this means taking risks by firstly continuing to believe in the value and potential of nursing knowledge to make a difference in people's lives and to commit to this belief by actively aligning with the recipient of care within complex and power laden fields of health care.

Firstly, a narrative approach would enhance the content of the current curricula and provide undergraduate students with skills to learn how to listen and hear patient stories and make them central to clinical reasoning and problem solving. Holloway and Freshwater (2007) note that "clinical reasoning involves making sense of and deriving meaning from knowledge gathered from encounters with patients and observations combined with theoretical and practical knowledge and these inform the choices made about how to proceed" (p.37). A narrative

approach would bring these elements together and provide skill development in consciously being in a space of attending and noticing. The experience of illness and change is characterised by uncertainty and it is through being heard, valued and believed that a patient or client can alleviate some of the tensions and anxieties accompanying uncertainty. The process of stories being shared and heard, followed by appropriate nursing action, contributes to the development of trust and the maintenance of a personal, social and cultural integrity. These are the conditions for a narratively- informed curriculum. Such a curriculum puts the patient at the apex of care and a narrative approach could reclaim a fundamental nursing tenet that is that nursing is concerned with person-centred care.

Secondly, this thesis has identified a tension between the field of cultural safety education and the field of practice. Bourdieu's concepts provide a practical understanding of agency and structure and these concepts guide an analysis of why things are the way they are and may facilitate the learning of skills which enable nurses to work within complex fields of practice. This ensures the voices of nurses will be heard.

8.9 Interdisciplinary culturally safe practice: Knowing the field

The major finding of this study has been the shift away from cultural safety as focusing on the individual nurse, toward culturally safe care being shaped by the settings within which nursing happens. This means a wider focus of teaching/learning for all health professionals. Further research positioned within specific care settings will build on the findings of this research and identify how cultural safety looks in different settings. Nurses and other health professionals practising in a culturally safe way need to be supported and their practice advanced through ongoing professional development. Health professionals who feel constrained in their ability to practice, or do not understand cultural safety, may be supported in increasing understanding through on-site cultural safety and setting-specific education. A focus on a settings approach links cultural safety with the drive to deliver culturally competent care because cultural safety will bring the experience of the recipient of care into the competency framework and connect with the values operating in that setting.

8.10 Cultural safety and the recipient of care

Ramsden (2002) consistently claimed that the recipient of care determined the outcome of culturally safe care. This study has demonstrated the need for further research into this aspect of

cultural safety as it is not known what the delivery of culturally safe care means to a person receiving care. Nor can it be claimed that the person receiving care has the power, opportunity or access to the information needed to assess care as safe at an institutional, as well as a personal level.

The Nursing Council of New Zealand Guidelines (2005/2009) reflect the socio-political thinking of the time they were developed. This research has identified that it is time to review these guidelines in light of contemporary nursing and health care practice. The challenge is to maintain the original intent of cultural safety and position the concept within a wider frame of reference encompassing all health professionals who come under the governance of the Health Practitioners Competency Assurance Act (2003). It is not enough to say that culturally safe care is determined by the recipient of care. Students need to have a practical and political understanding of what that means and to develop skills in facilitating processes whereby the recipient of care can safely comment on their care. To achieve this requires further research into what culturally safe care means for people using health care services.

It must be noted that these issues for further investigation are tentative and indicate a possible way forward. The thesis has examined what is present in everyday practice in terms of cultural safety and has offered a way forward to what could be. For this to be realised as a direct result of this research is not practicable. Just as changes in care delivery resulting from the introduction of cultural safety have been slow to take effect, so too will change in nursing curricula. Such change requires a willingness to critique one's self and current practices. Whilst small changes at the margins of education and practice will continue to evolve, a major shift in consciousness incorporating a practical understanding of power and social relations in health care will require a critical mass for major change to be effected.

8.11 Reflection on the process

In undertaking this research, I have come to the conclusion that the research process I engaged in mirrored the process of nursing in that both require the trust of the person being asked to provide information and the development of this trust cannot be assumed or taken for granted. Trust is created through the sharing of stories, as this is how we come to know who a person is and what is important to them. In nursing, the patient's stories are *carried* by the nurse and rendered into technical data. Clinical inferences, assessments and judgements are informed and made by the judicious use of theoretical nursing knowledge and applied through processes of negotiation and

participation with the patient or client. For the researcher the process is similar in the hearing, carrying and rendering of story, but with different outcomes. The researcher makes inferences about theories of nursing practice and provides an informed analysis about why things are the way they are and how they potentially could be otherwise.

8.12 Conclusion

In this final chapter I have considered implications and issues arising from this study of 16 registered nurses' narratives of cultural safety education and nursing practice. In choosing a narrative methodology I focused on depth of story rather than breadth. It is important to note criticism of the appropriateness of the term cultural safety which to some degree has had an influence on its acceptance within health care services. In keeping with the Nursing Council of New Zealand and the Health Practitioners Competence Assurance Act (2003), safety is the overarching commitment governing the provision of health care to the New Zealand public. This thesis has identified and confirmed that culture and safety are consistent with other safety requirements for the delivery of health care, and clinical, medical, technical and physical safety informed by appropriate disciplinary knowledge, are enhanced through the delivery of culturally safe care. Cultural safety brings to the attention of health professionals, the need for a conscious and active intent to support, protect and value a person's sense of identity and wellbeing during times of vulnerability, illness, suffering and life changes. This research has demonstrated that while the word culture, within the term cultural safety, shares space with other concepts of culture in health care, it does so, in this thesis, in the context of the wellbeing of a person rather than specific cultural characteristics or ethnicity.

The calling up of culture within the term cultural safety in this thesis has been in relation to the culture of nursing and the culture of the settings in which nursing takes place. Cultural safety embraces caring qualities inherent in the practice of everyday nursing. Both are concerned with connection by the nurse with people in times of illness, stress and change. Both aspire to maintain and sustain health and both hold the relational as a core defining value. Cultural safety and nursing take into account the worldview of the person receiving care and both subscribe to a moral idea of protecting and enhancing human dignity through acts of caring.

Cultural safety adds another dimension to those shared characteristics by foregrounding the role that power, difference and identity have in shaping health care interactions, thus bringing a

political dimension to nursing. Cultural safety, applied as an integral element of everyday practice means that a person using health services may safely draw on and use their culture and life experience to maintain and strengthen their cultural identity during times of change. Identity and culture can be resources for health in times of stress and vulnerability and it is through the development of trust in the nursing relationship that these resources are able to be fully utilised and supported. The degree of control and ability a person has to negotiate their way through the health care system can determine how their health care needs are met. If a person feels unable to express and control their participation within nursing and health care relationships they are more likely to withhold aspects of their being to protect their sense of self and integrity. This in turn may also shape the meaning they draw from their experience. Therefore, trust and the shared development of health care relationships are central to the delivery of safe nursing care and safe health services to ensure that a person's integrity and control is sustained during times of vulnerability.

The narratives presented here have established that applying cultural safety knowledge is not the sole responsibility of the individual nurse; it is also about institutional responsibility and institutional responses to the concept of cultural safety in health care in general. Caring is shaped by the social structures of health care and cannot be viewed independently from the fields in which these structures are embedded. Thus any examination of cultural safety in nursing practice must also provide an examination of the power relationships inherent in discourses and paradigms of health care which affect the delivery of culturally safe nursing. This study extends Ramsden's work on cultural safety and power to look at how nursing practice is influenced by doxa and the forms of capital that operate in different settings. It explores how the resources that are available to nurses within different fields open up or close down possibilities for them to create the conditions to provide culturally safe care. These narratives illustrate how culturally safe care is, or has the potential to set the standard for what constitutes effective and appropriate person-centred nursing and health care.

This thesis has identified that it is time for rethinking cultural safety education and practice in the context of present day nursing. It offers a theoretical direction guiding further development of the concept in light of contemporary health care practice. It makes explicit the link between health care practices which sustain and maintains the identity and social wellbeing of a person as they negotiate the health care system and barriers that may inhibit such practices. To build culturally safe health care settings there needs to be a fuller appreciation of meanings health professionals

attach to the concept as well as more informed understandings of the contexts within which culturally safe care happens.

8.13 Closing comment

This thesis has identified that the relationship between identity and health care is an important, and at times an invisible, shaper of health care. The participants in the study provided stories of culturally safe practice, that enabled me to identify why things are the way they are in the delivery of culturally safe education and practice. In this thesis I argue for a shift away from a reductionist, essentialist framing of cultural safety toward a narrative identity and settings approach, supported by a strong practice based framework for analysing and understanding fields of practice. Such an understanding has the potential to produce practices which enable rather than constrain, the delivery of culturally safe health care and which better meets the needs of the recipient of care. It extends understandings of cultural safety education and practice in the context of fields, doxa, and relational networks of power by examining the way registered nurses, in practice, negotiate and manage relationships at a personal, professional and institutional level to provide nursing and health care which increases the potential and possibilities for the recipient to experience their care as safe.

Appendices

Appendix 1

Copies of Te Tiriti o Waitangi and The Treaty of Waitangi

Appendix 2

Interview Schedule

Appendix 3

Return of transcripts to participants

Appendix 4

Massey University Ethics Committee: Acceptance of proposal

Appendix 5

Letter to Directors of Nursing

Appendix 6

Advertisement for notice boards seeking participants

Appendix 7

Letter to KaiTiaki Nurisng New Zealand seeking participants

Appendix 8

Information sheet for participants

Appendix 9

Consent form for participants

Appendix 10

Whānau/support person information sheet.

Appendix 11

Transcriber confidentiality form

Appendix 12

Letter giving feedback and use of pseudonyms

References

- Abbott, M. (1987). Taha Māori in comprehensive nursing education. *NZ Nursing Journal*, August, 25-27.
- Alcorn, G. (2007). The youth health specialty: Collaboration practice and future development. *NZFP New Zealand*, 34(3), 162-167.
- Allan, K. (1989). *The meaning of culture: Moving the postmodern critique forward*. Westport: Greenwood.
- Anderson, J., Perry, J., Blue, C., Browne, A., Henderson, A., Kausbambbi, B., Reimer-Kirkham, S., Lynam, J., Semeniuk, P., Smye, V. (2003). "Rewriting" cultural safety within the postcolonial feminist project: Toward new epistemologies of healing. *Advances in Nursing Science*, 26(3), 196-214.
- Andrews, M., Boyle, J., & Carr, T. (1995). *Transcultural concepts in nursing care*. Philadelphia: Lippincott.
- Andrist, L., Nicholas, K., Wolf, A. (2006). *A history of nursing ideas*. Ontario: Jones and Bartlett.
- Ansley, B. (1993). Anna and the rednecks. *New Zealand Listener* 14 August.
- Aranda, S. & Brown, R. (2006). Nurses must be clever to care. In S. Nelson and S. Gordon (Eds.), *The complexities of care: Nursing reconsidered*. (122-142). New York: Cornell University Press.
- Aschebrock, E. (1994). *Cultural safety: Who cares? A qualitative research study into awareness, feelings, and attitudes towards cultural safety amongst practising nurses*. Dunedin: Otago Polytechnic.
- Atkinson, D. (1999). TESOL and culture. *TESOL Quarterly*, 33(4), 625-755.
- Awatere, D. (1984). *Māori sovereignty*. Auckland: Broadsheet.

- Benhabib, S. (2002). *The claims of culture: Equality and diversity in the global era*. Woodstock: Princeton University Press.
- Benham, S. (2001). Cultural safety values difference. *Kai Tiaki Nursing New Zealand*, 7(1), 28.
- Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park. Addison -Wesley.
- Benner, P., & Wrubel, J. (1989). *The primacy of caring: Stress and coping in health and illness*. Menlo Park: Addison-Wesley.
- Berman, A., Synder, S., & Jackson, C. (2009). *Skills in clinical nursing*. New Jersey: Pearson-Prentice-Hall
- Bertalanffy, L. (1968). *General systems theory: Foundations, development applications*. New York: G Braziller.
- Betancourt, J., Alexander, R., Green, A., & Emilio Camillo, J. (2002). *Cultural competence in health care: Emerging frameworks and practical approaches*. New York: Commonwealth Fund.
- Bevis, E., & Watson, J. (1989). *Toward a caring curriculum: A new pedagogy for nursing*. New York: National League of Nursing.
- Bevis, E. (1978). *Curriculum building in nursing: A process*. Saint Louis: C.V Mosby.
- Bickley, J. (1988). Priorities for practice: Paper presented at Norman Peryer Forum 25-27 November, 1988. *NERF Studies in Nursing*, 14, 1-8.
- Bishop, A., & Scudder, J. (1997). A phenomenological interpretation of holistic nursing. *Journal of Holistic Nursing*, 15, 103.
- Blaikie, N. (2nd ed.). (2010). *Designing social research*. Cambridge: Polity Press.
- Blaikie, N. (2000). *Designing social research: The logic of anticipation*. Cambridge: Polity Press.

- Blank, A., Henare., M., & Haare, W. (Eds.). (1985). *He Korero Mo Waitangi*, Te runanga o Waitangi: Proceedings of national hui Ngaruawahia 1984. Ngaruawahia: Authors.
- Blumenreich, M. (2004). Avoiding the pitfalls of “conventional” narrative research: Using poststructural theory to guide the creation of narratives of children with HIV. *Qualitative Research*, 4(1), 77-90.
- Boler, M., & Zembylas, M. (2003). Discomforting truths: The emotional terrain of understanding difference, In P. Trifonas (Eds.) *Pedagogies of difference: Rethinking education for social change* (pp110-136). New York: Routledge Falmer.
- Boler, M. (1999). Posing feminist queries to Friere. In P. Roberts (Ed.). *Paulo Friere: Politics and pedagogy* (pp.61-69). Palmerston North: Dunmore Press.
- Boulton, A. (2005). *Provision at the interface: The Māori mental health contracting experience*. Unpublished doctoral thesis, Massey University, Palmerston North, New Zealand
- Bourdieu, P. (2000). *Pascalian meditations*. (Richard Nice. Trans). Stanford: Stanford University Press
- Bourdieu, P. (1998). *Practical reason*. Stanford: Stanford University Press.
- Bourdieu, P. (1990a). *In other words: Essays toward a reflexive sociology*. Cambridge: Polity Press.
- Bourdieu, P. (1990b). *The logic of practice*. Stanford: Stanford University Press.
- Bourdieu, P. (1984a). *Homo academicus*. Cambridge: Polity Press.
- Bourdieu, P. (1984b). *Distinction: A social critique of the judgement of taste*. (Richard Nice. Trans). Cambridge, Massachusetts: Harvard University Press.
- Bourdieu, P. (1972). *Outline of a theory of practice*. Cambridge: Cambridge University Press.

- Bourdieu, P., & Wacquant, L. (2005). *An invitation to reflexive sociology*. Cambridge: Polity Press.
- Brett, C. (1993). Putting Penn to paper. *North and South September*, 68-77.
- Browne, A., & Smye, V. (2002). A post-colonial analysis of health care discourses addressing aboriginal women. *Nurse Researcher*, 9(3), 28-41.
- Brown, A., & Varcoe, C. (2006). Critical cultural perspectives and health care involving Aboriginal people. *Contemporary Nurse*, 22(2), 155-167
- Bruner, J. (1990). *Acts of meaning*. Cambridge: Harvard University Press.
- Bruni, N. (1997). The nurse educator as teacher: Exploring the construction of the reluctant instructor. *Nursing Inquiry*, 4, 34-40.
- Bruni, N. (1995). Exploring nurse education: The case for post structural inquiry. *Nursing Inquiry*, 2, 131-132.
- Bunker, W. (2001). Integrating cultural safety into practice. *Kai Tiaki New Zealand*, 7(1), 18.
- Butler, J. (1992). Contingent foundations: Feminism and the question of 'Postmodernism' In J. Butler & J. Scott (Eds.) *Feminists theorize the political* (pp. 3-21). New York: Routledge.
- Butler, J. (1987). *Subjects of desire: Hegelian reflections in the twentieth century France*. New York: Columbia Press.
- Campesino, M. (2008). Beyond transculturalism: Critiques of cultural education in nursing. *Journal of Nursing Education*, 47(7), 298-304.
- Campinha-Bacote, J. (2006). Cultural competence in nursing curricula: How are we doing 20 years later? *Journal of Nursing Education*, 45(7), 243-244.
- Chapman, A. (1993). The cultural question. *Nursing New Zealand*, August, p.31.

- Carpenter, H. (1971). *An improved system of nursing education for New Zealand Report*. Wellington: Department of Health.
- Carryer, J. (1995a). Why is it thought necessary for all nurses to be 'culturally safe.' *The Christchurch Press*, June 26, p.11.
- Carryer, J. (1995b). Letter to the Editor, *New Zealand Listener*, August 12, 12-13.
- Chicago, J. (1997). *Beyond the flower: The autobiography of a feminist artist*. New York: Penguin Books.
- Chick, N., & Kinross, N. (2006). *Chalk & cheese: Trail blazing in Aotearoa New Zealand nursing*. Palmerston North: Authors.
- Chick, N., & Rodgers, J. (Eds.). (1997). *Looking back, moving forward: Essays in the history of Aotearoa New Zealand nursing and midwifery*. Palmerston North: Massey University Department of Nursing and Midwifery.
- Chodrow, N. (1989). *Feminism and psychoanalytic theory*. New Haven: Yale University Press.
- Christchurch Polytechnic. (1993). *Report of the Christchurch Polytechnic Council on the events and procedures which gave rise to media reports of a letter from a former nursing student*. Author.
- Christensen, J. (1990). *Nursing partnership: A model for nursing practice*. Wellington: Daphne Brassell Associates Press.
- Christensen, B., & Kockrow, E. (6th Ed). (2006). (Eds.). *Adult health nursing*. Philadelphia: Elsevier.
- Clanindin, J., & Connelly., M. (2000). *Narrative inquiry: Experience and story in qualitative research*. San Francisco: Jossey-Bass.
- Clear, G., & Carryer, J. (2001). Shadow dancing in the wings: Lesbian women talk about health care. *Nursing Praxis in New Zealand*, 17(3), 27-39.

- Clear, G. (2000). *Shadow dancing in the wings: Lesbian women talk about health care*. Unpublished masters thesis, Massey University, Palmerston North, New Zealand.
- Cody, W. (2006) (Ed.) *Philosophical and theoretical perspectives for advanced nursing practice*. Boston: Jones and Bartlett.
- Cohen, D., & Crabtree, B. (2008). Evaluative criteria for qualitative research in health care: Controversies and recommendations, *Annals of Family Medicine*, 6(4), 331-339.
- Cooney, C. (1994). A comparative analysis of transcultural nursing and cultural safety. *Nursing Praxis in New Zealand*, 9(1), 6-12.
- Council for International development resource kit. Retrieved from <http://www.cid.org.nz/training/Treaty-of-waitangi.pdf>
- Christensen, B., & Kockrow, E. (Eds.). (2005). *Adult health nursing*. St Louis: Elsevier Mosby.
- Crisp, J. & Taylor, C. (2005). (Eds.). *Potter and Perry's fundamentals of nursing*. Sydney: Mosby.
- Cortazzi, M. (2001). Narrative analysis in ethnography. In P. Atkinson, A. Coffey, S. Delamont, L. Lofland, & J. Lofland. *Handbook of Ethnography*, (pp. 384-394). London: Sage.
- Coup, A. (1996). Cultural safety and culturally congruent care: A comparative analysis of Irihapeti Ramsden's and Madeleine Leininger's educational projects for practice. *Nursing Praxis in New Zealand*, 11(1), 4-11.
- Crotty, M. (2004). *Foundations of social research: Meaning and perspective in the research process*. London: Sage.
- Culler, J. (1976). *Saussure*. Hassock: Harvester.
- Culley, L. (2006). Transcending transcultural care: Race, ethnicity and health care. *Nursing Inquiry*, 13(2), 144-153.

- Cummings, G., Estabrooks, C., Midodzi, N., Wallin, L., & Hayduk, L. (2007). Influence of organisational characteristics and context on research utilisation. *Nursing Research*, 56, 524-539.
- Daly, H. (2006). Population, migration, and globalisation. *Ecological Economics*, 59(2), 187-190.
- Daly, J., Speedy, S., & Jackson, D. (2006). *Contexts of nursing*. Sydney: Churchill Livingstone Elsevier.
- Daly, M. (1978). *Gyn/Ecology*. London: The Women's Press.
- Davis, A. (1981). *Women, race and class*. New York: Random House.
- Davies, B., & Harré, R. (1990). Positioning the discursive production of 'selves'. *Journal of the Theory of Social Behaviour*, 20(1), 44-63.
- De Lauane, S., & Ladner, K. (Eds.). (2006). *Fundamentals of nursing: Standards and practices*. Clifton Park: Thomas Delmar
- Denzin, N., & Lincoln, Y. (Eds.). (2005). *Qualitative research* (3rd ed.). Thousand Oaks: Sage.
- Department of Social Welfare. (1986). *Appendix to Puao-te-ata-tu: The report of the Ministerial Advisory Committee on a Māori perspective for the Department of Social Welfare*. Wellington: Author.
- De Souza, R. (2008). Wellness for all: The possibilities of cultural safety and cultural competence, *Journal of Research in Nursing*, 13, 125-135.
- Dew, K., & Davis, P. (2004). *Health and society in Aotearoa New Zealand* (2nd ed.). Auckland: Oxford University Press.
- Dew, K., & Kirkman, A. (2002). *Sociology of health in New Zealand*. Melbourne: Oxford University Press.

- Derrida, J. (1976). *Of grammatology* (1st American ed.). Trans G. Spivak. Baltimore: John Hopkins University Press.
- Diers, D. (2004). *Speaking of nursing: Narratives of practice, research, policy and the profession*. Sudbury, MA: Jones and Bartlett.
- Dolhenty, J. (2003). The myth of moral relativism. Retrieved from <http://www.radicalacademy.com/ethicsmyth.htm>.
- Dooris, M. (2006). Healthy settings: Challenges to generating evidence of effectiveness. *Health Promotion International*, 21(1), 55-65.
- Dreher, M., & MacNaughton, N. (2002). Cultural competence in nursing: Foundation or fallacy. *Nursing Outlook*, 50(5), 181-186
- du Chateau, S. (1992). Culture shock. *Metro*. June, 96-106.
- Dukes, J., Conner, M., & McEldowney, R. (2009). Becoming a culturally competent health practitioner in the delivery of culturally safe care: A process oriented approach. *Journal of Cultural Diversity*, 16(2), 40-46.
- Durie, M. (2001). *Māori ora: The dynamics of Māori health*. Auckland: Oxford University Press.
- Durie, M. (1997). *Puahō: A five point plan for improving Māori health*. Māori Mental Health Summit.
- Durie, M. (1994). *Whaiora: Māori health development*. Auckland: Oxford University Press.
- Durie, M. (1992). *Māori development: Māori health and the health reforms*. Palmerston North: Massey University.
- Easton, B. (1997). *The commercialisation of Aotearoa New Zealand*. Auckland: Auckland University Press.

- Elliott, J. (2006). *Using narrative in social research*. London: Sage.
- Ellison-Loschmann, L. (2001). Giving a voice to health consumers. *Kai Tiaki Nursing New Zealand, February*, 12-13.
- Fawcett, J. (2003). A conversation with Marilyn E. Parker. *Nursing Science Quarterly*, 16, 133-136-318.
- Feller, E. (2006). Asylum, migration and refugee protection: Realities, myths and the promise of things to come. *International Journal of Refugee Law*, 18(3-4), 509-536.
- Firestone, S. (1971). *The dialectic of sex: The case for feminist revolution*. London: Cape.
- Fitzpatrick, A. (1997). *Nurse meeting another: Cultural safety in nursing practice*. Unpublished masters thesis,. Victoria University of Wellington, Wellington, New Zealand.
- Fletcher, K. (2006). Beyond dualism: Leading out of oppression. *Nursing Forum*, 41(2), 50-59.
- Foucault, M. (1980). *Power knowledge: Selected interviews and other writings by Michal Foucault*. Trans E. Gordon. New York: Pantheon Books.
- Francis, K., Chapman., Y., Hoare, K., & Mills, J. (Eds.). (2007). *Community as partner: Theory and practice in nursing*. Sydney: Lippincott Williams and Wilkens.
- Frank, A. (2006). Interpretive phenomenology: Clinical ethics and research. *Health*, 10(1), 113-116.
- Frank, A. (2005). *The renewal of generosity: Illness, medicine and how to live*. Chicago: The University of Chicago Press.
- Frank, A. (2002). The dialogical ethics of narrative analysis. *International Journal of Qualitative methods*, 1(1), 109-117
- Frank, A. (1995). *The wounded storyteller: Body, illness, and ethics*. Chicago: The University of Chicago Press.

- Freedman, J., & Coombs, G. (1996). *Narrative therapy: The social construction of preferred stories*. New York: WW Norton.
- Frewin, T. (1993). Media mythology builds on original myth. *National Business Review*, August 13, 35.
- Friere, P. (1972). *Pedagogy of the oppressed*. Trans M. Bergman Ramos Hammondsworth: Penguin.
- Fulcher, L. (2002). Cultural safety and the duty of care. *Child Welfare*, 81(5), 689-708.
- Gadow, S. (1996). Ethical narratives in practice. *Nursing Science Quarterly*, 9(8), 8-9.
- Gadow, S. (1995). Clinical epistemology: A dialectic of nursing assessment, *Canadian Journal of Nursing Research*, 27(2), 25-34.
- Gerrish, K., & Papadopoulos, I. (1999). Transcultural competence: The challenge for nurse education. *British Journal of Nursing*, 8(21), 1453-1457.
- Gibbs, K. (2005). Teaching student nurses to be culturally safe: Can it be done? *Journal of Transcultural Nursing*, 16(4), 356-60.
- Giddings, L. (2005). A theoretical model of social consciousness. *Advances in Nursing Science* 28(3), 224-239.
- Gilson, L. (2003). 'Trust and development of health care as a social institution', *Social Science and Medicine*, 56, 1453-1468.
- Giroux, H. A. (1983). *Theory and resistance in education: A pedagogy for the opposition*. London: Heinemann Educational.
- Glaser, B. (1998). *Doing grounded theory: Issues and discussions*. Mill Valley: Sociology Press.
- Gray, P., & Thomas, D. (2006). Critical reflections on culture in nursing. *Journal of Cultural Diversity*, 13(2). 76-82.

- Greenwood, S., Wright, T., & Nielson, H. (2006). Conversations in context: Cultural safety and reflexivity in child and family nursing. *Journal of Family Nursing*, 12(2), 201-224.
- Gordon, S. (2005). *Nursing against the odds*. New York: Cornell University Press.
- Guba, E. & Lincoln, Y. (1989). (Eds.). *Fourth generation evaluation*. Beverly Hills CA: Sage.
- Gully, E. (2005). Creating a sacred space: A journey to the soul. In C. Johns and D. Freshwater (Eds.). *Transforming nursing practice* (2nd ed.) (pp. 142-161). Oxford: Blackwell.
- Gustafson, D. (2005). Transcultural nursing theory from a critical perspective. *Advances in Nursing Science*, 28(1), 2-116.
- Habermas, J. (1968). *Knowledge and human interest*. Trans J. Shapiro. Boston: Beacon Press.
- Hall, J. (2004). Marginalisation revisited: Critical, postmodern, and liberation perspectives. *Advances in Nursing Science*, 22(1), 88-102.
- Hanisch, C. (1969). The personal is political. In S. Firestone & A. Koedt (Eds.). *Notes from the Second Year: Women's Liberation* (pp. 86-89). New York: Redstockings.
- Harker, R. (1990). Schooling and cultural reproduction. In J. Codd, R. Harker & R. Nash (Eds.). *Political issues in New Zealand education 2nd ed*. Palmerston North: Dunmore Press.
- Harré., R., & van Langenhove, L. (1999) The dynamics of social episodes. In R. Harré & L. van Langenhove (Eds.), *Positioning theory* (pp.1-13). Oxford: Blackwell.
- Harrington, A. (2001). *Hermeneutic dialogue and social science: A critique of Gadmer and Habermas*. New York: Routledge
- Harris, R., Tobias, M., Jeffrey, M., Waldegrave, K., Karlsen, S., & Nazroo, J. (2006). Effects of self-reported racial discrimination and deprivation on Māori health and inequalities in Aotearoa New Zealand: A cross sectional study. *The Lancet*, 367, 2006-2008.

- Harwood, M., & Tipene-Leach, D. (2007). Diabetes. In R. Robson and R. Harris (Eds.). *Hauora Māori Standards of Health IV: A study of the years 2000-2005* (pp.161-167). Wellington: Te Rōpū Rongohau Hauora a Eru Pōmare.
- Hatrack-Doane, G., & Varcoe, J. (2005). *Family nursing as relational inquiry*. Philadelphia: Lippincott Williams & Wilkins.
- Health Practitioners Competence Assurance Act (2003). Retrieved from Knowledge Basket database.
- Heidigger, M. (1962). *Being and time*. Trans J. Macquarrie and E. Robinson. Oxford: Blackwell.
- Held, D., McGrew, A., Goldblatt, D., & Perraton, J. (1999). *Global transformations: Politics, economics and culture*. Stanford: Stanford University Press.
- Henare, M. (1990). *The Treaty of Waitangi and its significance for social and health policy development*. Catholic Commission for Justice, Peace and Development-Aotearoa New Zealand. Wellington: Catholic Commission for Justice Peace and Development.
- Henderson, V. (1966). *The nature of nursing and its implications for practice*. New York: Macmillan.
- Herzog, C., & Margaret, J. (2000). Te Tiriti in Tertiary Education Courses. In Treaty Conference 2000 Publication Group (Eds.). *Proceedings of Treaty Conference 2000* (pp.79-85). Auckland.
- Hill, P. (Ed.). (1991). *Cultural safety hui: Whanau Kawa Whakaruruhau*. Wellington: PSI Solutions.
- Hoagland, S. (1999). *Lesbian ethics: Toward new value*. Palo Alto: Institute of Lesbian Studies.
- Holloway, W., & Jefferson, T. (2007). *Doing qualitative research differently: Free association, narrative, and the interview method*. London: Sage.
- Holloway, I., & Freshwater, D. (2007). *Narrative research in nursing*. Oxford: Blackwell.

- Hooks, B. (1981). *Ain't I a woman: Black women and feminism*. Boston: South End Press.
- Horton, E. (1998). Cultural safety in Aotearoa New Zealand nursing education: A critique. Unpublished masters thesis, Waikato University, Hamilton, New Zealand.
- Horton, E., & Fitzsimmons, P. (1996). The cultural safety debate and the conservative restoration in Aotearoa/ New Zealand. *Journal of Educational Studies*, 31(2), 171-186.
- Hughes, M., & Farrow, T. (2006). Preparing for cultural safety assessment, *Kai Tiaki New Zealand*, 12(1), 12-14.
- Huygens, I. (2007). Processes of Pākehā change in response to the Treaty of Waitangi. Unpublished doctoral thesis, Waikato University, Hamilton, New Zealand.
- Huxley, E. (1975). *Florence Nightingale*. London: Weidenfeld and Nicolson.
- Indiana, G. (2010). *Andy Warhol: The can that sold the world*. New York: Basic Books.
- Jackson, D., & Borbasi, S. (2007). In J. Daly, S. Speedy & D.Jackson (Eds.). *Contexts of nursing* (pp.73-85). Marrickville: Elsevier.
- Jacobs, J., Holmes, D., & Buus, N. (2008). Humanism in forensic psychiatry. *Nursing Inquiry*, 15(3), 224-230.
- Jeffs, L. (2001). Teaching cultural safety the culturally safe way. *Nursing Praxis in Aotearoa New Zealand*, 17(3),41-50
- Jirwe, M., Gerrish., K., Keeney, S., & Emani, A. (2009). Identifying the core components of cultural competence: Findings from a Delphi study. *Journal of Clinical Nursing*, 18(18), 2622-2643.
- Jones, C. (2001). Cultivating cultural harmony. *Kai Tiaki Nursing New Zealand*, 17(1), 10-11.

- Johnson, J. (2000). A dialectical examination of nursing art. In W. Cody (Ed). *A Philosophical and theoretical perspectives for advanced nursing practice* (pp. 131-142). Boston: Jones and Bartlett.
- Johnson, M. (2004, June 21). Abuse complaints should be believed. *New Zealand Herald*.
- Johnson, M., & Kanitsaki, O. (2007). An exploration of the notion and nature of the construct of cultural safety and its applicability to the Australian health care context. *Journal of Transcultural Nursing*, 18, 247-256.
- Jungersen, K. (2002). Cultural safety: Kawahakarurhau: An occupational therapy perspective. *Aotearoa New Zealand Journal of Occupational Therapy*, 49(1), 4-9.
- Kearns, R. (1997). A place for cultural safety beyond nursing education. *The New Zealand Medical Journal*, 110(1037), 23-24.
- Kearns, R., & Dyck, I. (1996). Cultural safety, biculturalism and nursing education in Aotearoa/ New Zealand. *Health and Social Science Care in the Community*, 4(6), 371-374.
- Kelsey, J. (1990). *A question of honour: Labour and the Treaty 1984-1989*. Wellington: Allen & Unwin.
- Kenny, M. (2004). *The politics of identity*. Cambridge: Polity Press.
- Kenway, J., & McLeod, J. (2004). Bourdieu's reflexive sociology and 'spaces of points of view': Whose reflexivity, which perspective? *British Journal of Sociology of Education*, 24(4), 525-544.
- Kickbusch, I. (1996). Health promotion: A global perspective. *Health promotion an Anthology*, 9, 14-22.
- Kikuchi, J. (2005). Cultural theories of nursing responsiveness to human needs and values. *Journal of Nursing Scholarship*, 37(4), 302-307.

- Kincheloe, J. & McLaren, P. (2007). *Critical pedagogy: Where are we now*. New York: Peter Lang.
- Kincheloe, J. (1993). *Toward a critical politics of teacher thinking: Mapping the postmodern*. Connecticut: Bergin and Garvey.
- Kirkham., S., & Anderson., J. (2002). Postcolonial nursing scholarship: from epistemology to method. *Advances in Nursing Science*, 25(1), 1-17.
- Kuhse, H. (1997). *Caring: Nurses, women and ethics*. Oxford: Blackwell.
- Kupa, K. (2009). Te vaka ata faga: A Tokelau assessment model for supporting holistic mental health with Tokelau people in Aotearoa New Zealand. *Pacifica Health Dialog*, 15, 156-163.
- Labov, W., & Waletzky, J. (1997). Narrative analysis. *Journal of Narrative and Life History*, 7, 3-38.
- Lakes District Health Board. (2008). *Tikanga best practice guidelines*. Rotorua: Author.
- Laracy, K. (2003). *Exploration of the self: The journey of one Pākehā cultural safety nurse educator*. Unpublished Masters thesis. Victoria University of Wellington. Wellington: New Zealand
- Larsen, K. (2003). Emergence if Nordic nursing research: No position is an island. *Scandinavian Journal of Caring Sciences*, 23, 757-766.
- Lashley, M. (2000). Implementing treaty settlements via indigenous institutions: Social justice and detribalization in Aotearoa New Zealand. *The Contemporary Pacific*, 12(1), 1-55.
- Lawler, S. (2008). *Identity: Sociological perspectives*. Cambridge: Polity Press.
- Le Guin. U. (1989). *Dancing at the edge of the world: Thoughts on words, women and places*. London: Gollanz.

- Leininger, M. (1996). Culture care theory, research and practice. *Nursing Science Quarterly*, 9(2), 71-78.
- Leininger, M. (1995). *Transcultural nursing: Concepts, theories, research & practices*. New York: Wiley.
- Leininger, M. (Ed.). (1991). *Culture care diversity and universality: A theory of nursing*. New York: National League for Nursing Press.
- Leininger, M. (1978). *Transcultural nursing: Concepts, theories & practices*. New York: Wiley.
- Leonard, B., & Plotnikoff, G. (2000). Awareness: The heart of cultural competence. *AACN Clinical Issues*, 11, 51-59.
- Levine, H. (2005). Moving beyond cultural essentialism. In J. Liu, T. Mc Creanor, T. McIntosh & T. Teaiwa (Eds.) *Aotearoa New Zealand Identities* (pp.104-117). Wellington: Victoria University Press.
- Liaschenko, J. & Peter, E. (2004). Nursing ethics and conceptualisations of nursing: Profession, practice and work. *Journal of Advanced Nursing*, 46(50), 488-495.
- Lipson, J., & Desantis, L. (2007). Current approaches to integrating elements of cultural competence in nursing education. *Journal of Transcultural Nursing*, (1suppl), 16-20.
- Lorde, A. (1984). *Sister outsider: Essays and speeches*. Trumansberg: Crossing Press.
- Lupton, D. (2003). *Medicine as culture*. London: Sage.
- Lyotard, J. (1979). *The postmodern condition: A report on knowledge*. Manchester: Manchester University Press.
- Mauthner, N., & Doucet, A. (2008). What can be known and how: Narrated subjects and the listening guide. *Qualitative Research (special issue on narrative methodology)*, 8(3), 399-409.

- McCance, T., McKenna, H. & Boore, J. (2001). Exploring caring using narrative methodology: An analysis of the approach. *Journal of Advanced Nursing*, 39, 96-102.
- McEldowney, R., Richardson, F., Turia, D., Scott, W., Laracy, K., & McDonald, S. (2007). *Opening our eyes-shifting our thinking: the process of teaching and learning about reflection in cultural safety education and practice*. Wellington: Victoria University of Wellington.
- McEldowney, R. (2002). *Shape-shifting: Stories of teaching for social change*. Unpublished doctoral thesis, Victoria University of Wellington, Wellington, New Zealand.
- McEvoy, S. (2000). Caring for lesbian women. *Kai Tiaki Nursing New Zealand*, March, 24-25.
- McHoul, A., & Grace, W. (1997). *A Foucault primer: Discourse, power and the subject*. New York: New York University Press.
- McIsaac, C. (2000). Identifying institutional racism: Researching a tertiary institutions commitment to the Treaty of Waitangi charter provisions. In Treaty Conference 2000 Publication Group. (Eds.). *Treaty Conference 2000* (pp. 109-115). Tamaki Makaurau: Treaty Conference 2000 Publication Group
- McKinney C. (2005). Linking cultural safety to practice: Issues for student nurses and their teachers. *Vision*, 13(1), 3.
- MacLeod, M. (1996). *Practising nursing: Becoming experienced*. New York: Churchill Livingstone.
- Manchester, A. (2002). Challenging and changing the culture of nursing. *Kai Tiaki Nursing New Zealand*, 8(1), 20-21.
- Mattingly, S., & Garro, L. (1994). Introduction. *Social Science Medicine*, 38(6), 771-774.
- Merleau-Ponty, M. (1983). *Phenomenology of perception*. Trans C. Smith. London: Routledge.
- Mertens, D. (1998). *Research methods in education and psychology*. London: Sage.

- Metge, J. (2010). *Tuamaka: The challenge of difference in Aotearoa New Zealand*. Auckland: Auckland University Press.
- Mezirow, J. (1977) Perspective transformation. *Studies in Adult Education* 9 (pp. 153-164).
- Mishler, E. (1986). *Research interviewing: context and narrative*. Cambridge: Harvard University Press.
- Mitchell, M.& Egudo, M. (2003). *A review of narrative methodology*. Commonwealth of Australia: Australian Government Department of Defense.
- Moccia, P. (1998). At the faultline: Social activism and caring. *Nursing Outlook*, 36(1), 30-31.
- Mol, A. (2008). *The logic of care: Health and the problem of patient choice*. New York: Routledge.
- Montgomery Dossey, B., & Keegan, L. (5th ed.). (2009). *Holistic nursing: A handbook for practice*. Boston: Jones and Bartlett.
- Morgan, R. (1978). *Going too far: The personal chronicles of a feminist*. New York: Vintage Books.
- Morgan, K., & Bjorkert, S. (2006). 'I'd rather you lay me down on the floor and start kicking me': Understanding symbolic violence in everyday life. *Women's Studies Journal International Forum*, 29, 441-452
- Morse, J. (1999). Qualitative nursing research: A free for all. In J. Morse (ed.) *Qualitative nursing research: A contemporary dialogue* (pp 14-22). Newbury Park: Sage.
- Morse, J., Barrett, M., Mayan, M., Olsen, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods*, 1(2), 1-19.
- Mulholland, J. (1995). Nursing-humanism and transcultural theory: 'The bracketing out' of reality. *Journal of Advanced Nursing*, 15(3), 442-449

- Munro, R. (1993, July 13). *Inquiry into failed hui examination*. The Christchurch Press.
- Munhill, P. (2007). Epistemology in nursing. In P. Munhill (ed). *Nursing research: a qualitative perspective*. (4th ed). 37-64
- Murchie, E. (1984). *Rapuora: Health and Māori women*. Wellington: Māori Womens' Welfare League.
- Murchie, E., & Spoonley, P. (1995). *Report to the Nursing Council of Aotearoa New Zealand on cultural safety and nursing education in Aotearoa New Zealand*. Wellington: Nursing Council of New Zealand.
- Nairn, M. (2000). *The future of the Treaty of Waitangi*. In Treaty Conference 2000 Publication Group (Eds.). *Proceedings of Treaty Conference 2000* (pp 9-13). Auckland.
- Nairn, S. (2009). Social structure and nursing research. *Nursing Philosophy*, 10(3), 191-202.
- National Health Committee. (1999). *Review of Maternity Services in New Zealand*. Wellington: (Author).
- National Council of Māori Nurses/Kaunihera o nga neehi Māori. (1987). *Report on the Gisborne hui on Māori and nursing education*. Gisborne: Author.
- National Health Committee. (1998). *The social, cultural and economic determinants of health in New Zealand: Action to improve health*. Wellington: The National Advisory Committee on Health and Disability.
- Nelson, S. (2006). Ethical expertise and the problem of the good nurse. In S. Nelson and S. Gordon (Eds.), *The complexities of care: Nursing reconsidered* (pp. 69-80). Ithaca, New York: Cornell University Press.
- Nelson, K., Conner, M., & Alcorn, G. (2009). Innovative nursing leadership in youth health. *Nursing Praxis in New Zealand*, 25(1), 27-37.
- Newman, M. (1986). *Health as expanding consciousness*. St Louis: C.V. Mosby.

- Network Waitangi. (2008) *Treaty of Waitangi: Questions and Answers*. Otautahi, (Christchurch): Network Ōtautahi.
- Ngata, P. & Pōmare, E. (1992). Cultural factors in medicine taking. *New Ethicals*, June, 43–50.
- Nightingale, F. (1860). *Notes on nursing: What it is and what it is not*. New York: Appelton.
Retrieved from <http://digital.library.upenn.edu/women/nightingale/nursing/nursing.html>
- Noddings, N. (2003). *Caring: A feminine approach to ethics and moral education*. London: University of California Press.
- Nursing Council of New Zealand. (2009). *Guidelines for cultural safety, the Treaty of Waitangi, Māori health in nursing education*. Wellington: Author.
- Nursing Council of New Zealand. (1996). *Guidelines for cultural safety in nursing and midwifery education*. Wellington. Author.
- Nursing Council of New Zealand. (1992). *Kawa Whakaruruhau: Guidelines for Guidelines for nursing and midwifery education*. Wellington: Author.
- O'Brien, R., Hart, K., & Hunt, G. (2007). Standing out from the herd: Renegotiating masculinity in relation to men's experience of illness. *International Journal of Men's Health*, 6(3), 178-200.
- O'Conner, T. (1993). Parallel nursing programme begins. *Nursing New Zealand*, August, 24.
- Papps, E. (2005). Cultural safety: What is the question? In E.Papps (Ed.). *Nursing in Aotearoa New Zealand: Critical Issues, Different Perspectives*. Auckland, Pearson.
- Papps, E., & Ramsden, I. (1996). Cultural safety in nursing: The New Zealand experience. *International Journal for Quality in Care*, 8(5), 491-497.
- Patterson, B., Osbourne, M., & Gregory, D. (2004). How different can you be and still survive: Homogeneity and difference in clinical nurse education. *International Journal of Nursing Education Scholarship*, 1, 1-13.

Patton, M. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks: Sage.

Peplau, H. (1952). *Interpersonal relations in nursing*. New York: G. P. Putnam & Sons.

Pere, L. (1997). *A study of kawa whakaruruhau/cultural safety and its effect on the nursing practice of recently graduated registered comprehensive nurses*. Unpublished masters thesis, Victoria University of Wellington, Wellington, New Zealand.

Perron, A. & Holmes, D. (2006). Advanced Practice: A Clinical or Political Issue? *Canadian Nurse*, 102(7), 26-28, 35.

Perron, A., Fluet, C., & Holmes, D. (2005). Agents of care and agents of the state: Bio power and nursing practice. *Journal of Advanced Nursing*, 50(5), 536-544

Phibbs, S. (2008). Four dimensions of narrativity: Towards a narrative analysis gender identity that is simultaneously personal, local and global. *Aotearoa New Zealand Sociology*, Spring Edition.

Phibbs, S. (2007). Four dimensions of narrativity: Towards a narrative analysis that is simultaneously personal, local and global. Paper presented at the *TASA & SAANZ Joint Conference, 2007. Public Sociologies: Lessons and Trans-Tasman Comparisons*. Auckland, New Zealand, December, 3-7.

Plummer, K. (2001 2). *Documents of life: An introduction to a critical humanism*. London: Sage.

Poata-Smith, E. (2001). *The political economy of Māori protest politics, 1968-1995: A Marxist analysis of the roots of Māori oppression and the politics of resistance*. Doctor of Philosophy, University of Otago, Dunedin.

Poland, Green & Rootman (2000).(Eds.) *Settings for health promotion: Linking theory and practice*. Thousand Oaks: Sage Publications.

Polletta, F. (2006). *It was like a fever: Storytelling in protest and politics*. Chicago: University of Chicago Press.

- Puloto Endomen, K. (2001). *Fonfale model*. Retrieved from <http://www.hpforum.org.nz/resources/Fonofalemodelexplanation.pdf>
- Polaschek, N. (1998). Cultural safety: A new concept in nursing people from different ethnicities. *Journal of Advanced Nursing*, 27, 452-457.
- Polkinghorne, D. (1988). *Narrative knowing and the human sciences*. Albany: State University of New York.
- Pōmare, E., & De Boer, G. (1988). *Hauora: Māori standards of health 1970-1984*. Wellington: Ministry of Health.
- Pōmare, E., Keefe-Ormsby, V., Ormsby, C., Pearce, N., Reid, P., Robson, B., & Watene-Haydon, N. (1995). *Hauora. Māori standards of health III. A study of the years 1970-1991*. Wellington: Eru Pōmare Māori Health Research Centre.
- Raille-Alligood, M., & Marriner-Tomey, A. (2010). *Nurse theorists and their work*. Missouri: Mosby Elsevier.
- Ramsden, I. (2005). Towards cultural safety. In D. Wepa (Ed.), *Cultural safety in Aotearoa New Zealand* (pp. 2-19). Auckland: Pearson Education.
- Ramsden, I. (2002). *Cultural safety and nursing education in Aotearoa and Te Waipounamu*. Unpublished doctoral thesis, Victoria University of Wellington, Wellington, New Zealand.
- Ramsden, I. (2001). Improving practice through research. *Kai Tiaki Nursing New Zealand*, 7(1), 23-28.
- Ramsden, I. (2000). Cultural safety/ Kawa whakaruruhau ten years on: A personal overview. *Nursing Praxis in New Zealand*, 15(1), 4-12.
- Ramsden, I. (1996). The Treaty of Waitangi and cultural safety: The role of the Treaty in nursing and midwifery education in Aotearoa. In *Guidelines for cultural safety in nursing and midwifery education* (pp.21-35). Wellington: Nursing Council of New Zealand.

- Ramsden, I. (1995a). *Nurses and Midwives Bill: Comments on the draft Nurses and Midwives Bill*. Unpublished manuscript.
- Ramsden, I. (1995b). Own the past and create the future. In K. Irwin., & I. Ramsden (Eds.), *Toi Wahine: The worlds of Māori women* (pp. 109-115). Auckland: Penguin Books.
- Ramsden, I. (1994). *The outcomes of colonisation for Māori people and Māori health status*: Paper presented at Hui Whakapumau. Māori Development Conference, Massey University, Palmerston North.
- Ramsden, I. (1993a). *Korero whakaruruhau: Phase one of a qualitative research project into culturally acceptable standards of health service delivery to Māori*. Wellington: Author.
- Ramsden, I. (1993b). *Kawa whakaruruhau: Cultural safety in nursing education in Aotearoa (New Zealand)*. Paper presented at the 2nd National Transcultural Nursing Conference, Cumberland College of Health Sciences, Sydney, Australia.
- Ramsden, I. (1993c). Nursing safety. *New Zealand Listener*, p. 7.
- Ramsden, I. (1992). Teaching cultural safety. *New Zealand Nursing Journal*, 85(5), 21-23.
- Ramsden, I. (1990a). *Kawa whakaruruhau: Cultural safety in nursing education in Aotearoa*. Wellington: Ministry of Education.
- Ramsden, I. (1990b). In anticipation of better days. *New Zealand Nursing Journal*, 83(1), 16-18.
- Ramsden, I. (1990c). Moving to better health. *New Zealand Nursing Journal*, 83 (2), 15-17.
- Ramsden, I. (1990d). Cultural safety. *New Zealand Nursing Journal*, 83(11), 18-
- Ramsden, I., & Spoonley, P. (1994). The cultural safety debate in nursing education in Aotearoa. *New Zealand Annual Review of Education 1993*, 161-174.

- Rashotte, J. (2005). Dwelling with stories that haunt us: Building a meaningful nursing practice. *Nursing Inquiry*, 12(1), 34-42.
- Reay, D. (2004). 'It's all becoming a habitus': Beyond the habitual use of Pierre Bourdieu's concept of habitus in educational research *Special Issue of British Journal of Sociology of Education on Pierre Bourdieu*, 25(4), 431-444.
- Reed, P. (2006). Nursing: The ontology of the discipline. In W. Cody (Ed). *Philosophical and Theoretical Perspectives for Advanced Nursing Practice* (pp. 123-133). Boston: James Bartlett.
- Reid, P., & Robson, R. (2007). The state of Māori health. In M. Mullholland (Ed), *Twenty first century issues in Aotearoa* (pp.17-31). Auckland: Reed.
- Reid, P., Robson, B., & Jones, C. (2000). Disparities in health: Common myths and uncommon truths. *Pacific Health Dialog*, 7(1), 38-47.
- Rhynas, S. (2005). Bourdieu's theory of practice and its potential in nursing research. *Journal of Advanced Nursing*, 50(2), 179-186.
- Rice, P., & Ezzy, D. (2004). *Qualitative research methods*. Melbourne: Oxford University Press.
- Ricouer, P. (1981). *Time and narrative*. Trans K. McLaughlin and D. Pellauer. Chicago: Chicago University Press.
- Richardson, F. (2000). *What is it like to teach cultural safety in a New Zealand nursing education programme?* Unpublished masters thesis, Massey University, Palmerston North: New Zealand
- Richardson, S. (2004). Aotearoa/New Zealand: From eugenics to cultural safety. *Nursing Inquiry*, 11(1), 35-42.
- Richardson, F., & Carryer, J. (2005). Teaching cultural safety in a New Zealand nursing education programme. *Journal of Nursing Education*, 44(5), 201-8. Erratum in: *Journal of Nursing Education* 2005 44(8), 346.

- Riessman, C. (1993). *Narrative analysis*. Newbury Park: SAGE.
- Ritchie, S. (1993). A bicultural journey. *Nursing New Zealand*, July, 22-23.
- Robinson, J., & Hawpe, L. (1986). Narrative thinking as heuristic process. In Sarbin, T.R. (Ed.). *Narrative psychology: The storied nature of human conduct* (pp. 60-68). New York: Praeger.
- Robson, B., & Harris, R. (Eds.). (2007). *Hauora. Māori standards of health IV: A study of the years 2000-2005*. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare.
- Roy, C. (1988). An explication of the philosophical assumptions of the Roy adaptation model. *Nursing Science Quarterly*, 1(1), 26-34.
- Royal Commission. (1988). *Future directions: Report of the Royal Commission on social policy: Te komihana a te Karaumu mo nga Ahuatanga-a-iwi April*. Wellington: Daphne Brassell Associates.
- Ryan, A., Carryer, J. & Patterson, L. (2003). *Healthy concerns: Sociology for New Zealand nursing and midwifery students*. Auckland: Pearson Education New Zealand.
- Ryan, P. (1995). *The Reed dictionary of modern Māori*. Auckland: Reed.
- Schaefer, K. (2006). Myra Levine: The conservation model. In A. Marriner-Tomey and M. Allgood, *Nursing Theorists and their Work* (pp. 244-265). St Louis: Mosby.
- Scholes, R. (1981). *Elements of fiction: An anthology*. New York: Oxford University Press.
- Salmon, E. (1982). *A profession in transition*. Wellington: C.L. Bailey Nursing Education Trust.
- Sandelowski, M. (1993). Theory unmasked: The uses and guises of theory in qualitative research. *Advances in Nursing Science*, 16(3), 213-218.
- Samuels, S. (2009, November 4). *Te are turama o maos*. Cook Island News.

- Sarachild, K. (1978). Consciousness-raising: A radical weapon. In Redstocking (Ed.) *Feminist Revolution* (pp.144-150). New York: Random House.
- Sawicki, J. (1994). Foucault, feminism and questions of identity in G. Gutting (Ed). *The Cambridge Companion to Foucault* (pp. 236-313). Cambridge: Cambridge University Press.
- Sawicki, J. (1991). Foucault and feminism: Toward a politics of difference. In M. Shanley and C. Patemen (Eds.). *Feminist interpretations and political theory*, (pp. 217-231). Cambridge: Polity Press.
- Scott, J. (1992). Experience. In J. Butler & J. Scott (Eds) *Feminists theorize the political* (pp. 22-40). New York: Routledge.
- Sherrard. I. (1991). How can you teach cultural safety. *New Zealand Nursing Journal*, Oct, 25.
- Silverman, D. (2006). *Interpreting qualitative data. Methods for analysing talk, text and interaction* (3rd ed.). London: Sage.
- Smith, G. (1999). Paulo Friere: Lessons in transformative practice. In P.Roberts (Ed.). *Paulo Friere: Politics and Pedagogy*, (35-41). Palmerston North: Dunmore Press.
- Smith, M. (1996). False assumptions, ethnocentrism and cultural imposition, Madeleine Leininger's theory of culture care and its place in Aotearoa. *Nursing Praxis in New Zealand*, 12(1), 13-16.
- Smith, L. (1999). *Decolonizing methodologies: Research and indigenous peoples*. Dunedin: University of Otago Press.
- Smye, V., & Browne, A. (2002). 'Cultural safety' and the analysis of health policy affecting aboriginal people. *Nurse Researcher*, 9(3), 42-56.
- Soanes, C., & Stevenson, A. (2004). (Eds). *Concise Oxford English dictionary*. Oxford: Oxford University Press.

- Somers, M. (1994). The narrative constitution of identity: A relational and network approach. *Theory and Society*, 23, 605-649.
- Southwick, M. (2001). *Pacific women's stories of becoming a nurse in Aotearoa New Zealand: A radical hermeneutic reconstruction of marginality*. Unpublished doctoral thesis, Victoria University of Wellington, Wellington, New Zealand.
- Spence, D. (1999). *Prejudice, paradox and possibility: Nursing people from cultures other than one's own*. (Unpublished doctoral thesis). Massey University, Palmerston North, New Zealand.
- Street, A. (1995). *Nursing replay: Researching nursing culture together*. Melbourne: Churchill Livingstone.
- Sumner, J. (2008). Is caring in nursing an impossible ideal for today's practicing nurse. *Nursing Administration Quarterly*, 32(2), 92-101.
- Swartz, D. (1997). *Culture and power: The sociology of Pierre Bourdieu*. Chicago: University of Chicago Press.
- The Dominion. (1997, July 23). *Former student nurse denies being racist*, p.10.
- Tilbury, F. (2001). Haunting traces of difference. Derrida and kiwi identity. In L. Simmons & H. Worth (Eds.), *Derrida Downunder* (pp.198-215). Palmerston North: Dunmore Press.
- Tilly, S. (2003). "Challenging" research practices: Turning a critical lens on the work if transcription. *Qualitative inquiry*, 9(5). 750-773.
- Thompson S. (2001 Feb). Developing a cultural safety curriculum. *Kai Tiaki Nursing New Zealand*, 7(1). 14-15.
- Thorne, S., & Hayes, V. (Eds.). (1997). *Nursing action: Knowledge and action*. Thousand Oaks: Sage.

- Timu-Parata, C. (2007). *Ma te hurahura te manu erere ai: The decade of Māori development, 1984-1994*. Unpublished masters thesis, Victoria University of Wellington. New Zealand.
- Travelbee, J. (1972). To find meaning in illness. *Nursing*, 2(2), 6-8.
- Traynor, M. (2009). Morality and self-sacrifice in nursing talk. *Journal of Advanced Nursing*, 65(11), 2485-2493.
- Walker, R. (1996). *Ngaa pepa a Ranginui: The Walker papers*. Auckland: Penguin Books.
- Walker, R. (1990). *Ka whawhai tonu matou: Struggle without end*. Auckland: Penguin.
- Warren S. (2003). How students understand cultural safety. *Kai Tiaki Nursing New Zealand*, 9(5), 26-28.
- Watson, J. (1990). *Postmodern nursing and beyond*. London: Churchill Livingstone.
- Weedon, C. (2004). *Feminist practice and post structuralist theory 2nd ed*. Oxford: Blackwell.
- Webb, J., Schirato, T., & Danaher, G. (2002). *Understanding Bourdieu*. Crows Nest New South Wales: Allen & Unwin.
- Wepa, D. (2008). Cultural safety versus cultural competence. *Nursing Review*. July, 10.
- Wepa, D. (2003). An exploration of the experiences of cultural safety educators in Aotearoa New Zealand: An action research approach. *Journal of Transcultural Nursing*, 14, 339-348.
- Webb, J., Schirato, T., & Danaher, G. (2000). *Understanding Foucault*. N.S.W: Allen & Unwin.
- Webb, J., Schirato, T., & Danaher, G. (2002). *Understanding Bourdieu*. Crows Nest, NSW: Allen & Unwin.
- Wenzel, E. (1997). A comment on settings in health promotion. *Internet Journal of Health Promotion*. [http://www. Monash.edu.au/health/IJHP/1997/](http://www.Monash.edu.au/health/IJHP/1997/)

- White, L., Duncan, G., & Baumle, W. (2010). *Adult health nursing*. Clifton Park: Delmar.
- Whitelaw, S., Baxendale, A., Bryce, C., MacHardy, C., Young, I., & Witney, E. (2001). Settings base health promotion: A review. *Health Promotion International*, 16(4), 339-353.
- Williams, G. (2000). *The primacy of the nurse in New Zealand, 1960s -1990s: Attitudes beliefs and response over time*. Unpublished doctoral thesis, Victoria University of Wellington. Wellington. New Zealand.
- Williams, H. (1990). *A dictionary of the Māori language*. Wellington: GP Books.
- Williams, R. (1988). *Keywords: A vocabulary of culture and society*. London: Fontana.
- Wilson, D. (2008). The significance of a culturally appropriate health service for Indigenous Māori women. *Contemporary Nurse*, 28, 172-88.
- Wilson, D. (2001). *Transforming nursing education: A legitimacy of difference*. Unpublished doctoral thesis, University of Canterbury, Christchurch, New Zealand.
- Women's Refugee Commission. (2009). *Peril or protection: The link between livelihoods and gender-based violence in displacement settings*. New York: Author.
- Wood, P., Schwass, M. (1993). Cultural safety: A framework for changing attitudes. *Nursing Praxis in New Zealand*, 8(1), 4-15.
- World Health Organisation. (1986). The Ottawa charter for health promotion. *Health Promotion International*, 12(2), 99-101.
- Yon, D. (1999). The discursive power of schooling: On theories of power and empowerment in multiculturalism and racism. In A. Cheater (Ed.), *The anthropology of power* (pp. 28-41). London: Routledge.
- Young, I. (1990). *Justice and the politics of difference*. Princeton: Princeton University Press.