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# **PREJUDICE, PARADOX and POSSIBILITY**

**Nursing people from cultures  
other than one's own**

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## Abstract

This study explores the experience of nursing a person, or people, from cultures other than the nurse's own. Informed by the tradition of philosophical hermeneutics, and drawing specifically on some of the notions articulated by Hans-Georg Gadamer and Charles Taylor, it seeks to understand everyday nursing practices within their cultural and historical context.

Against a background of Maori resurgence, nurses have been challenged in Aotearoa-New Zealand to recognise and address racism in their practice. Meeting the health needs of all people has long been important in nursing yet the curricular changes implemented in the early 1990s to enhance nursing's contribution to a more equitable health service created uncertainty and tension both within nursing, and between nursing and the wider community.

In this study, I have interpreted the experiences of seventeen nurses practising in an increasingly ethnically diverse region. Personal understandings and those from relevant literature have been used to illuminate further the nature of cross-cultural experience from a nurse's perspective.

The thesis asserts that the notions of prejudice, paradox and possibility can be used to describe the experience of nursing a person from another culture. Prejudice refers to the prior understandings that influence nursing action in both a positive and a negative sense. Paradox relates to the coexistence and necessary interplay of contradictory meanings and positions, while possibility points to the potential for new understandings to surface from the fusion of past with present, and between different interpretations. As New Zealand nurses negotiate the conflicts essential for ongoing development of their practice, the play of prejudice, paradox and possibility is evident at intra-personal and interpersonal levels as well as in relation to professional and other social discourses. This thesis challenges nurses to persist in working with the tensions inherent in cross-cultural practice. It encourages continuation of their efforts to understand and move beyond the prejudices that otherwise preclude the exploration of new possibilities.

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## Key to Transcriptions

In presenting the research findings, the following abbreviations and conventions have been used:

*Italics* Identifies the interview data provided by the nurses participating. Entries quoted from the researcher's journals are also italicised.

Names With the consent of the participants, the nurses' voices are identified through the use of pseudonyms.

(Name, 1:53) References the participant's name, interview and page number.

[ ] Indicates alterations made by the researcher to enhance clarity and grammatical flow.

... Denotes material deleted from the original text

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## Chapter One: Introduction

Inquiry does not begin with conceptual organisation or relevances of ...  
discourse, but in actual experience embedded in the particular historical  
forms of social relations which determine it  
*(Smith, 1977, p.135)*

### Becoming involved

As a teacher working with nursing students, I assist in the implementation of Kawa Whakaruruhau<sup>1</sup>, or cultural safety, in nursing education. I particularly enjoy the “human-ness”<sup>2</sup> (Travelbee, 1971, p.30) and diversity of people and have strong views about justice and equality. Inspired by Schon’s (1983) work on the reflective practitioner and confronted by the disparities between the ‘real’ and the ‘ideal’ of nursing practice, it was the journaling of my experiences in practice settings that provided the impetus for this work. On April 26 1992, I recorded:

*The non-English speaking patient of a student with whom I was working today was denied access to an interpreter because of its cost to the ward’s budget. Subsequent discussion with the senior nurse on duty revealed drug costs in the speciality area to be very high and that, because the interpreter service was also expensive, it was necessary to prioritise medications. This raises questions about patients’ rights, ‘user pays’, cultural sensitivity, and gate keeping. It also undermines nursing’s philosophy of caring.*

*I feel angry and quite stunned by this decision.*

The hospital charge nurses had only recently been given budgeting responsibilities. Pressures to reduce expenditure were high and ‘user pays’ philosophies were gradually being introduced throughout the New Zealand health services. Yet elsewhere in the same institution, nurses were actively promoting the understanding and acceptance of cultural difference. A bicultural action group had recently been established, its aim to implement practical changes that would recognise and respect the cultural values of Maori people. How could such disparities exist? How could

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<sup>1</sup> In the nursing or midwifery context of Kawa Whakaruruhau, the nurse or midwife recognises, respects and nurtures the unique cultural identity of tangata whenua (New Zealand’s indigenous people), and safely meets their needs, expectations and rights.

<sup>2</sup> The term ‘humanness’ is congruent with humanistic nursing literature. In this study it refers to relationships in which attention is focused on human beings as unique individuals.

nurses on one hand uphold patients' <sup>3</sup> cultural difference and on the other, deny a person the fundamental right of communication?

Then, several weeks later, I wrote of another disturbing experience:

*May 12 1992*

*I was contacted today by a student who, feeling shocked and confused, needed support because the husband of the woman she had been nursing had made a 'pass' at her.*

*For two weeks, Mary has been nursing an Asian woman who is unconscious. The woman and her husband had been on holiday in New Zealand when, as a pedestrian, she sustained a serious head injury. Throughout the woman's hospitalisation the husband has been a constant companion. But, as a student, Mary's clinical rotation was nearing completion and it was during her efforts to say 'goodbye' to the couple, that the young man suddenly made it known that he wanted to take Mary out.*

Having listened to how Mary was feeling, I explored several possible interpretations. Together we considered the issue of sexual opportunity, wondered about loneliness and discussed professional boundaries. It was also possible, that in making this gesture, the husband was expressing his gratitude. But Mary did not think so. From her perspective as a nurse, she had tried to attend to both of their needs. She had provided physical care for the woman and monitored her progress. The husband needed support and empathy. Mary had tried to communicate with him and thought she had succeeded. Yet he seemed to have misconstrued her intentions. Feeling guilty and distressed, Mary was appalled by what seemed to her to be a totally improper suggestion and, for me, the tentative answers seemed to raise more questions. In our efforts, as educators, to encourage the culturally safe provision of care that met holistic health requirements, were we overlooking the contextually dependent nature of these goals? It seemed that attention also needed to be paid to the safety of students in cross-cultural<sup>4</sup> encounters.

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<sup>3</sup> The term 'patient' is used throughout this study rather than 'client' or 'consumer' because this was the term most commonly used when the participants referred to the people whom they nursed.

<sup>4</sup> I have selected the term 'cross-cultural' to describe interaction between people from differing cultural backgrounds. This term has historically been used more commonly in New Zealand nursing literature than has the term 'transcultural' which was introduced and developed by Leininger (1978)

### **Refining the question**

With the introduction of Kawa Whakaruruhau (Nursing Council of New Zealand, 1992), significant moves had been made in nursing education towards ensuring the provision of a culturally safe nursing service. Yet the complex nature of such nursing demanded further inquiry. Interested in understanding nurses' perspectives better, but not knowing whether others shared my interest, I undertook a pilot study in 1993 which focused on how cultural issues, particularly 'cultural safety'<sup>5</sup>, were being interpreted and implemented in practice. Through semi-structured interviews, I canvassed six nurses' interpretations of the term 'cultural safety'. I also asked for descriptions of the ways in which the nurses practised cultural safety and what factors were supportive, or otherwise, of their efforts. The study confirmed that the introduction of cultural safety was a contentious issue and reinforced my belief that nursing must continue the work of addressing racism in its practice. On the basis that little was known about the values, attitudes and actions of New Zealand nurses towards people from other cultures, I therefore concluded that an exploratory descriptive study using a qualitative approach would be both useful and appropriate.

A review of the nursing literature revealed research and theory development in the area of cross-cultural nursing to be predominantly anthropological in orientation. Most literature derived from the United States of America (USA) with the work of Madeleine Leininger (1970; 1978; 1991) being particularly prominent. Writing in New Zealand was mostly focused on Maori and oriented towards the promotion of biculturalism (Ramsden, 1990; Wood & Schwass, 1993; Cooney, 1994; Ramsden, 1995). The voices of practising nurses, apart from a study carried out in England by Murphy and MacLeod Clark (1993), were all but absent.

Inspired also by Benner's (1983; 1984) revelations of the knowledge embedded in nursing practice, I believed that a study exploring the meaning of nurses' practice experiences could contribute valuable knowledge. Yet I had experienced negativity from some teaching colleagues who believed that 'cultural safety' was a Maori issue and therefore not an appropriate research topic for nurses, like me, from the colonising Pakeha<sup>6</sup> group. The term 'cultural safety' had been coined by a Maori nursing student

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<sup>5</sup> In 1992 and 1996 the Nursing Council of New Zealand defined cultural safety as: "The effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on his/her own cultural identity and recognises the impact of the nurse's culture on his/her own nursing practice" (Nursing Council of New Zealand, 1996, p.9).

<sup>6</sup> Maori term given to New Zealanders of European or non-Maori descent

(Wood & Schwass, 1993) and further developed by Irihapeti Ramsden, a Maori nurse and educationalist. Perhaps their reactions related to concerns regarding cultural property or intellectual ownership? However it is also argued that institutional racism is a Pakeha problem. Why then, was my interest in furthering nursing's understanding of such issues not acceptable?

It was also apparent, from the pilot study, that the nurses who had participated had felt comfortable expressing their views about cultural safety but that others who were less sure, or who were opposed to these ideas, would be unlikely to participate. Yet I wanted to hear these stories too and therefore decided to refocus my exploration. Instead of concentrating on the meaning of 'cultural safety', I would ask a more general question. I decided to explore 'the experience of nursing a person or people from cultures other than one's own'.

### **Selecting the approach**

In searching for an appropriate framework to guide this study, I was drawn to an interpretive approach because I believe human inquiry needs to be based firmly in the experience it claims to understand (Rowan & Reason, 1981). Nursing is an interpersonal practice. Its experiences embrace the dimensions of emotion and cognition as well as the cultural, historical and political contexts of individuals in unpredictable situations (Lumby, 1991). Nurses see and respond to patients within the contexts of time, location and the patients' physical and emotional conditions. Indeed, it is this dynamic or 'contextual' presence that is the core of nursing (Boucher, 1998). But the nursing world is busy and nurses have embodied practice traditions which often discourage reflection on practice (Street, 1991). Nursing is a purposeful activity. It has been suggested that nurses think primarily in order to act (Teekman, 1997). They tend often to 'pass over' or 'take-for-granted' their experiences and thus may inadequately understand them (Benner, 1983). Useful exploration of the meaning of nursing experience must therefore be undertaken in a manner that accounts for this complexity. The approach taken in this study acknowledges the importance of context in creating meaning. It also recognises the fluid nature of reality and the inter-relatedness of all phenomena (Streubert & Carpenter, 1995).

The politically sensitive nature of 'cultural safety' (see Chapter Three) and the effects its politicisation was having on nurses, the nursing profession, and more generally in

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society, caused me to consider using a framework informed by critical social theory because this would reveal the forces controlling nursing action. According to Habermas (1971), the value of recognising such influences is that individuals are empowered through the process of gaining insight. Yet such an approach seemed both risky and pre-emptive. I was aware that the willingness of participants to share their experiences depended, in part, on my ability to establish and maintain their trust and safety. I was concerned that if I assumed the priority of power issues I might alienate the nurses participating. I also wanted to minimise the impact of my views on the nurses' responses. In fact, I was far from certain about the nature of my own views. They seemed to be evolving and changing as my understanding broadened and deepened.

### **A summary of my beginning position**

First-hand experience of the complex, controversial and unpredictable nature of cross-cultural nursing had strengthened my resolve to research this area. Writing on the subject of transcultural nursing had contributed valuable understanding of the health beliefs and practices of differing cultural groups. Literature relating to the developing concept of cultural safety was providing further epistemological guidance pertinent to the New Zealand context. But where were the voices of nurses as practitioners? I wanted to know more about nurses' feelings, their thoughts and their actions. I wanted to know what it was like to be nursing people from increasingly diverse cultural backgrounds at a time when the attention being given to cultural issues was challenging expectations both within nursing and within New Zealand society as a whole. The focus I sought was more ontological. Thus the phenomenon of interest became the experience of nursing people from other cultures.

### **The justification for selecting hermeneutics**

Research which uses a hermeneutic framework recognises that all understandings and events are interrelated and connected aspects of the same reality. Such work acknowledges the limitations of detached observer research when inquiry seeks to understand holistically, phenomena that are embedded within practice. I cannot, as a nurse researching nursing experiences, stand outside the phenomenon in question because embedded in me are understandings derived from my experiences as a nurse.

Nursing, furthermore, is a human science in which there are inextricable relationships between practical and theoretical activity. The term praxis refers to the reflexive

process by which actions are informed by values, reasons and ethics and how thinking is shaped and changed through experiencing action (Wheeler & Chinn, 1991). Thus “action informs reflection which, in turn, informs action” (Lumby, 1991, p.467). Based on a form of reasoning or ethical know-how, described by Aristotle as ‘phronesis’ or practical wisdom (Bishop & Scudder, 1990), praxis, in nursing, describes the interplay between being and knowing. It refers to understanding that is not separate from the interpreter but something that becomes constitutive of his or her practice. It includes knowing that derives both from reflection on practice (after the event) and reflection in practice (during the event) (Schon, 1983; Bishop & Scudder, 1990). In phronesis, understanding comprises practical and moral rather than epistemological or technical activity, however, reflection is an essential part of praxis because it is only through reflection that we become aware of our values and actions (Lumby, *ibid.*).

Emphasis on research of an empirical-analytic nature has contributed significantly to nursing’s knowledge development. Yet the less easily measurable ‘how’ of nursing practice has long been regarded as being as important as ‘what’ nurses do. Early in nursing’s history, Florence Nightingale talked of the need to balance character with knowledge (Salmon 1982). A ‘proper demeanour’ and the ‘right disposition’ were deemed to be as essential, in a nurse, as the ‘scientific’ knowledge necessary for effective practice. Meyer (1960) was similarly concerned, in the middle of this century, that nursing’s development was placing too much emphasis on nursing science and insufficient on the art of nursing. In a study of nursing values, entitled “Tenderness and Technique: Nursing values in transition” she recognised that in some areas of nursing the balance between these aspects of practice was being restored (Salmon, 1982). But how easy is it to evaluate character and tenderness? In a world that emphasises knowledge and technique, Carper (1978) speaks of a “self-conscious reluctance ... to include those aspects of knowing in nursing that are not the result of empirical investigation” (p.16).

For a significant period in nursing’s history, the influences of medical science overshadowed the development of knowledge through qualitative research. Although an understanding of the different ways in which knowledge from the paradigms guiding disciplined inquiry is developing (Guba, 1990), the path is not straightforward. Churchill (1977) argues that nursing’s quest for recognition and independence, is complicated by the myths and distortions in its role. Identifying and discussing the sources of accountability for nurses, he suggests that from within the profession, the ethic of competence constitutes one source of accountability and from without, there is



another, the ethic of compassion. In proposing the relationship between these two accountabilities, Churchill's argument that the ethic of competence grows out of the ethic of compassion, as nursing's motivating source, has parallels with van Manen's (1995, p.12) references to "gnostic" and "pathic" knowing. Gnostic knowledge, which is commonly allied with diagnosis and prognosis, refers to knowing which is rationally informed. The term pathic derives from pathos: pathic referring to a general mood, or 'felt' sense of being in the world. Although recognising both types of knowledge to be essential, van Manen (ibid.) argues that gnostic insights cannot produce pathic experience. Thus knowing, in the 'being' or experiential sense, is prior to knowing in the rational and more measurable sense, yet they intersect and fuse.

Philosophical hermeneutics recognises the existential nature of human experience. It also acknowledges that understandings can change where there is openness to other interpretations. In making sense of human phenomena, such inquiry therefore rejects empiricism on the basis that more 'holistic' or contextualised theories of meaning are required. Hermeneutics is able to accommodate the situated, dynamic and interactive nature of nursing. Moreover, in this study, use of the notions articulated by Gadamer facilitates a consciousness of anterior influences that has the potential to challenge and extend existing understanding.

### **The philosophical assumptions underpinning the study**

The experience of nursing a person, or people, from a culture other than one's own is a dynamic and complex phenomenon. Human life involves a multiplicity of relationships and interactions with other people and things (B. Taylor, 1994). Thus to be a nurse is to always be experiencing in a new way because neither the objects of experience, nor the subjective experiencing of them, is static.

The nurse is a person who relates through language and practices with others in a pre-existing world which both limits and facilitates action. Born with a cognitive and emotional capacity to think and respond, nurses, like all human beings, come to embody the values and expectations of those with whom they interact through processes of socialisation. They have feelings, expectations and desires. They are beings for whom things have significance and value and it is against these evaluations that they derive meaning from experience.

Nurses furthermore, expect and are expected by others, to reach out to and provide specialised assistance to people needing their skills. Patients (or clients) bring

particular values and expectations to the nursing encounter and likewise interpret their experiences against a background of meaning. Thus each and every individual encounter is uniquely different. Each person derives differing understandings from their situation and yet, paradoxically, interdependent and common understandings are also possible. Similarity coexists with difference.

William Saroyan, (as cited in Moore, 1994, p.199), suggests that “the very little difference between one person and another ... is what makes the difference so precious” and, certainly in western cultures such as my own, individual difference is highly valued. Internationally too, the nurse providing care is expected to promote “an environment in which the values, customs and spiritual beliefs of the individual are respected” (Fry, 1994, inside cover). Yet also essential to human coexistence is the sense that alongside such differences there is common understanding among cultures with respect to human care. Madeleine Leininger’s theory of Culture Care (Leininger, 1991) argues forcefully that both diversities and universalities need to be accommodated by culturally congruent nursing.

The roots of culture care are deep and widespread. It requires that health personnel discover the similarities and differences in a sensitive and competent way in order to provide meaningful health care service (Leininger, 1995, p.115).

The ICN Code of Nursing Ethics, adopted in 1973 and reaffirmed in 1989, states further that “[T]he need for nursing service is universal” and that professional nursing service is therefore not restricted by nationality, race, creed, colour, age, sex, politics or social status. Nurses are primarily responsible for those who require nursing care and people in need of care have a right to receive such care regardless of religious and other considerations (ICN Council of National Representatives, 1989).

In the context of New Zealand nursing, however, Ramsden (1997) challenges these codes of ethics for seeming to deny difference. Arguing that nursing practice must be ‘culturally safe’, as defined by the client, she suggests that people should be nursed “**regardful** of all that makes them unique, rather than **regardless** of colour or creed” (p.116, emphasis in the original). The challenge is indeed a valid one. But are these philosophies necessarily antithetical? The following couplet by Pat Parker (1978) seems to exemplify the paradoxical nature of respect for difference:

The first thing you do is forget that I’m black,  
Second, you must never forget that I’m black (p.68).

Perhaps, as Lacan (1978) suggests, the most paradoxical facts are the most instructive. Perhaps the truth reveals itself most fully, not in dogma but in the paradox, irony and contradictions that distinguish compelling narratives (Lopez 1989). My task in this study is to listen, ponder, question, analyse and stimulate thinking. In listening to the nurses' stories, I must ponder their meaning and question the relationship between my understandings and theirs. In exploring the phenomenon and offering possible meanings, my aim is to illuminate subtleties of meaning that go beyond, yet remain congruent with, everyday experience. The approach that I have taken therefore assumes that:

1. Nurses are cultural, historical and dialogical beings.
2. Nursing practice reflects the values, interests and understandings of nurses.
3. Nurses are able to communicate their experience and practical knowledge in an honest and trustworthy manner.
4. The findings of the study represent interpretation as an interaction between historically and culturally produced data, a historically and culturally situated researcher (Allen, 1995; Lampert, 1997) and readers who are similarly situated.

I seek to produce a text that is 'thought-full', thought-provoking and "one that reflects on life while reflecting life" (van Manen, 1997, p.368).

### **The key terms used**

In illuminating the experience of nursing people from cultures other than one's own, this study draws heavily on data derived from the experiential narratives of nurses currently working with people from diverse cultural backgrounds. The other major source of data comprises the literature which contextualises the nurses' experiences.

Use of the term 'nurse' in the study refers specifically to the registered nurse participants who, like the researcher, interpret their nursing experiences individually and situationally against a background of experiences. The focus on the 'experience of nursing' includes self-described, emotional, cognitive and behavioural nursing responses, to people who are defined by the nurse as being 'culturally other'. 'A person, or people, from cultures other than the nurse's own' is a cumbersome expression and is often shortened throughout the study to 'people from other cultures', 'another culture' or the person who is 'culturally different' or 'other'. 'Other' and 'another' are used in the sense of meaning difference. Although these terms are

regularly used to describe cultural membership they are not meant to marginalise or to 'put down' difference with connotations of dominant culture supremacy. In this study 'other' refers to a person's (usually the patient's) difference from the nurse.

The term 'culture' was purposefully not defined by myself for the participants. Its meaning emerged in the course of the research, unfolding in a way that is amply described by Ritchie (1992) who stated:

[T]he real stuff of culture in any of its meanings is messy, confusing, paradoxical ... unclear ... allowing alternatives and interpretations on some occasions and not on others (p.99).

### **An overview of the study**

An interpretive approach based on some of the philosophical ideas articulated by Hans-Georg Gadamer (1976; 1996), Charles Taylor (1985a; 1985b), Susan Hekman (1986) and Jay Lampert (1997) was used in this study. Nurses in Auckland were asked by a New Zealand-born, nurse-researcher to describe cross-cultural nursing experiences. The findings of the study are therefore constituted by meanings derived from being a nurse and being in New Zealand.

There is a sense in which nursing any person is about nursing a stranger, for every patient is in some way 'strange' or different from, unknown by and unfamiliar, to the nurse. But nursing people from another culture invariably means encountering behaviours and expectations that differ significantly from one's own. Less able to accurately interpret verbal and non-verbal messages when communicating with a person with whom they are not familiar, nurses experience higher levels of uncertainty and anxiety. Their ability to reduce these levels of tension in turn influences the degree to which they can effectively communicate (Gudykunst & Kim, 1992). The tensions and anxieties experienced intra-personally are contributed to further by the numerous competing discourses that both enable and constrain nursing action. Thus the experience of nursing a person, or people from cultures other than one's own, is akin to "striving towards certainty while constantly wrestling with the discomfort of uncertainty" (Paterson & Zderad, 1988, p.38). Moreover striving, when nursing a person from another culture, can mean 'getting it right', 'getting it wrong' and simultaneously 'getting it right and wrong'.

This study grew out of an uncomfortable awareness, on my part, of the difficulties associated with the implementation of theoretical ideals in practice. It explores the

anxieties, uncertainty and satisfaction inherent in cross-cultural nursing, illuminating the often contradictory and ambiguous nature of such work. It offers the notions of prejudice, paradox and possibility as descriptive of the experience of nursing people from cultures other than one's own. The findings constitute a contribution to the dialectic between science, humanity, reflective practice, professional dialogue and practical wisdom (Lumby, 1996). They are offered with the expectation that they will provoke further contemplation and other possible meanings for, in hermeneutic inquiry, all understandings are open to growth and change. As Gadamer (1996) stated, "It would be a poor hermeneuticist who thought he could have, or had to have, the last word" (p.579).

### **An overview of the chapters**

The hermeneutic approach taken in this study assumes that as situated, self-interpreting beings, the participants and I are guided by past understandings that project forward to inform present interpretations and future hopes.

Chapter Two begins, therefore, to establish the "**Cultural and Historical Horizons**" that constitute the phenomenon of interest. The values inherent both in nursing culture and New Zealand culture are explored with emphasis placed on the way in which past, present and future anticipations contribute to evolving existential understandings. Historical description of some of New Zealand's enduring visions is undertaken alongside an exploration of ideals that similarly endure in nursing. The disparities between the ideal (what we ought to be) and the real (what we are) become evident as the tensions between humanitarianism and the politics of power are revealed. Thus being a nurse in New Zealand means sharing hopes for a peaceful and prosperous future while living with, and perpetuating, elements of racism. Despite the fact that New Zealand is becoming a multi-cultural nation in the sense that it's ethnic diversity is increasing, in institutional terms it is historically a monocultural society. This chapter provides an essential background for a more specific focus on the meaning of culture in nursing.

Chapter Three explores "**The meanings of culture in New Zealand nursing**". It describes the evolutionary, and at times quite revolutionary development of the concept of culture. I have argued that New Zealand nurses' understandings of culture have moved from being well-intentioned but assimilationist, to being anthropologically focused on health beliefs and patterns of behaviour, and then to a more explicitly

political interpretation which recognises and seeks to eliminate health inequalities that are 'racial' in origin. Discussion of the contemporary relationship between culture and nursing in New Zealand sets the scene for a hermeneutic interpretation of the experiential data provided by nurses working with people from diverse cultural backgrounds.

In philosophical hermeneutics, the distinctions between philosophy, methodology and method are not always easy to make because each informs and is informed by the other. The titles of the next two chapters convey the coalescent nature of these facets of the research process.

Chapter Four, entitled "**From philosophy to methodology**", begins with discussion of the philosophy underpinning the research approach. A brief overview of philosophical hermeneutics and the relationships between understanding, interpretation and experience is given prior to a more detailed explication of the specific hermeneutic notions guiding this study. Of particular significance are my interpretations of 'prejudice', 'horizons', 'historically effected consciousness', 'fusion of horizons' and 'play' (Gadamer, 1996). In drawing on Gadamerian philosophy, I am emphasising the historical and cultural situatedness of nursing experience. The notions, 'strong evaluations' (Taylor, 1985a) and 'cross-cultural interpretation' (Lampert, 1997) are also important for their illumination of the way in which our emotions reveal our values and how contact with difference engenders the conflict essential for ongoing critique and understanding.

Chapter Five, which moves "**From methodology to method**", outlines the way in which the inquiry was undertaken. It provides both an audit trail of the research project and a description of the interpretive processes used. Details are given about the way in which the participants' understandings are mediated by the pre-understandings<sup>7</sup> that I brought to the interviews and to interpretation of the texts as a whole. Description of the phenomenon therefore arises from the multiple layers of interpretation and re-interpretation that are constituted by my horizons of prejudice, those of the participants' and those within the literature which contextualise the experience of nursing a person, or people, from cultures other than one's own.

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<sup>7</sup> The term 'pre-understanding' is used by Gadamer (1975) to describe the fore-structures of understanding that influence and are influenced by our social world.

Chapters Six, Seven and Eight present the experience of nursing a person, or people, from a culture other than one's own through the use of descriptive sub-themes. Chapter Six is entitled "**Encountering difference**". Taking the nurses' perspective, it describes what announces a person as being 'from another culture' and illuminates the significance attached to this descriptor when the person becomes a patient. Chapter Seven: "**Experiencing tension(s)**", explores the anxieties and dilemmas inherent in nursing those defined by the nurse as 'culturally different'. Experiencing tension has meaning as anticipated prior to an encounter, and lived-through in the moment, as well as that reflected upon after the event. There is also a constant interplay between the tensions experienced intra-personally, interpersonally and in relation to the institutions influencing nursing practice. The focus of Chapter Eight, "**Striving**", is nursing action. Description centres on the embodied responses of nurses and their efforts, successes and failures when nursing people from other cultures. Striving describes the nurses' 'trying to be', their 'ways of doing' and their experiences adapting and compromising in uniquely dynamic situations.

Chapter Nine, the fourth data chapter, presents "**Working with prejudice, paradox and possibility**" as descriptive in an overall sense of the experience of nursing a person, or people, from cultures other than one's own. Prejudice draws attention to the positive and negative pre-understandings that pervade the phenomenon of interest. Paradox refers to the necessary interplay between different and seemingly contradictory positions, and possibility points to the potential for new understandings to arise from the temporal and cross-cultural fusion of different perspectives.

The final chapter "**State of the Play**" discusses the thesis findings in relation to its hermeneutic underpinnings. Appropriating the notion of play (Gadamer, 1996) enables further explication of the dynamic and situated nature of the phenomenon. A return to the notions of contact, conflict and critique (Lampert, 1997) then facilitates discussion of the substantive nursing literature, selected educational theory and the recommendations made for education, practice and research.

## **Conclusion**

In this chapter, I have introduced myself as a teacher of nurses and described two of the incidents that provided impetus for this study. The ensuing discussion and questioning have thus indicated something of what I bring to the inquiry. The selection of an interpretive approach has been justified, the study's purpose and philosophical

assumptions have been articulated and a brief overview of findings has been presented.

An analysis of the background horizons of meaning commences in the next chapter and continues in Chapter Three. Literature sources are used to contextualise the experience of nursing a person, or people, from cultures other than one's own. In addition to relating to the research question, the construction and interpretation of data reflects my responses to the texts' meanings as a nurse in contemporary New Zealand.



## Chapter Two: Cultural and Historical Horizons

It is not enough to understand what we ought to be unless we know  
what we are;  
And we do not understand what we are, unless we know what we ought  
to be  
(Eliot, 1935).

T. S. Eliot reminds us of the reciprocity between our beliefs and values and our interactions, interpretations and responses. Thus 'what we ought to be' and 'what we are' are not dichotomous. They coexist, interact and illuminate the interplay between the 'ideal' (visions, hopes and dreams) and the 'real' (their actuality, the outcome). 'Ideal', in the context of this study, refers to the fundamental values that underpin nursing practice in New Zealand and includes the outcomes towards which nurses strive. 'Real' refers to actual occurrences, to what is experienced when nursing. When related to the ideal, real is suggestive of a tension and/or disparity between these two phenomena.

This chapter examines the cultural and historical horizons that contribute to the phenomenon of nursing a person from another culture. It identifies the values, beliefs and circumstances that inform contemporary experiences. In seeking to set up, yet not to pre-empt the study findings, I will explore some of the tensions inherent in the understandings brought by nurses to cross-cultural encounters. Culture in this chapter is the nurses' culture. It is inclusive of both 'New Zealand culture' and 'nursing culture' because these interrelated contexts or horizons background the nurses' experiential understandings.

### **Early horizons**

#### **The meeting of two disparate cultures**

In the late nineteenth century, Maori and the settlers, who were predominantly British, had similar but different visions for the future of Aotearoa<sup>8</sup> / New Zealand. The following conversation captures the expectations of one Maori chief:

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<sup>8</sup> The land of the long white cloud: name given by Maori to New Zealand.

“I thought you would have nine or ten [Pakeha]”, Te Wharepouri told Jerningham Wakefield “I thought I could get one placed at each pa, as a white man to barter with the people and keep us well supplied with arms and clothing and that I should be able to keep these white men under my hand and regulate their trade myself” (Sorrenson, 1992, p.142).

Te Wharepouri expected the immigrants to serve his needs in a manner with which he was familiar. He envisaged being able to trade profitably on his own terms. The hopes and ideals of the wife of an immigrant farmer are similarly revealed in the following poem:

We left our homes with hearts elate,  
 Utopian visions dreaming; “Adieu,” we cried, “to tax and rate,  
 Adieu to wrangling and debate,  
 Adieu to strife ‘twixt Church and State,  
 And welcome hope and freedom!” As brothers all we meant to live,  
 To age, and birth, and wisdom give  
 The honour each beseeming;  
 And feed our woolly flocks in peace,  
 Till they grew betimes to a golden fleece,  
 On Union Banks bright gleaming!  
 (Raven, 1856, p.26)

Sarah Raven had left the constraints of life in Britain in the 1850s. Like other settlers in Canterbury, she expected to be able to reside in New Zealand and dreamed of making the land profitable through farming. Thus Maori and settler shared similar hopes of prosperity. Neither anticipated being thwarted by the aspirations of the other yet neither did either party fully comprehend each other’s differences.

The settlers charted, surveyed and renamed the landscape. Seeking to build a ‘Britain of the South’ (Hursthouse, 1857) they imposed a British administration and expected Maori to assimilate. A common settler vision for New Zealand was that of a country free from the poverty and class constraints of Europe. New Zealand was to be a “paradise for brides, governesses, carpenters, gentry, invalids and investors” (King, 1992, p.306) and, in order to achieve this vision, the settlers needed land.

The view that land is central to New Zealand identity is argued by both Maori and Pakeha (Steven, 1989; Walker, 1989; Durie, 1998), but for different reasons. Since the nineteenth century in western cultures, land has been owned by individuals and is a primary source of economic status. Maori society, by contrast, is tribal in structure and land has meaning in ways that differ from, and conflict with, European notions of ownership and use (Mulgan, 1989; Durie, 1998). Although cooperation in the form of trade was mutually beneficial and, at first some Maori willingly sold their land, the loss

of land through conquest and its continued acquisition by other devious means transformed the relationship between Maori and Pakeha into one of opposition (Walker, 1989).

Yet settler survival also depended on the maintenance of amicable relationships with Maori who, until the 1860s, were greater in number (Orange, 1989; Durie, 1998). Having received poor publicity for their dealings with other indigenous peoples, and fearing that Maori would resist large-scale settlement, the British government resolved to do better in New Zealand (Orange, *ibid.*). In 1839 Captain Hobson arrived to negotiate with Maori leaders and February 6<sup>th</sup> 1840 marked commencement of the signing of the Treaty of Waitangi.

Although the Treaty has played a minor role for periods in New Zealand's history, the constitutional and legislative structure of New Zealand is founded on this document (New Zealand 1990 Commission). Signed between some Maori and the British Crown, the Treaty marked a new relationship with Britain. Maori expected both parties to play an equal role in the governing of New Zealand (Orange, *ibid.*). However, the Treaty was not, in Pakeha eyes, based on any sense of a co-equal partnership. Hobson had already begun drafting laws and regulations when the Treaty was signed and, in doing so, had ignored the rights of the chiefs to run their own affairs (Pearson, 1990). The appropriation of Maori land continued unabated and, increasingly alienated from their land, Maori also lost rangitiratanga<sup>9</sup>, mana<sup>10</sup>, identity and their economic base (Yensen, 1989).

There was, however, some evidence of settler respect for Maori. Samuel Marsden, an early missionary, writes:

The Natives of New Zealand are far advanced in Civilisation, and apparently prepared for receiving the Knowledge of Christianity more than the Savage nations I have seen. The Habits of Industry are very strong; and their thirst for Knowledge is great, they only want the means. The more I see of these people, the more I am pleased with, and astonished at their moral Ideas, and Characters. They appear like a superior Race of men (Orange, 1989 p.9).

Yet, in action and word, settler belief in the superiority of European values and practices pervaded and dominated all aspects of New Zealand life. When Governor

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<sup>9</sup> Chieftainship.

<sup>10</sup> Spiritual power, prestige, authority.

Grey prophesied in 1893 that “hereafter a great nation would occupy these islands”, he did not mean Maori (Belich, 1996, p.447). Hugh Carleton, a politician quoted on the subject of franchise, stated: “The natives have a natural right, not to vote, but to be well governed” (Sorrenson, 1992, p.184), and Hursthouse (1861, p.525) an early writer, argued that: “Without a British emigrant population, New Zealand [would] rise to no more than Tahiti, the Sandwich Islands, the Fejees, or any other semi-savage island group of the South Pacific”.

At the beginning of the twentieth century, most Maori lived rurally (King, 1992) and were not expected to contribute to New Zealand’s economic development (Parsonson, 1992). The settlers’ cultural and economic orientation was towards Europe. For most, the United Kingdom or Ireland was ‘home’, and what was British was best. Cultivating a BBC accent, for example, was preferable to speaking with “that colonial twang” (Gordon, 1989, p.77). Early landscape artists “saw Scotland, Norway and England lurking behind every crag” and, although local art was encouraged, it was local art “judged according to British criteria” (Batten, 1989, p.214).

The vision of New Zealand as a pastoral paradise required that its bush and tussock be cleared and replaced by pasture. Jones (1989) provides evidence that Maori, like the bush, were regarded as an obstacle to progress. A poem by Golder (1867, p.60) argued that the Maori were “not the true possessors of the soil”, but rather “a race” under whose stewardship “the wilderness remained an idle waste”. Reference is also made to George Wilson’s (1874) equation of the passing of Maori with the passing of the bush as part of inevitable progress and the following excerpt from the novel “Tussock Land” further demonstrates settler expectations that Maori will assimilate: “As a people the brown Maori must cease [for their] destiny [is] intermarriage with the Pakeha” (Adams, 1904, p.31).

The settlers, however, did not see themselves as oppressors of the Maori people. Christian beliefs and Anglo-Saxon values were believed to be innately superior and therefore of benefit to all (Yensen, 1989). The attitudes of paternalism that prevailed privately were also embodied in legislative terms because Europeans were assumed to have greater expertise in affairs of the State. In 1867, the Maori Representation Act established four Maori parliamentary seats when, on a population basis, Maori should have been entitled to twenty of the seventy seats in the House (Walker, 1990; Durie, 1998). Other assimilationist policies included the Native Schools Act (1867) which prohibited the speaking of Te Reo (Maori language) in school grounds and the

Tohunga Suppression Act of 1907, which outlawed traditional healers and effectively destroyed the organisation of Maori knowledge and understanding (Durie, 1996). Paradoxically, the Suppression Act, which sought to promote Maori health, in effect actively discouraged Maori well-being and autonomy. Thus, although not recognised at the time, the fact that most settlers enjoyed a higher standard of living was directly related to the undermining of Maori authority and increasing poverty among Maori (Willmott, 1989).

### **Nursing culture: humanitarian intentions**

Health care in colonial times reflected the dominance of British institutions. Particularly strong in nursing were the interrelated influences of Christianity and the Nightingale tradition. Many of New Zealand's early nurses were missionaries and nuns. Then, towards the end of the nineteenth century, women, who had either trained under the Nightingale system in Britain or who had served with Nightingale during the Crimean War, sought work in increasing numbers in New Zealand and subsequently gained positions of leadership in nursing (Rodgers, 1985).

New Zealand's first hospital was established as part of St John's College, Auckland, its nurses vowing to "minister to the wants of the sick of all classes without respect of persons or reservation of service, not for any material reward, but for the love of God" (Auckland Hospital Board, 1966, p.27). Congruent with Christian beliefs, Nightingale espoused the idea that the service of man was the service of God (Woodham-Smith, 1952) and, in arguing that "the sick and infirm or mad pauper ceased to be a pauper when so afflicted" (ibid. p.353), she demonstrated understanding of the discriminatory functions of social class. Nightingale's support of egalitarian policies in India provided further evidence of humanitarian philosophy. Recognising that opposition at the time was based on 'racial' grounds, her statement that the health missionaries teaching elementary principles of health in India "were not to lecture women, but to work with them" (ibid. p.424), suggests an awareness of the risks of colonial imposition.

Thus, nursing in the western world is founded on the belief that all persons are entitled to alleviation from suffering because all are God's people. Humanitarian notions of justice and human rights are fundamental nursing values. However, this does not exclude the possibility that the assistance provided accords more with the nurses' values and expectations than with those of the person receiving the care.

Reviewing past and present traditions in New Zealand nursing, Beatrice Salmon (1982, p.68) suggests that the “self-sacrificing” and “somewhat self-righteous” nurse that “flourished” in the early twentieth century, was attributable to authoritarian influences from the church and army, both of which required the subordination of individuals and considerable dedication. Sargison (1993) also hints at the tensions and possible contradictions inherent in missionary nursing when she comments that, “unlike most of the Protestant missionaries”, Mother Mary Aubert, a nurse initially associated with the Roman Catholic mission, “recognised and respected Maori culture” (p.4). Questions can therefore be asked about the extent to which relief from suffering depends upon receptivity to God’s, or the nurses’, word. How do entrenched organisational structures influence the nature of service provision and to what extent can different beliefs legitimately coexist?

During the latter part of the nineteenth century, Aubert established orphanages for Maori in Auckland, the Hawkes Bay and Wanganui. She visited schools teaching and bringing them nursing skills, but she also learned their language and traditions. Having studied medicine and botany, Aubert used these skills together with the knowledge of traditional remedies shared by Maori to market a range of herbal products throughout Australasia in the 1890s (Sargison, *ibid.*). Of Maori, she is reputed to have said: “Christianise them, but ... do not aim to make second-rate Europeans out of them. Be sure and let them stay Maori” (Sargison, 1993, p.6).

However, Aubert’s message appears to be at odds with the views held by many during her time. There is ample evidence that the nurses’ humanitarian efforts were often hindered by their insufficient knowledge and by negative attitudes towards different cultural beliefs. References were frequently made by nurses to the “Natives being addicted to very dirty living ... a great deal of tohungaism” [and] “the most detrimental custom ... that of parting with their children ... the adoption of infants ... by relatives and friends....” (McKegg, 1992, p.156).

The Maori Health Nursing Scheme, an initiative founded by Maori for Maori in 1897, actively promoted the training of Maori nurses (McKillop, 1998). It was, however, less successful than hoped partly due to resistance from within the hospital bureaucracy (McKegg, 1992). Although one Napier matron advocated a three-year course for Maori nurses on the basis that it would provide these nurses with sufficient mana to work

effectively in their communities, Hester Maclean<sup>11</sup> believed that ‘Maori women lacked application and reliability’ (ibid; p.150).

By 1911, most of the nurses appointed to its successor, the Native Health Nursing Scheme, were Pakeha. Although this service was purported to have been driven by humanitarian concerns to improve Maori health, also prominent were assimilationist motives and fears about the spread of disease from Maori to Pakeha (McKillop, 1998). Nevertheless, many early nurses worked hard to gain the trust of Maori. Nurse Gates, at Pongaroa, wrote in 1913:

It takes much time and patience and infinite tact to gain the confidence of the good-hearted, hardworking people, and make them feel one comes to be a help and comfort and not to uproot the traditions of generations (Gates, 1913, p.65).

Nursing during the 1911 typhoid epidemic, Miss Bagley learned through experience that throwing dirty mouth swabs on the fire was offensive to local Maori, and thereafter, she discontinued this practice (Bagley, 1911). Of her work in Ahipara, she wrote:

We have at last, I think, persuaded them to bring the sick ones ... I think they believe in me a bit, for Wakatai, one of the Maori Council members, came to me this morning and asked, if I had any wishes, to make them known to them ... He said “They do what you wish; they like you; you the good nurse!” I was surprised, for I had been compelled to scold them for not milking the cow, and lots of things. But I may give enemas with impunity now. They credited a nurse with someone’s death, because it happened soon after that “operation” (Bagley, 1911, pp.109-110).

This story contains evidence of beginning cross-cultural trust. The fact that Wakatai was able to approach and offer assistance to Miss Bagley suggests that her presence as a nurse in his community was acceptable. But there is also evidence of profound difference and a potential for the violation of trust. How compatible with Maori tradition is travelling during sickness, the consumption of milk and the milking of cows? And what of enemas? Miss Bagley not only assumed that Maori would comply with her expectations in this regard, but also that they would accept her authority. She may not have wanted to scold, yet she did so repeatedly and, having achieved a degree of success, appeared to believe that she had been given a mandate: “I may give enemas with impunity now!” Where is the recognition that the success of her contribution was contingent upon Maori receptivity and furthermore that sustained success required movement in understanding on her part? Maori were considering bringing their sick

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<sup>11</sup> A leader in nursing during the establishment and development of the Maori and Native Health Nursing Schemes.

ones, even though their health beliefs were so vastly different from those of the nurse. What thought was given to the reciprocal need for nurses to find out about and consider Maori wishes?

Nurse Street's account of her experiences reveals a similar paradox:

I cannot speak highly enough of the kindness and consideration shown by the Maoris to their nurse ... the difficulties are many, but not great, the language is one, but usually there is a Maori on hand who can speak English ... then ... there is the great objection generally, to consulting a doctor.... Underlying the work to be done by the nurse is a great work to be done by the tactful and womanly woman. The future of the Maori race with their brains and physique, land that means wealth in a few generations, is a subject that should be seriously considered by all New Zealanders who have their country's welfare at heart, for they [Maori] should be fitted for their possession of brains and money by a good practical education, to enable them to use both wisely (Street, 1911, p.110).

Although this story communicates a genuine sense of respect towards Maori, it is also ethnocentric.<sup>12</sup> The fact that language barriers were overcome because some Maori spoke English suggests that the learning of Maori by nurses was not necessary. Although there was positive recognition of Maori attributes, these were acknowledged in relation to their potential for enhancement by a "good practical education", the underlying assumption being that the education required was British. The anticipation of future progress and wealth was defined according to the nurse's cultural values and, embedded within her apparently well-meaning intentions, was a view of Maori as deserving but inherently inferior.

It is important to remember, however, that neither of these nurses had recourse to the decades of knowledge development in the human sciences that have enabled this critique. Working from the confines of their worlds, the nurses demonstrated how hard it is to move beyond the horizon of one's own understanding. The following excerpt, from *Great Days in New Zealand Nursing* published in 1961, further exemplifies the difficulty of seeing beyond one's prejudices.

Care of the Europeans never detracted from the careful attention given to the natives of New Zealand – the Maoris. Nurses who served the Native Health Department ... were some of the finest in New Zealand's history. At the turn of the century the fate of the Maori race had reached

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<sup>12</sup> This term refers to the tendency to evaluate the members of other groups according to the folkways of one's own group (Sumner, 1940).



its lowest ebb. This great race, apparently passing out of existence, was saved from extinction by the determined efforts of Maori leaders, statesmen, and churchmen, and by friends and well-wishers, and, not least of all, by the nurses of the Native Health Department. Their job was made more difficult because, although Maori were free to enjoy the same hospital privileges as Europeans, they were slow to accept new methods, since native customs, traditions and superstitions were still under the influence of the 'tohunga'<sup>13</sup> (Ratray, 1961, p.43).

Although not a nurse, Joan Ratray spent sixteen years researching and writing a book that she hoped would enlighten and “inspire New Zealand women to adopt nursing as a career” (ibid. p.12). The account presents a romantic view of nursing history, the excerpt above referring to health issues prior to the 1920s. Although Ratray acknowledges Maori input into their survival, most of the contributors listed are European. Yet knowing in the mid-1960s that earlier efforts to improve Maori health were only minimally successful, Ratray seems to be defending previous actions and policies. Perhaps the hint of defensiveness also derives from belief in a discourse that blames the victim? The claim that progress expected from “the determined efforts” was “made more difficult” by the “tohunga” and “native superstitions” is congruent with the colonial notion that health services were undermined by Maori beliefs. Ratray’s judgement demonstrates the effect of history on interpretation.

Although Maori and Pakeha may have similarly hoped for improvements in health, the beliefs and expectations of each group had little in common with each other. In Maori society, the office of tohunga usually descended from father to son (Best, 1924; Te Rangi Hiroa, 1950) and, as respected elders, tohunga were an integral part of tribal existence. In contrast, the colonial nurse was female and generally young. Even if she lived closely to Maori, she lived differently and as a visitor to the Maori community. How could each know or easily come to appreciate the other’s perspective? How realistic was the expectation that any society reject centuries of embodied tradition in favour of an alternative and unknown mode of existence?

There is also evidence that such ‘missed’ understanding surfaced more overtly. In relation to the Maori Health Nursing Scheme, the Matron of Thames Hospital, for example, is known to have stated that she did not want Maori nurses because she was having “enough trouble with the white ones” (McKegg, 1992, p.150). The Matron at Waikato also declined to accept any more Maori probationers suggesting, “We ought to

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<sup>13</sup> Maori priest, expert, chosen one.

have a rest for a time and give one of the other hospitals the privilege of training a few” (ibid. p.151).

The use of ‘ought’ connotes more an obligation than a genuine desire to provide Maori nurses with an opportunity for training and the words “privilege” and “trouble” convey a sense of frustration that is both ethnocentric and covertly racist. Similarly, it would seem that Lambie’s later suggestion that the Maori nurse needed special attention and understanding by their tutors and ward sisters because “it must be remembered that her background of experience is often very different from her fellow nurses” (Lambie, 1936, p.47) was minimally successful. Only four of the forty nurses trained and employed in the Native Health Nursing Scheme were Maori (McKillop, 1998).

The inherently problematic nature of cross-cultural interaction is further alluded to in the practice of using epithets throughout early publications of New Zealand’s nursing journal, *Kai Tiaki*. The following quotation from Ruskin appeared below an article in 1912 entitled “Native Nursing”:

In every moment of our lives we should be trying to find out, not in what we differ from other people, but in what we agree with them (p.27).

Although the intention of the excerpt can be interpreted as encouraging the finding of a common base from which to begin the communication necessary for development of cross-cultural understanding, perhaps overlooked is the risk that a focus on commonality can preclude the understanding and acceptance of difference?

Consistent with society’s views at the time, the nurses’ stories reveal, on one hand, their belief that Maori advancement depended on the extent to which they could assimilate to Pakeha ways and, on the other, their respect for and willingness to learn about Maori beliefs and treatments. It seems that close involvement with Maori offered the possibility of knowing and appreciating difference on a one-to-one basis but that distance and collectivity intervened and limited the opportunity to experience cross-cultural reciprocity and understanding. Despite signs of a contrary reality, a vision of equality persisted within minds of many New Zealanders.

### **New Zealand's vision of opportunity for all**

The 'social dream'<sup>14</sup> is a dominant theme throughout New Zealand's literature (Jones, 1989). The father in the novel *The Toll of the Bush* offered a toast to "the country of our children - The Fairest Land in the World" (Satchell, 1905, p.189). New Zealand promised to be a paradise for both labourer and the middle class largely because of its natural abundance (Fairburn, 1989). The country's temperate climate, luxuriant vegetation and naturally good harbours contributed to settler expectations that, as proclaimed by Governor Sir George Grey, "New Zealand would become a great country and ... everyone would have a chance to get on" (Graham, 1992, p.112). The description of New Zealand as "God's Own Country"<sup>15</sup>, which was later popularised to become "Godzone" referred to "the finest place on earth" (Ell, 1994, p.80). Egalitarianism and social welfare had made New Zealand a promising place to live in the early 1900s.

Graham (1992) suggests that the colonial ethos of 'opportunity for all' derived from the staunch egalitarianism of the settler working class who, in larger numbers, achieved prosperity and a new-found pride. 'All' however, did not include Maori. Nor did it eventuate for women or many men from the lower classes. 'Getting on', despite Grey's expectations to the contrary, depended on access to credit and thus favoured those, like the sheep-lords and the merchants, who could gain capital credit. Opportunity and prosperity were, therefore, far from universal. They were dependent on gender and class (Belich, 1996) but most significantly, they were also related to 'race'.

In addition to the undercurrent of racism towards Maori, other ethnic groups, particularly the Chinese, Indians and Yugoslavs, were early targets of substantial racism (Gibbons, 1992; Spoonley, 1993). A report entitled "In Defence of Race and Empire" (Leckie, 1985) documented the formation of the White New Zealand League and clearly illustrated prejudice against non-Europeans in the early part of the twentieth century. Even New Zealand-born women married to foreign men were regarded as alien, denied New Zealand passports and disenfranchised (Coney, 1993). The belief that British views should be central actively penalised minority and subordinate groups, the tendency towards ethnocentrism manifesting as institutional racism.

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<sup>14</sup> This term refers to the portrayal of New Zealand as a 'Pastoral Paradise' and 'Just City'. Jones explored the various dreams and myths relating to this image.

<sup>15</sup> This term, attributed to the poet Thomas Bracken, was frequently lauded by the Liberal Premier, Richard John Seddon, in the early 20<sup>th</sup> century.

Another recurring theme which supported the 'God's Own' notion, was settler belief that New Zealand was an exceedingly healthy country (Bryder, 1991). Yet, this too, was fraught with contradiction. Infant mortality rates were similar to those in Britain, and although New Zealand escaped the scourge of cholera, its rates of dysentery, typhoid and scarlet fever were slightly higher than those in Britain (Rice, 1991). Moreover, the failure to include Maori statistics in 1889, made the New Zealand death rate appear more favourable when compared with the Australian colonies and European countries (Brookes, 1991). Largely unknown, by Pakeha, was the fact that the Maori population fell from 175,000 in 1800 to 42,650 in 1896 (Durie, 1996).

Evidence of further, perhaps unintended, discrimination is also recognisable in many of the solutions implemented in health. The treatment of tuberculosis in sanatoria and children's health camps, for example, failed to meet the needs of Maori whose rate of incidence by 1935 was ten times that of Pakeha (Bryder, 1991). The emphasis on education implied that sufferers were personally responsible for contracting the disease. Little was done to improve the housing conditions that fostered its spread and the practice of making tuberculosis notifiable had the unintended consequence of stigmatisation. Despite a call by Hester Maclean in 1929 that the supervision of patients in their homes would be more effectively carried out by nurses, it was 1940 before the Health Amendment Act transferred the follow-up of tuberculosis cases to district nurses (Bryder, *ibid.*). Similarly, in the women's health arena, the introduction of free antenatal clinics, together with emphasis on aseptic midwifery and the increasing medicalisation of childbirth, did little to improve mortality and morbidity statistics for Maori women and children. The need to consider factors such as rural isolation, poor housing conditions, medical unwillingness to provide contraception and Maori women's preferences for home confinement were largely overlooked and again contributed to the disparity in the health outcomes between Maori and Pakeha communities (Brookes, 1991).

Following the depression of the 1930s, however, social welfare became a matter of deep public concern (Oliver, 1977) and, through legislation, enormous advances were made in public health. Labour's housing policy enabled a generation of poorer families to live in reasonable comfort (Chapman, 1992). The 1938 Social Security Act introduced medical and hospital benefits for the young, orphaned, unemployed and elderly, exemplifying a 'cradle to the grave' concern for citizen welfare which persisted into the 1980s (Rice, 1992). For the first time in New Zealand's history, Maori gained rights as citizens to universal benefits.

The New Zealand dream of an egalitarian society was embodied in the expansion of the welfare state and the country gained an international reputation as a leader in welfare legislation (Vellekoop Baldock, 1977). Belief in the equality of access and treatment was based on a belief that welfare policies were neutral in their conversion of opportunity into life chances but the ethos of equality infused in such systems was also contradictory. The need to consider cultural differences remained absent and the attitudes of paternalistic monopolisation that encouraged conformity continued to perpetuate the myth that New Zealand was an egalitarian society.

### **Nightingale's legacy**

By the 1940s, New Zealand nursing had embodied a strong "Nightingale ethos" (Rodgers, 1985, p.62). The ideal nurse possessed feminine virtues of patience, gentleness and obedience together with an ability to nurture and maintain cleanliness and order. But the qualities of gentleness and patience, which were advantageous at the bedside, had not facilitated development of the attributes necessary to promote and enhance the voice of nursing in the health care system. The efforts of early Nightingale trained nurses to advance nursing's status were undermined by their support of an 'apprenticeship system' and medicine's involvement in nursing training. The main function of a nurse was to serve (Tennant, 1991). The concept of 'nursing as service' was supported by hospital administrators for economic reasons. It was also supported by medical staff who were concerned to restrict nurses' independence. Thus, although nursing had become an acceptable occupation for women, the strength of the Nightingale ethos significantly tempered any visions of autonomy (Rodgers, *ibid.*).

### **Stimulus for change**

In the twentieth century, war, as it had in the Crimea, again provided a catalyst for change within nursing. The New Zealand nurses who served in World War One "left a splendid reputation ... concerning ... [their] ability" (Auckland Hospital Board, 1966, p.17). World War Two also provided nurses with numerous opportunities for extended practice and increased autonomy (Salmon, 1984). In addition to serving in Europe, the Middle East and North Africa, New Zealand nurses took up senior positions within many Asian and South Pacific health services. They organised the training of nurses, set up hospitals in prisoner of war camps and provided missionary services in China (Lambie, 1956; Rattray, 1961; Rodgers, 1994).

The skills of those who remained at home also developed as efforts were made to maintain essential services under very austere conditions (Wilson, 1997). One nurse remembers her experiences at Wellington Hospital during this time:

Somehow the ward routine was maintained. At times the shortage of nurses was acute, and towards the middle of that year, I went without a leave day for three weeks. And somehow we coped with routine surgery, emergencies and the bed shortage (Edmond, 1986, p.242).

Thus the ideals of loyalty, commitment and humanitarianism continued to underpin nursing action. Yet the development of other, more autonomous attributes was neither recognised nor valued. The frustration experienced by many of these nurses following the war, sowed seeds for further change. War had stimulated and revealed the value of many new treatments. There was a need to keep up with advances in technology and nursing's role expanded to include the provision of rehabilitation programmes for returned servicemen. Nurses were beginning to embrace a potentially expansive horizon.

### **The middle horizon**

Following the Second World War a complacent optimism prevailed as New Zealand experienced a period of economic growth lasting almost three decades. Most New Zealanders were employed and a system of universal monetary benefits and social services provided lifelong security. Public health measures had significantly reduced rates of typhoid and infant mortality among Maori (King, 1992) and life expectancy was similarly on the rise. New Zealanders tended to live in ethnically homogeneous areas until the 1960s. Because most Maori lived in semi-isolated rural communities, relations between the groups were perceived to be cordial (Thompson, 1977). Yet signs of discrimination were evident.

In a narrative entitled "The School Picnic" Gaskell (1953) provides a rich description of conflicting and discriminatory cultural values. Maori are cast, by Miss Brown a young Pakeha teacher, in the role of 'primitive'. Miss Brown resents 'wasting' her Saturday on a social engagement with the Maori community in which she is relief teaching. She worries about her appearance being ruined, complains about Maori lateness and is revolted both by the children's "snotty noses" and the picnic food being prepared.

Laughter and the use of Maori language are interpreted by Miss Brown as “telling dirty yarns”. When an elder arrives, her recognition of his mana is fleeting and patronising:

Old Araroa had arrived and was standing there, leaning firmly on his stick, white-haired and full of gentleness and dignity, handing out the *cheap* toys for prizes (Gaskell, 1953, p.297, emphasis added).

Then, leaving the picnic early, Miss Brown’s final accompanying thought is as follows: “All this for a pack of bloody savages” (ibid. p.300). Miss Brown seems to lack understanding of a different system of values. Yet it is also possible that her responses are attempts to hide feelings of discomfort, vulnerability and fear.

### **Increasing diversity**

Assisted by continued migration and the rapid demographic growth of Maori, New Zealand’s population expanded and began to diversify during these decades. The skilled labour required for industrial expansion came from the United Kingdom and other European countries, eg. The Netherlands, while unskilled positions were filled by the migration of Maori from rural to urban areas and by migrant labour from the Pacific Islands (Ongley, 1991).

Early policy changes included the Maori Economic and Social Advancement Act of 1945, which set up tribal committees to “preserve, revive and maintain the teaching of Maori art, crafts, language genealogy and history in order to perpetuate Maori culture” (Thompson, 1977, p.160). The Act also recognised, to some extent, that Maori interests in relation to subsistence fishing (referred to as ‘kai moana’) were different from those of Pakeha, but it assumed that the future of Maori lay in the urban areas rather than in traditional iwi (tribal) or rural contexts.

More overt signs of racial prejudice also existed. Asian and other ‘alien’ immigration restrictions continued to be argued on the basis of assimilation difficulties. As Maori and Pacific Islanders increasingly populated certain urban areas, their physical and cultural differences become a sign of minority status (Trlin, 1971). In 1964, Sir Eruera Tirikatene (Member of Parliament for Southern Maori) received support for his claim that discrimination was rampant in relation to property leases and a Private Members Bill, forbidding tenancy clauses which excluded people from “coloured races”, was put forward by the then Auckland Central MP, Mr N. V. Douglas. Yet, following recommendations made at the Convention for the Elimination of All Forms of Racial Discrimination, the Government’s reluctance to introduce the 1971 Race Relations Act

was based on the continued belief that New Zealand was an egalitarian society with little need for such legislation (Thompson, 1977).

### **Unmasking the visions**

A visit in the 1950s by an American psychologist challenged commonly held views about New Zealand's race relations (Ausubel, 1960). Yet his views received little support from New Zealand's intellectuals (Oliver, 1992) and it was 1960 before the overwhelming social and material inequality between Maori and Pakeha was recognised (Hunn, 1961). The Hunn report revealed that Maori were more likely to be unemployed, or on low wages. Maori male offending rate was three times that of Pakeha (Walker, 1992) and 85% of Maori left school without an educational qualification (Walker, 1996). Yet, on the basis of increasing Maori-Pakeha intermarriage, the report was optimistic. The 'problems' of inequality would be solved through rural-urban migration and continued intermarriage. Stressing "integration" rather than "assimilation", Hunn argued that the aim was to "combine (not fuse), Maori and Pakeha elements to form one nation wherein the Maori culture remains distinct" (Thompson, 1977, p.160). But, despite government assurances that integration and unity would prevail over assimilation and conformity, there was little recognition of the need for different structures to support tribal philosophies (Durie, 1998).

Some improvements were made in Maori health and life expectancy during the post-war period (Pearson, 1990), yet the poor position of Maori relative to non-Maori continued and was largely unrecognised. Statistical analysis in the mid to late 1980s revealed that, on an average, Maori died 7.5 years earlier than non-Maori. Their rates of cot death were twice that of non-Maori. Maori had higher incidences of respiratory and cardiac disease, diabetes, liver, lung, gastric, and cervical cancers. They also experienced hepatitis, ear disease and psychiatric illnesses in greater numbers than their non-Maori counterparts (Pomare, 1980; Pomare & de Boer, 1988). Moreover, despite the fact that New Zealand rated as one of the world's wealthier nations, these figures were similar to those found in third world countries (Durie, 1996). Compounded by education and employment disparities, such health statistics thus provided indisputable evidence of social injustice in New Zealand. Not recognised in nursing, the ethnocentric practices and attitudes embedded in the profession continued.

### **Signs of change in the nursing focus**

Going back in time to focus on the corresponding nursing history, an article in the New Zealand Woman's Weekly is illuminating. Miss J. M. Kirkness who, as Matron-in-Chief



of the Auckland Hospital Board, interviewed many of those seeking entry to nursing during the 1950s and 1960s, recalls most applicants saying, "I want to do something worthwhile", or, "I want to live a useful life". Furthermore, few mentioned pay, and if they did, it was "usually last of all" (Newcomb, 1963, p.18).

Although an underlying commitment to humanitarian ideals and other as deserving continued, there were signs internationally of a change in emphasis. Nursing schools in the USA were increasingly being located in universities and the quest for acceptance as a scientific discipline was a catalyst for academic development. Nursing scholars (see for example Peplau, 1952; Orlando, 1961; Travelbee, 1971), focused on developing humanistic theories which emphasised the relationship with patients, proposing that the professional nurse was "a person who possessed and used a disciplined approach in combination with therapeutic use of self" (Travelbee, *ibid.* p.18).

In New Zealand, nursing education remained within the hospital context. Its development was influenced to some extent by the use of North American text-books but mostly by teachers, both nursing and medical, whose experiences had been gained within the confines of an apprenticeship system modelled according to medical and bureaucratic interests. Referring to Irving Goffman's concept of the "total institution", Salmon (1982, p.68) warned of the danger of "destroying individuality and of instilling the same attitudes and behaviours in all nurses". As a student nurse apprenticed to a hospital, the job certainly took precedence over the person. Subservient to the authority of others, I vividly recall learning to 'bolt my food', make running look like walking and the importance of following 'the correct procedure' as if no other way existed. Salmon cited the church and army as contributors to this tendency in nursing. It is clear however, that the institution of medicine similarly inculcated conformity and furthermore, that in a stable, conservative and relatively prosperous society, there was little stimulus for change.

New Zealand nurses' fight for autonomy via graduate education has been long and difficult. First mooted in 1922 by Bicknall, the programme proposed and accepted at Otago University in 1925 did not materialise. Rodgers (1985) suggests that advancing the education of nurses conflicted with those interested in maintaining the status quo. University education threatened the equilibrium of the hospital structure and also created uncertainty within nursing leadership. Concerned that nurses should first demonstrate their suitability for nursing by way of hospital training, a compromise was reached in 1928 and, instead, a one-year postgraduate course was established in

association with the Department of Health (Miller, 1984). Known as the Post-Graduate School of Nursing Studies, and then as the School of Advanced Nursing Studies (SANS), the programme established by Lambie and Moore facilitated the development of a small core of nurses. Scholarships awarded for overseas travel contributed to the acquisition of new ideas (Lambie, 1956) but organisation of the School precluded achieving the critique essential for the rigorous development of nursing knowledge and its numbers were insufficient to ensure significant change. It was 1973 before the first undergraduate students were accorded status as tertiary students (Carroll, 1984) and 1990 before the last hospital-based school of nursing closed (Brown, Masters, & Smith, 1994).

There is evidence however, that New Zealand nursing's continued participation within the International Council of Nurses, CORSO<sup>16</sup> and the World Health Organisation stimulated some progress (Salmon, 1984). A 1959 *Nursing Gazette* article from the Department of Health demonstrates an evolutionary change in nursing philosophy. Nursing was recognised to have "wider and deeper responsibilities than in the past" (Cameron, 1959, p.25). The articulation of the recommendation by the World Health Organisation that the care of patients needed to include environmental, social and spiritual, as well as physical well-being, exhorted nurses to embrace an expanding notion of health and led to the enthusiastic adoption of holism by nursing education.

An extended letter to the editor in the *New Zealand Nursing Journal* from the staff at Waiariki College's School of Health Studies (1985) provides evidence of commitment to incorporate the long established Maori view of holism with the European approach to health care. Yet Owen and Holmes (1993) suggest that exposure to this philosophy was not reinforced for students in the practice environment. The narrower, medical model of health care is recognised by numerous authors to dominate service delivery (Kramer, 1974; Kanitsaki, 1988; Gordon, 1991; Murphy & MacLeod Clark, 1993; Spence, 1994).

### **The recent horizon: two decades of challenge and change**

In the 1970s, as the cold, hard facts of New Zealand's economic position eroded the provision of universal benefits as of right (Dunstall, 1992), the task of achieving social

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<sup>16</sup> Council of Organisations for Relief Services Overseas.

justice and racial harmony in New Zealand became increasingly difficult. 'Race' relations had become a key issue. Treaty rights were being articulated more assertively by Maori. Moreover, the arrival of television and advanced forms of communication had increasingly exposed the public to issues such as apartheid, the Civil Rights movement and the numerous, and graphically illustrated, examples of ethnic resistance occurring across the globe. Following world-wide economic difficulties in 1973-74, a survey in New Zealand revealed the existence of poverty among the elderly, the unskilled, Maori and people from the Pacific Islands. New Zealanders heard with disbelief that the assistance of aid agencies such as CORSO and VSA<sup>17</sup> was required at home (Trlin, 1977).

Until the mid-1980s, government intervention had, with reasonable success, ameliorated the effects of economic and fiscal policies (Rice, 1992). But despite comprehensive consultation in the form of The Royal Commission on Social Policy (1988) that set standards for a fair society, it became increasingly clear that social justice depended on funding capacity and market priorities were privileged over the social services. Dunstall (1992) argues that the inability to sustain New Zealand's dream of a utopia is directly related to the insatiable demands of materialism. Thus, as expectations increase, so too does the tension inherent in simultaneous adherence to social welfare ideals and the principles of a market economy (Trlin, 1977; Cheyne, O'Brien, & Belgrave, 1997).

Nursing similarly wrestles with dilemmas. Much has been written about the effect of ideological conflicts on nurses' lives (Kramer, 1974; Street, 1991). Nursing philosophies, both at individual and collective levels, exist alongside the differing views of medicine, health administrators and culturally diverse clientele, each of which is a source of potential conflict for the nurse. Implicit within holism, for example, is an expectation that an individual's cultural beliefs impact upon their health. Thus most nurses now recognise the need to provide care in a way that accommodates difference. But persistently problematic in relation to the practice of nursing are issues relating to who interprets the needs and to what extent the nurse and the agencies funding nursing are committed to the implementation of culturally appropriate health care.

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<sup>17</sup> Volunteer Service Abroad.

Few people would argue against the notion that the patient or recipient of care should be the primary focus of nursing. Changes in nursing International Codes of Ethics demonstrate a move by nurses away from medically oriented allegiances towards greater accountability to clients and community (Bergman, 1976). Bishop and Scudder (1990) suggest furthermore that the contemporary interpretation of values such as helpfulness, fortitude and loyalty is changing to include notions of self-help, independence, openness and loyalty balanced with justice. Reference is made to a loyalty that maintains the system of health care but which also argues for a more equitable and fair distribution of services.

Nurses are also professionally accountable to colleagues and employers, and they have personal commitments outside their nursing role. Yeaworth (1978) and others, more recently (Meleis, 1991; Perry, 1993) suggest that many nurses are socialised primarily to be wives, mothers and carers of those dependent within the family context. The extent and direction of a nurse's commitment to the meeting of patients' specific needs is therefore tempered by the situational interplay of these differing orientations.

In examining ethical decision-making, Murphy (1983) noticed that nurses demonstrated differing degrees of allegiance to the patient, institutional ideals and to the priorities of other health professionals, notably the medical staff. Nurses, whose major focus was getting the job done without questioning authority, were described as being committed to a bureaucratic model. Those who emphasised the development of technological skills and good nurse-physician relationships belonged to the physician advocate group and those whose focus was clearly the recipient of care formed a third group of patient advocates.

In New Zealand, few nurses are autonomous in the sense that they work alone, or are paid directly by their patients. Being a nurse therefore means being committed to one's employer and to working harmoniously with other health professionals. Thus tension exists as medical staff and administrators expect commitment and accountability on their terms, from nurses.

Allen (1995) reminds us that being a nurse also means participating in services that do not meet the key health needs of large sections of the community. Thus he argues that nursing needs to engage in analysis and critique of the political and social conditions of practice. Yet, as already shown, the traditions embodied through one's socialisation as a nurse and woman do not make the involvement in politics easy for most nurses.

### Revisiting the Treaty

Frustrated by past Maori political ineffectiveness, a new generation of more militant Maori leaders emerged in the 1970s. Prior to this time, the Treaty was virtually redundant in the eyes of Pakeha and, although it had played a significant part in the Kotahitanga<sup>18</sup>, Ratana<sup>19</sup> and Kingitanga<sup>20</sup> movements, it had also remained relatively insignificant for some Maori. However, through the increasingly vociferous demands of young Maori activists during the 1970s and 1980s, and the establishment of the Waitangi Tribunal by the Labour Government in 1975, the Treaty gained increasing public recognition and acceptance.

For Maori, the issues, although variously interpreted, were the same: Treaty rights and Maori sovereignty. The strategies were new. The 1975 Land March and protest events at Bastion Point and the Raglan golf course exemplified the more assertive approach being taken by Maori. The continued quest for self-determination also produced organisations eg. The Maori Organisation of Human Rights (MOOHR), Nga Tamatoa, the Maori Women's Welfare League and Mana Motuhake (Awatere, 1984; Walker, 1990; Durie, 1998).

The Treaty of Waitangi has been reinterpreted and is the central focus of the argument for Maori equity (Durie, 1988; Temm, 1990). For many Pakeha, however, the politicisation of ethnicity is deeply threatening (Spoonley, 1990), particularly when related to land claims. There is anxiety about what sort of society New Zealand is to become, how much land will be returned to Maori and whether the resource base, to be eventually owned by iwi authorities, will yield the returns required by the market place (Laidlaw, 1990).

Media coverage of 'racial' issues has made it more difficult to ignore the clashes of values and has further exposed the myth of New Zealand as an egalitarian and harmonious society. Although Pakeha support has been evident in groups such as HART<sup>21</sup>, Project Waitangi and CARE<sup>22</sup>, the majority of the public is far from adequately informed on Treaty issues (Kelsey, 1990) and, as stated by Richie (1992), "what

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<sup>18</sup> The Maori Parliament established in the 1890s.

<sup>19</sup> The religious movement founded by Tahupotiki Wiremu Ratana in 1918.

<sup>20</sup> The King Movement, which developed in response to the colonial expansion of the mid-nineteenth century.

<sup>21</sup> Halt All Racist Tours

<sup>22</sup> Citizens Association for Racial Equality

Pakeha ... think they own, they ... wish to go on owning ... assimilation is still the ruling political agenda for most non-Maori New Zealanders” (p.146).

Although public awareness of Maori presence in everyday life can be seen as positive in the sense that differences are coming more openly to the fore, when distorted by the media the acrimonious arguments also serve to entrench racist views. Significant changes in ethnic relations are being debated at a time of considerable economic uncertainty and there is evidence of a “backlash”, “victim-mode” and “Treaty of Waitangi fatigue” (Piddington, 1994, p.240).

An analysis of complaints to the Race Relations conciliator (McCreanor, 1989) provided insight into the nature of racism in New Zealand. A major recurring theme is that Maori culture is regarded, by some people as inferior on the grounds that it is based on simple legends, has only primitive technology and is slow to progress. The most stereotypical images were of Maori as either passive, fun loving and non-disruptive, or as urban, aggressive stirrers. On the issue of identity, opinion of those sampled was largely that intermarriage had ensured there were no true Maori in existence and that those who claimed to be Maori did so in order to gain special benefits. It is clear that racist attitudes continue to exist within New Zealand society.

The Values Study (Webster & Perry, 1992) of 1000 randomly selected New Zealanders in the late 1980s revealed Maori and non-Maori beliefs and goals to be similar, different and contradictory. Both church-goers and non church-goers believed that New Zealand’s most important problems were unemployment and crime. The environmental movement received greater support from church-goers than did the Maori Rights movement. Yet this was reversed among the non-church-goers. Most respondents believed that “Maori get a fair go in New Zealand” (ibid. p.78) and few believed the Treaty of Waitangi should be strengthened, although the non-religious groups were slightly more supportive of Maori in this respect. The figures also suggest that although “the majority are happy, [there are] real concerns”. Reference is made therefore to the capacity of New Zealanders to be “happy but complaining” (ibid. p.128) and it is suggested that two, deeply rooted, yet paradoxical, myths explain this situation: a belief in equality coexists with the belief that life should be secure and enjoyable. The following poem, expresses aspects of this contemporary anxiety.

ONE LAND, ONE FUTURE

Would you dispossess me of my country,  
 Who claim as yours the only one I know;  
 Land which slumbered, undisturbed, untouched until the Moriori came?  
 In the name of ownership, you sing your chant  
 Of hardship-driven voyages to reach this fish that Maui beached,  
 and fling the gauntlet down as challenge to my birthright.  
 I, too, was born here, and my grandparents before me;  
 Those who landed on this soil, as your forefathers did,  
 sailed as hazardous a journey to find another, better place  
 than from which they fled – some other, distant islands.  
 Like your people, mine wrought their changes,  
 damaged the bush for homes, and craft to move them onwards,  
 killed the native fish and birds for food – and play.  
 ... As much at fault, both races now should bear the blame for what was  
 done in ignorance, for the sake of preservation, not of what was offered,  
 but of the family, and the whanau. Together, then we must agree  
 they did us wrong, in many ways, your forebears as well as mine,  
 not seeing that our legacy was under threat,  
 yet destined for destruction by men who fought to keep it theirs,  
 for our inheritance. How long will it be before we share responsibility,  
 all aware that the future of our children is at stake?

(P. Golding, personal communication, 1996).

### **Glimpses of possibility**

Glimpses of a more equitable future are evident throughout New Zealand's history. They include the vision of an egalitarian society, the gradual liberation from a colonial/provincial mind-set (Simpson, 1992), legislative changes (Education Amendment Act, 1990; Mental Health Act, 1992; Health and Disabilities Act, 1996) and the gradual exposure to, and recognition of, difference. Indigenous and other minority groups are being heard, and to some extent, heeded. Their role is valuable in terms of achieving moderation (Meikle, 1989). There is increasing discussion and debate over the meanings of 'culture' and 'identity' and a proliferation of literature on these topics (King, 1985; Novitz & Willmott, 1989; Ritchie, 1992; Ihimaera, 1994; Belich, 1996).

Piddington (1994) suggests that Pakeha are becoming more sensitive to difference. In the 1950s, few Maori words were understood or used and those that were were often derogatory or mispronounced. Today words like 'aroha'<sup>23</sup>, 'mana'<sup>24</sup> and 'kia ora'<sup>25</sup> are more common and greater effort is being made by many Pakeha to correctly pronounce Te Reo<sup>26</sup>. Attempts are also being made to resolve complex cultural issues. Tribal land and resource claims are slowly and painstakingly being settled despite

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<sup>23</sup> Love, pity, sympathy.

<sup>24</sup> Influence, authority, prestige.

<sup>25</sup> Hello, May you have health.

<sup>26</sup> Maori language.

threats from “John Birch Pakeha [and] fundamentalist radical Maori” (Meikle, *ibid.* p.57). A valuing of harmony, on one hand, prompts an avoidance of ‘stirring things up’. Yet also recognised is the need to settle grievances because ‘they are not going to go away’. However, alongside collaborative effort and evidence of cultural inclusion, there is also uncertainty, confusion and resentment.

Blythe (1994), for example, warns that the Treaty can be seen as a Gordian knot, its power dependent upon its ambiguous definition. Scott (1995 p.148) questions the validity of the Treaty of Waitangi, citing historian Ruth Ross’s conclusion that “to persist in postulating that this was a ‘sacred compact’ is sheer hypocrisy”. King (1985) sees the Treaty as a powerful symbol of national mythology in a more positive way and, in New Zealand’s most recent social studies curriculum (1997), the imagery of plaited flax symbolises the integrated nature of strands and processes. Like Ihimaera’s (1989) analogy of the rope, these intertwining strands offer the possibility for collective strength on one hand and, on the other, acknowledge that there are times when the rope may thin, perhaps to only one strand. Ihimaera argues that the Waitangi debate similarly entwines all New Zealanders and that they can neither stop, nor avoid the issues involved. The relationship between Maori and Pakeha, although divisive, is also passionate. Mulgan (1994) suggests that a country without values or vision is a country in real crisis. But the questions remain: whose values and whose vision?

### **The current situation: an overview**

Most New Zealanders have grown up believing New Zealand to be an egalitarian society, yet they have also lived with and/or perpetuated an element of racism. Living in contemporary New Zealand means being aware of ‘things cultural’ in a way perhaps unprecedented in recent history (King, 1985). It means being increasingly aware of Maori presence and encountering the greater ethnic diversity occurring through immigration. Yet, while New Zealanders continue to hope for peace and prosperity, however defined, they remain variably committed to redressing racial inequalities.

In nursing, the traditional humanitarian threads persist alongside new insights and emphases. Examining the nature of nursing over time, Bishop (1996) suggests that an age-old moral sense commits nursing to foster the health and wellbeing of the people it serves and that, furthermore, it is this moral sense that motivates changes in nursing. In nursing, the notion of ‘good’ (Bishop & Scudder, 1990) links with humanitarian concepts of equality, justice, respect for dignity and individual difference and, as ‘new’ knowledge is acquired, nurses cannot easily refrain from extending their commitment.



Thus, when the poorer health statistics of Maori were made known (Pomare, 1980; Pomare & de Boer, 1988), it became increasingly difficult for nurses to oppose measures designed to address these differences.

As nursing has focused more on the manner in which its services are delivered, efforts have been made to illuminate the qualitative dimensions of nursing practice (see for example Leininger, 1978b; Watson, 1985; Benner & Wrubel, 1989; Bishop & Scudder, 1991). 'Caring' has been 'recaptured' as a central philosophical tenet. The New Zealand Nurses Organisation (NZNO) Code of Ethics defines caring as "an involvement of self in a real concern for the well-being of another", stating also that "it is experienced rather than measured" and that its "complexity defies neat definition" (New Zealand Nurses' Organisation, 1995, p.10). Yet always problematic is that such qualities are taken for granted by society. Nurses are often expected to care and to continue caring in the face of inadequate resources and lack of tangible support for this ideology (Kurtz & Wang, 1991). This does not mean that nurses do not wish to be known as caring, or that they reduce their efforts to care. However, the tension inherent in balancing an ethic of care with economic rationalism is undeniable.

New Zealand nurses have been, and are constantly, faced with the practical limitations that are imposed on health care delivery. They must juggle their priorities with those of the patient, others in the health team and the employing institution. Inevitably, decisions made in favour of one area mean that support in other areas is compromised. Barriers in the past related to access, a lack of nursing autonomy, limited understanding of others and inadequate resources. They were also societal in terms of attitudes to women and Maori. But have things really changed?

The image of nurses as missionaries is no longer common in New Zealand. The image of 'a doctor's handmaiden' is also beginning to change. Street (1992) presents evidence that Australian nurses recognise and resist medical power plays and personal experience leads me to conclude that New Zealand nurses are similar in this respect. The transfer of nursing education from hospital-based programmes to the general system of education has, to some extent, reduced medical dominance of nursing in New Zealand (Chick, 1983). Increasing awareness of the influences of power on health care delivery has prompted changes within nursing education. Research, and other writing, by New Zealand nurses from the critical, feminist and post-modern paradigms (Perry, 1985; Ramsden, 1990a; Carryer, 1997) is further challenging nursing's philosophies and taken for granted assumptions. But voice and the capacity to be

heard are hardy perennials. Contemporary nurses must compete with others who are also clamouring within an increasingly competitive and culturally diverse society.

Such observations illuminate the ever present interplay between the 'what we ought to be' and the 'what we are' in nursing. Given that nursing is a situation-specific activity (Christensen, 1990), both continuity and change coexist because it cannot be otherwise.

For good or ill, a person is affected to the core by ... social history, ... membership of family, neighbourhood and class.... Hence ... much that we wish to improve in nursing may have to wait upon changes in society itself (Salmon, 1982, p.69).

However, it is also possible for nursing to contribute to and stimulate change in society.

The success or failure of any major change in a community service will ultimately be decided by the community expressing its views through its political leaders. This does not spare us from the responsibility to live and plan at the level of the ideas of our time (ibid. p.79).

## **Conclusion**

This chapter has focused primarily on interpreting the past in order to facilitate understanding of the present. Like Gadamer, I have assumed that the influences of history are continuous. "One of the conditions of understanding in the human sciences is belonging to tradition" (Gadamer, 1996, p.328) and for Gadamer, the notion of 'tradition' comprises the shared understandings that reside in and through language, history and culture. Important too, is the recognition that multiple traditions coexist and interpenetrate simultaneously.

New Zealand nurses share understandings with their overseas counterparts yet they have also been influenced by understandings that relate specifically to events in New Zealand. This study's exploration of the accounts given by nurses of their experiences recognises that interpretation is shaped by past understandings and strong evaluations or prejudices (Taylor, 1985; Gadamer, 1996). The interpretation of such experiences influences and is influenced by 'being a nurse' and 'being in New Zealand'. Engaging with the cultural and historical horizons of New Zealand nursing is thus a means of entering the hermeneutic circle of understanding. It is a way of beginning to illuminate the experience of nursing a person, or people, from cultures other than one's own.

In the next chapter, the values of nursing and New Zealand cultures culminate in Kawa Whakaruruhau or cultural safety in nursing education. Against a background of contradictory meanings, New Zealand nurses are grappling with new notions of egalitarianism. Nursing's future requires the building of new partnerships and, for some nurses, there are new visions in the making.

### **Chapter Three: Exploring the meanings of culture in New Zealand nursing**

Culture can be defined in terms of:

A philosophical base  
A way of living in the world  
Attitudes, behaviours  
The individual's role in society  
Links and relationships with others  
(Ramsden, 1992, p.21)

In the previous chapter, a background for the study was set in terms of the discourses and philosophies dominant both in New Zealand life generally and in nursing's development. This chapter seeks more specifically to explore the meaning of culture within the context of New Zealand nursing.

Nurses engage primarily with the concept of culture through the people whom they nurse. 'Culture' is a term that is often used very loosely in nursing conversation yet, within the discipline internationally, substantial literature related to the topic exists. A retrospective analysis of the concept of culture in nursing by Hagey (1988) suggests that definitions of the term 'culture' have changed from early associations with physicality to interpretations based on anthropological understandings. Although this statement describes early understandings of the term culture, examination of New Zealand's nursing literature demonstrates that the meaning of culture has evolved beyond an anthropological interpretation. It is clearly evident that awareness of cultural issues in nursing has changed quite significantly in the past decade. From a situation of relative invisibility, culture as a concept became very visible in New Zealand nursing during the early 1990s. Although there had always been interest in, and literature contributions on, the topic of culture in nursing by nurses individually, the profession as a whole faced sudden and considerable public and political outcry over the introduction

(in 1992) of 'cultural safety' in nursing and midwifery education and culture, interpreted sociopolitically, became a potentially divisive force. This chapter traces the evolving meaning of culture in New Zealand nursing.

### **Colonial Meaning: Nurses as bearers of 'civilised' health care**

During the colonial era, culture had meaning in relation to a 'racialised other', in this case, Maori (Sinclair, 1960; Richie, 1963; Metge, 1964). In the first two decades of this century, articles on "Nurses for Maori", "The Health of the Maoris" and "Nursing the Maoris" were published regularly in the *New Zealand Nursing Journal (Kai Tiaki)* demonstrating nursing's interest in and commitment to Maori, especially in public health and district nursing settings. Reference to the 'Natives of New Zealand' was also popular. Thus culture, for nurses of this era, has meaning in terms of the visible differences between the Maori and the settlers.

Nightingale, whose influence on New Zealand nursing was discussed in the previous chapter, is known to have supported the view that native people might be simple-minded but they were quite equal in knowledge and intelligence to those who had had greater social advantage (Nightingale, 1865, in Hagey, 1988). Nurse Street, a 'backblocks'<sup>27</sup> district nurse in 1911, speaks of the "difficulty [of] the entirely different view taken by a very intelligent people, only partly civilised, and the highly and scientifically trained nurse" (Street, 1911, p.110), and Lambie (Director of the Division of Nursing), writing retrospectively about colonial nursing, implies that the 'Native race' was both fortunate and in need of civilising:

It was natural that when such attention was being given to the European population some thought should be given, in this enlightened era, to the care of the Native race New Zealand is responsible for, and it was felt that the same principle of appointing a nurse to work amongst their homes would be the best method of dealing with this complicated problem (Lambie, 1960, p.11).

Inherent in the nursing interpretation of an indigenous people as 'racialised other' is an assumption that Maori lack the advantages of British civilisation. In the late nineteenth and early twentieth century, culture was recognised largely in terms of the differences between 'primitive' and 'civilised races' and nurses are humanitarian bearers of 'civilised' health care. The nurses' feelings of responsibility towards Maori are patronising by contemporary standards but, at the time, the notion that 'native races' should receive the 'same' treatment as 'Europeans' was quite radical. Associated with

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<sup>27</sup> A lay term describing New Zealand's remote rural areas.

the notion of 'racialised other' is a view of Maori as deserving equal health service provision.

Members of the New Zealand Registered Nurses Association (NZRNA) also speak positively of those who earlier had "blazed the trail" in public health nursing (National Public Health Committee of the New Zealand Registered Nurses' Association, 1956, p.12) and of the "great foresight" of the nursing leaders who "took every opportunity to champion new developments" (ibid. p.9). Another excerpt from the above report by Miss Lambie is exemplary:

These early nurses experienced great difficulty as they had to live very isolated lives ... the Maoris did not understand their work.... Probably no one will ever realise the heroic deeds these women carried out so quietly and devotedly (Lambie, 1960, p.11).

This excerpt hints at the misunderstandings between Maori and Pakeha and written retrospectively, an awareness of less than hoped for outcomes is evident. Yet there are other, perhaps unrecognised, tensions. Although the willingness to endure hardship and forgo personal comfort and the familiarity of one's own culture is facilitated by the nurses' humanitarian beliefs, also co-existent is the quest for professional recognition in a society that believes in the necessity of Maori assimilation to European practices. In relation to the Native Health Nursing Scheme, for example, McKillop (1998) acknowledges the praise given by Health Department officials to these nurses for successfully converting Maori to Pakeha ways.

The notion of the nurse as a 'benevolent and knowledgeable bearer of civilised health care' is also evident in relation to nursing's "service in other lands" (Rattray, 1961, p.98). New Zealand nurses wrote proudly of their involvement in the educational preparation of nurses in the Pacific Islands (Lambie, 1956; Salmon, 1984). In addition to being exciting and challenging work, such activity was believed to be important in terms of advancing both nursing's status and New Zealand's position in the Pacific.

Associated with the sense of adventure and 'missionary zeal' conveyed in these early nursing stories is the view that the cultures of others are visible as 'other' because they are 'different from' and 'unusual' or 'exotic' when compared with that of the nurse. Although Maori may have been regarded as 'primitive', they were also seen as possessing desirable qualities.

Natives did not do exercises. They danced instead. And because they danced with their bodies, not solely with their feet, like Europeans, it did them more good than exercise did Europeans. As a result they did not suffer from constipation and had better sex lives - between which there was a direct correlation (Tolerton, 1992, p.227).

Thus the positive acknowledgment of Maori potential and physical prowess has connotations with other as 'noble savage' (Blythe, 1994) and the tragic image of the dying out of Maori, as the noble savage, irresistibly taunts the Pakeha conscience (McKillop, 1998).

A little over one hundred years ago New Zealand was peopled by Maoris who were a virile Polynesian race of splendid physique. The Maori of that day could have taught his white brother much in the way of healthy living; and many of his religious practices were merely laws of good public health. The Maori villages were clean and unpolluted and their diet well balanced. There were large numbers of aged people which leads us to believe that there was little or no tuberculosis, and there did not appear to have been much in the way of other infectious disease (NZRNA, 1956, p.9).

This statement is also made with the benefit of hindsight. Reflection on the past facilitates a beginning awareness that the settlers may have contributed to health inequalities for Maori, yet at the time, such insights did not exist.

The nurses' backgrounds were predominantly British and most nurses lacked understanding of different health beliefs and practices. Much of the assistance offered to Maori is therefore unwittingly inappropriate. The relationships between culture and nursing are not visible and neither the nurses nor the public have considered the impact of cultural difference on health and illness. Yet it is not coincidental that Maori morbidity and mortality rates continue to worsen (Pomare, 1980; Pomare & de Boer, 1988; Chick & Madjar, 1993).

There are, however, notable exceptions, particularly among those nurses who are aware of and sensitive to Maori beliefs. The approach taken by Nurse Robinia Cameron, during the 1920s, provides early evidence of bicultural nursing service.

Nurse Cameron spoke to the chiefs, and was able to set up health clinics on the marae. With the help of concerned Europeans, she gave lectures and presented films on health, and helped the Maori women to form health committees (Brell, 1991, p.122).

Cameron's continued involvement with Rangī Royal and Ngahuia Raharuihi<sup>28</sup> led to the formation of the Maori Women's Welfare League in 1951 and the establishment of other marae-based centres offering the services of doctors and nurses alongside those of traditional Maori healers (Brell, *ibid.*). Thus, Nurse Cameron's understanding of the relationship between culture and nursing appears more consistent with the contemporary notion of negotiated and equal partnership as articulated by Ramsden in 1992 (see page 47 for further discussion).

In her reports to parliament during the 1930s, Lambie also speaks of nurses liaising with Maori communities through regular meetings and their support of the Women's Institute because of its patronage by Maori. Although noting the importance of "stimulating pride in the race [because] no race can progress unless it is conscious of its own ability and aware of its own defects" (Lambie, 1935, p.55), one cannot help but wonder, however, which of these received the greater emphasis. The following excerpt from an article published by nursing members of the National Public Health Committee recognises some of the adverse effects of the so-called 'civilised' British lifestyle, but continues to emphasise the contribution of Maori deficiencies.

The Maori left his own village and came into closer contact with the new European settlers. He also became 'civilised' and in doing so, dropped many of his barbarous habits, but also, unfortunately, he gave up his healthy way of living. His diet became poor. He no longer fished and hunted, but bought tinned food and ate refined starches instead of his root and fern bread. His clothes were a poor imitation of the white man's, and he forgot to keep them as clean as he had kept his flax mats. He became soft and lazy and the very existence of his race was threatened by the huge death rate from infectious diseases (NZRNA, 1956, p.9).

This description vividly portrays what we now recognise to be the impact of colonisation on the health of indigenous people see (see Durie, 1988; Nairn, 1990; Ramsden, 1990b; Ramsden, 1990c). Strong beliefs about cultural superiority largely precluded understanding, by Pakeha, of the negative consequences of colonisation on the health of Maori. Believing their health services to be valuable, the settlers overlooked the fact that the need for such services by Maori, was often related to the introduction of diseases previously unknown among Maori and the escalation of suffering through warfare and the introduction of technologies such as muskets and gunpowder.

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<sup>28</sup> Full name provided by Inez Kingi personal communication, September, 1999.

Prior to the mid-1900s then, culture was interpreted by New Zealand nurses principally as 'racial other'. Indigenous and settler cultures were perceived to differ in terms of their physical characteristics and levels of civilisation and nurses, despite altruistic intentions were, for the most part, certain of the superiority of their values, beliefs and practices. Several decades would pass before cultural difference was considered in the provision of nursing care.

### **The relative invisibility of 'culture' in nursing**

Throughout the middle years of this century, nursing's interest in cultural difference appeared to decline. Relative prosperity, the rural situation of Maori vis-a-vis most Pakeha, and the increasing dominance of a medical model of health care contributed to a decrease in knowledge and recognition of Maori values and health beliefs, particularly in the urban areas (Chick & Madjar, 1993). Nursing was also focusing inwardly on its quest for professional status. Major changes in nursing education were being mooted (Carpenter, 1971). The Nurses' Act 1971 had established the Nursing Council of New Zealand as a corporate body and improvements in nursing services were being planned (New Zealand Board of Health Committee on Nursing Services, 1974).

Stories about cross-cultural public health and psychiatric nursing experiences continued to appear in *Kai Tiaki* (Taylor, 1967; Withy, 1967; Matheson, 1973). However, although definitions of health were expanding to embrace holism, and thus to include culture, the practice of nursing remained oriented towards that of western medicine and the technological advances which had been precipitated by the World Wars. Perhaps too, Maori seemed less exotic? Perhaps the novelty and excitement of 'backblocks' nursing had worn off? Or were Maori now regarded as less deserving? Between 1926 and 1936, only 10% of the Maori population lived in urban areas, but by 1971 this had increased to more than 50% (Pomare, 1980). Generally concentrated in the lower income groups and least favoured types of accommodation, Maori were regarded as 'undesirable' by urban landlords (Thompson, 1977) and, as illuminated in the previous chapter, discriminatory attitudes were rife.

### **The emergence of an 'anthropological' understanding of culture**

Signs of nursing interest in people from other cultures persisted, however, and, like their international counterparts, many of the New Zealand nurses who chose to extend their education did so at university in the areas of social science and the humanities. Among the more popular subjects were those of psychology, social anthropology and



comparative religions. Several of the nurses who were to become prominent in New Zealand's nursing education gained their academic qualifications in these fields, initially internationally and then, in nursing, in New Zealand.

An appreciation of the relevance of anthropology to nursing began in 1960s in the USA. Morse (1988), in reference to cross-cultural nursing, cites as catalytic the papers by Jewell (1952) and Zborowski (1969), which challenged the belief that people should be treated the same, regardless of nationality and cultural background. The establishment of the Council of Nursing and Anthropology in the USA in 1969 first demonstrated nursing's interest in cultural issues (Morse, 1988) and, in the early 1970s, Madeleine Leininger introduced the notion of transcultural nursing to describe the fusion of nursing and anthropology (Leininger, 1970; 1978a).

Thus, as the utility of the various anthropological sub-disciplines (physical, social, cultural and psychological) was recognised (Brink, 1984), 'culture' in nursing came to have meaning in terms of the shared values, beliefs, traditions and disease susceptibilities of particular groups. Attention focused on acquiring knowledge about the cultural beliefs and health practices of various ethnic minority groups (Leininger, 1970), the formal development of cultural assessment tools (Tripp-Reimer, Brink, & Saunders, 1984) and the generation of an all-encompassing nursing theory based on the concepts of culture and caring (Leininger, 1978a; 1978b). The 'Sunrise' model was developed by Leininger to assist nurses towards a holistic view of the patient's cultural world and the theory of "Culture Care Diversity and Universality" (Leininger, 1991), focused on the development of culturally congruent nursing care.

Yet the theory of cultural care which Leininger advocated did not impact significantly in New Zealand, perhaps because the theoretical articulation of nursing practice by North Americans was perceived to have little practical relevance by nurses whose education had been confined by an apprenticeship model. At the time, culture was only minimally recognised in New Zealand nursing under the umbrella of holism. Then gradually, as nursing education moved into the tertiary education sector, further development occurred as the social science subjects of psychology, sociology and anthropology were introduced nationally into undergraduate curricula.

### **The beginnings of a ‘sociological’ interpretation of culture<sup>29</sup>**

North’s (1979) publication “The Nurse, the Patient, and Culture” provides the earliest substantial evidence that cultural awareness was developing in New Zealand nursing. Yet, this too, was a largely overlooked contribution. North’s experiences as a missionary in Nepal had contributed to her interest in cross-cultural nursing. Thus her initial motivation towards understanding had little to do with Maori (N. North, personal communication, August, 1999). In hindsight, the apolitical nature of both the writer and her writing appears to have contributed to its minimal impact. North was not a nursing leader and nor was she Maori, as was Ramdsen (1990d), who was credited later with the introduction of cultural safety (for further discussion, see page 46).

For North (ibid.), culture was an elusive, complex and “man made”, rather than “natural”, (p.8) phenomenon. Early anthropological emphases on habits, customs and artefacts were expanded to include understanding of the systems of thinking underlying patterns of behaviour. The notion of enculturation, for example, was significant because it explained the means by which culture was reproduced. Other important insights included culture’s independence from personality, its diversity and its dynamism. Recognition of the generally unconscious, and therefore naively ethnocentric nature of culture, provided further evidence that its meaning was evolving to acknowledge the contribution of social factors. Strong emphasis was placed, therefore, on the nurse becoming aware of the influence of culture on the development of his or her own behaviour and values.

For a nurse to give good care to a person from another culture, knowledge of cultural variations is not enough. Sensitivity must extend to the point where behaviour is modified. Attitudes are accepting and judgements suspended (North, 1979, p.12).

Yet North also acknowledged the difficulty of achieving such an ideal:

... the task of lifting it [culture] into consciousness is a formidable one (North, ibid.).

In making recommendations for practice, she recognised the need for effort to be directed towards “analysing ones’ own behaviour”. Also acknowledged as necessary was the “willingness to give up habitual ways” of behaving if and when these conflicted with those of the patient’s culture. Emphasis was placed on respecting difference,

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<sup>29</sup> The heavy use of quoted material from North serves two purposes: Firstly, it enables others to evaluate my interpretations and secondly, it increases the visibility of work not utilised in the development of cultural safety.

displaying patience, compassion and acceptance. But, because raising the nurses' level of sensitivity was "meaningless unless [they] carried over into practice", nursing action needed "to extend to the point of reinforcing the values of the other culture". North therefore recommended that nurses record their experiences for the purpose of sharpening clinical powers of observation. She advocated using the mental practice of "standing in the shoes of others", deliberately seeking opportunities for interaction with people from other cultures and communicating information, both verbally and in writing, to others in the health team (ibid. pp.26-27).

Clearly evident in North's work is an understanding that knowledge of cultural differences on its own, does not necessarily improve the quality of nursing care. Nurses' attitudes are also centrally important because of their insidious influence on behaviour. Thus North places emphasis on action, not rhetoric, yet the focus of change is the nurse rather than social structures. At the intra-personal level, improvement is dependent upon the development of nurses' capacity for critical reflection on practice and at the interpersonal level, nurses are exhorted to become pro-active in their support of others' differences. Allied to this argument is a strong belief that such learning is best gained clinically because these contexts provide an opportunity for nurses to communicate their understandings to other members of the health team.

There is much in this work that is similar to Leininger (1978, 1991) and Ramsden (1990a). Each of the authors recognises the significance of the relationships between nursing, culture and health. Each also recognises the tendency towards ethnocentrism in nursing. Yet their backgrounds, the contexts in which they are writing, and the solutions sought, vary considerably. Leininger has had access to resources that assist the dissemination of knowledge and it is clear that "the circle of contagiousness" (Meleis, 1991, p.232-233) has been a factor in the "geographic spread" (Stevens Barnum, 1994, p.191) of her work. In addition to travelling widely herself, Leininger has published prolifically. She has also established post-graduate speciality courses, the Transcultural Nursing Society, the *Journal of Transcultural Nursing* and has been the instigator of numerous international conferences.

North, in contrast, was one of few nurses engaged in tertiary study in New Zealand at a time when there was neither the funding nor a sufficient groundswell of nursing support to ensure the visibility of her contribution. Recognising the influence of attitudes on behaviour, she, like Ramsden, sought changes in nursing practice. But North's was a lone voice and, like Leininger, she focused attention on the nurse, rather than the

impact of historical and sociocultural contexts on the interpretation of meanings and their practical effects. Significant change in New Zealand nursing waited upon a reinterpretation of culture that was inextricably linked with biculturalism and the politics of power.

### **The emergence of a 'sociopolitical' meaning of culture**

In the 1980s, against the background of a visible resurgence of Maori interest in the Treaty of Waitangi and legislative encouragement of bicultural developments in health (most significantly, the Treaty of Waitangi Act, 1975), changes began to appear in education, the practice arena and in the cultural emphases of nursing publications. Between 1976 and 1982, individual Pakeha nurses attended anti-racism workshops run by New Perspectives on Race (Nairn, 1995). A seminar on cultural issues, attended by the Heads of New Zealand's nursing schools was held in 1980 (I. Sherrard, personal communication, August 1999). Maori nurses similarly "reflect[ed] and find [found] voice" (Nairn, *ibid.* p.5), a hui<sup>30</sup> held at Te Puea Memorial Marae, in 1984, calling for changes aimed at improving Maori health. The National Council of Maori Nurses was formed at this time. Then in 1985, following the launching of Project Waitangi, anti-racism workshops were introduced for staff at Auckland Hospital. In 1986, a memorandum from the Department of Health (1986) required that the Treaty of Waitangi be incorporated into the health services and, throughout New Zealand, Area Health Boards and Schools of Nursing began incorporating anti-racism and the Treaty of Waitangi into their policies and curricula.

Articles, in the *New Zealand Nursing Journal*, by Sherrard (1984) and Hault (1984; 1987) described courses and strategies designed to help raise students' awareness of both their own and other cultures. An extensive feature on Maori Health entitled: "A real need for understanding", was published in 1985. Including extracts from several sources (ie. seminar addresses, Department of Health circulars and reports of hui experiences), its aim was to assist nurses towards a "wider and deeper understanding of Maori culture" (Bazley, 1985, p.5). A further three-part series presented by Abbott (1987a; 1987b; 1987c) discussed survey information relating to the inclusion of Taha Maori<sup>31</sup> in nursing curricula.

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<sup>30</sup> meeting; gathering of people for a purpose

<sup>31</sup> the Maori dimension

The workshops promoted by the Department of Health in 1986 and 1987 (see the Review of the Preparation and Initial Employment of Nurses (RPIEN) 1991), recommended that nursing education be committed to biculturalism. Concern was expressed by the nurses participating in the workshops that Taha Maori was often “tacked on” rather than being pervasive throughout curricula (ibid. p.22). Ongoing discussion between the Council of Maori Nurses and the RPIEN National Action Group thus led to the formation of guidelines for bicultural development in nursing and, based on the following philosophy, culture in nursing came to be associated with biculturalism.

Biculturalism in Aotearoa has its roots in Te Tiriti O Waitangi and has the potential to be a driving force behind the aspirations of national solidarity. However, biculturalism requires systems of relationships which promote power sharing, understanding, mutual respect for language, lifestyles and beliefs which could lead to beneficial interaction between the two major and inter-dependent cultures (Cooper as cited in RPIEN 1991, p.9).

Biculturalism, in this statement, acknowledges Maori and Pakeha as New Zealand’s two major cultures. The interdependence of these cultures is claimed to derive from the Treaty of Waitangi and it is argued that New Zealand’s future depends upon the development of systems that facilitate the sharing of power. Although continuing to include the anthropological notion of shared group practices as manifested in language, lifestyle and beliefs, the meaning of culture in nursing has started to become more explicitly political.

In August 1987, the Auckland branch of the National Council of Maori nurses hosted Madeleine Leininger. Following what was perceived to be a valuable discussion of cultural concepts and experiences in nursing, the Maori nurses present concluded that the first commitment of nursing and other health bodies in New Zealand was to biculturalism. Leininger’s conceptualisation of transcultural nursing was perceived to parallel that of Taha Maori in the nursing curriculum. The practical implementation of bicultural principles and practices were therefore argued to be prerequisite to transculturalism in New Zealand nursing (McKinney, 1988). Cooney (1994) contends further that although the transcultural model may be sufficient to guide effective nursing, the bicultural model developed by Ramsden (see below) differs significantly in that it proposes a partnership strategy.

Also demonstrating the sociopolitical meaning of culture was an article entitled “The white nation has a lot to answer for” (Bickley, 1987). Using Sivanandan’s Marxist-

inspired theory of racism as a framework for analysing the relationships between Maori health and government policy in New Zealand, Bickley drew attention to the part played by nurses in perpetuating oppressive state practices.

There were also articles that focused at the level of individual prejudice. Kerslake (1987; 1988) published papers outlining Samoan beliefs and cultural practice, her experiences as a nurse in a different culture providing valuable insight into cross-cultural encounters. Like North, Kerslake urged that sensitivity should extend to the point that behaviour was modified and that negative value judgements be suspended in favour of attitudes that accepted difference.

A contribution by Boddy (1988) more explicitly focused on culture in nursing as having meaning in terms of the differences between Maori and Pakeha views of health and illness. Attention was drawn to the conflict between western notions of holism which, in relation to lifestyle disorders, assume individual responsibility for health, and Maori philosophies of holism as encompassing the inextricably interrelated dimensions of spiritual, mental, physical and family well-being. Maori believe that the mind (*te taha hinengaro*), body (*te taha tinana*) and soul (*te taha wairua*) are closely related and inseparable from family wellbeing (*te taha whanau*) (Barham, 1986; Pomare & de Boer, 1988). Moreover, the concept of family is that of an extended kinship system that includes tribal affiliations, ancestral relationships and spiritual links with the land. Discussion of the consequences for Maori of a lack of shared understanding and description of some of the moves being made by Maori towards self-determination gives the term culture both anthropological and sociopolitical meaning in this work.

### **Nursing as negotiated and equal partnership**

It was the Hui Waimanawa (1988), sponsored by the Department of Education, which provided an impetus for significant change in the interpretation of 'culture' by New Zealand nurses. Maori students at this hui were concerned by two major issues. Firstly, there was disquiet about the socialising power of nursing education against their Maoriness and its assault on their identity. Secondly, Maori students doubted the capacity of their programmes to adequately prepare them to nurse their own people (Ramsden, 1990a). During discussion about cultural sensitivity in nursing education, a Maori student, revealing both her nursing and Maori horizons of understanding, is reported to have asked: "Why can't we go a step further than cultural sensitivity and have cultural safety?" (Wood & Schwass, 1993). Although cultural sensitivity was recognised as an essential component, its tendency towards neutrality could not

guarantee an end to discriminatory practices. Appropriating the term 'safety' emphasised the need for nurses to demonstrate that they were not only academically and clinically competent and ethically and legally safe but also that they were culturally safe (Dyck & Kearns, 1995). The notion was supported and extended at subsequent hui (in July 1989 and January 1990), prompting the development of a model of education based on negotiated and equal partnership. It also stimulated initiatives relating to the recruitment and retention of Maori students. Thus Maori visions of partnership and participation, deriving from the Treaty of Waitangi, melded with nursing philosophies of holism and humanism. Thus in addition to the acknowledged importance of physical, ethical and legal safety in nursing, tangata whenua<sup>32</sup> contributed cultural safety as a further criterion for the safe delivery of health care in New Zealand. Subsequent documents, notably "Kawa Whakaruruhau: cultural safety in nursing education in Aotearoa" (Ramsden, 1990a), heralded the implementation of this new dimension.

The definition of culture in the 1990 Kawa Whakaruruhau document included the perspective of Maori. Culture was defined as "the way groups of people do things as a result of the example of their tipuna<sup>33</sup>, their ideology, their philosophy and geography" (Ramsden, 1990a, p.12). Cultural safety in nursing education recognised the right of Maori to have their culture validated through the teaching for health practice that did not put the culture and values and beliefs of Maori at risk (Ramsden, *ibid.*).

The essential elements articulated in this document included training in understanding of the Treaty of Waitangi as preparation for participation in mutually defined partnership. Cultural content was to be negotiated with tangata whenua and facilitated by tutors who were Maori. Furthermore, responsibility for setting the standards and assessing culturally safe practice was to reside with Maori. Racism awareness training was also a significant component of the programme. Nurses were to receive information about the impact of colonisation on the health of Maori and, in relation to the practical application of culturally safe practice, it was argued that nurses had obligations regarding their approach, attitude and skills in negotiated advocacy with Maori. Ramsden (1993) argues that all nursing interactions are bicultural because the messages given and received are always filtered through the participants' cultural horizons. Moreover, the nurse is a bearer of culture who, regardless of numbers of

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<sup>32</sup> The indigenous people of Aotearoa/New Zealand

<sup>33</sup> Ancestors

people involved, can only interact with one person at a time, and thus it is essential that nurses examine the ways in which their cultural beliefs impinge on others (Walker, 1993). The aim of Kawa Whakaruruhau was not to create experts in Te Reo Maori<sup>34</sup>, Tikanga Maori<sup>35</sup> and Kawa Maori<sup>36</sup>, but rather to educate nurses towards being open minded and non-judgemental. They were not to blame the victims of historical and social processes for their plight (Ramsden, 1990d).

The model for Negotiated and Equal Partnership outlined by Ramsden (1990a) is founded on a sociopolitical definition of culture. Demanding the sharing of power, it takes a more activist stance than the works articulated by both Leininger and North. Ramsden's model is radically different in that it challenges nursing to address the health inequalities for Maori through the appropriate education of *all* nurses. North had advocated a generalised attitude change within nursing, but had not formally developed curricula strategies towards this end. Leininger had emphasised the development of such expertise and implemented programmes at the post-graduate level. Ramsden's model focused on undergraduate nursing education, although its impact was broader than this. With the Treaty of Waitangi as its base and the de-institutionalisation of racism as its aim, Ramsden's work focused at both individual and structural levels of health service delivery. The critical elements in this model provided a framework both for developing partnerships both within education and with patients in the clinical setting (Cooney, 1994).

### **Parallel developments in the practice arena**

Bicultural policies were also being developed and implemented in the practice arenas of health care during the 1980s. Consultation between local Maori tribes and representatives from health and education resulted in the commencement of several Maori health care initiatives involving nurses. In South Auckland, a birthing centre was set up at the Papakura Marae. Spiritual assistance was provided by the Te Awhina Programme at Manu Ariki Marae to complement medical health care in Taumarunui (Barham, 1986) and, at Auckland's Carrington/Oakley Hospital, psychiatric assessment and in-patient units based on Maori kaupapa<sup>37</sup> were established (Quinlan, 1988).

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<sup>34</sup> Maori language

<sup>35</sup> Maori protocols; lore

<sup>36</sup> Maori customs

<sup>37</sup> Maori agenda



At the beginning of 1985, the Director of Nursing at Auckland Hospital (Mary Futter), recognised that many hospital staff, including herself, were 'missing the point' when caring for Maori and Pacific Island patients and their families, especially in the area of paediatrics (Knight, 1989). Knowing also of the difficulties being experienced in relation to bicultural initiatives at Middlemore and Carrington Hospitals, Auckland Hospital decided that work "should begin with the Pakeha problem; that of institutional racism" (Knight, *ibid.* p.5). Thus nursing became instrumental in the appointment of a Project Worker (Pakeha and not a nurse, yet paid for out of the nursing budget) and the commencement, in 1987, of a Racism Intervention Project. Several months later, a Maori Liaison Officer was appointed and from this developed the Te Whanau Atawhai service whose role is to assist families through the experience of being hospitalised.

Also embryonic at this time was another group, Te Roopu Arahi Ki Te Ora, which comprised Maori, Tongan, Niuean and Samoan nurses. Together with Mereana Solomon (previously from In-Service Education), the group developed an orientation programme for new staff, the second day of which focused on Maoritanga.<sup>38</sup> Supporting the Treaty of Waitangi, biculturalism, and the Racism Intervention Project, the group then expanded to include all 30 Maori staff at Auckland hospital and was involved, with Te Whanau Atawhai, in developing Auckland Health Care's Bicultural Policy. The principles of partnership, participation and active protection underpin this policy. Partnership refers to the relationship between the Crown's agencies and local iwi.<sup>39</sup> Participation emphasises Maori involvement in the provision of health services at all levels and active protection implies the adoption of pro-active approaches aimed at enhancing Maori health. Thus the policies developed sought to ensure the following:

1. demonstration of the capacity to empower Maori
2. active involvement, by Maori, in public health services
3. the elimination of practices offending or marginalising the cultural and spiritual safety of Maori, and
4. the building of a responsive health service that protected Maori intellectual, cultural and spiritual property rights (Te Whanau Atawhai, 1996).

A number of Pakeha nurses, inspired through attending a Treaty of Waitangi and Racism Intervention workshop, also became active in the setting up of a Bicultural

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<sup>38</sup> Maori culture  
<sup>39</sup> tribes

Action Group. In liaison with tangata whenua, these nurses sought to implement practical changes that would enhance the cultural safety of Maori patients in their working environment.

But the progress towards biculturalism has not been easy and the responses have been mixed. On two occasions, the Project Worker's office was broken into and vandalised. There were times when posters, advertising public meetings on the subject of biculturalism, were ripped down (Knight, 1989), and in relation to racism workshop attendance, the numbers of nurses significantly outweighed those in the institution with greater power and influence. Medical staff, in particular, saw little need for such education. Desmond Beckett, Medical Superintendent at Auckland Hospital, expressed his regret at having failed to get "the junior doctors involved" in the Treaty workshops. He explains further:

I have negotiated with the chiefs of the hospital and ... the medical school staff ... they are just too busy to be spared.... My response is that if it were a three-day conference on medicine in Wellington they would find time to go, but because it's a seminar on race relations ... taking place in this hospital, they're too busy (Knight, 1989, p.15).

Thus there are changes that demonstrate commitment to a bicultural health service. There is also evidence of an increasing awareness that people from non-Pakeha cultures need to be treated in accordance with their own cultural values. Yet the road is not smooth, as can be seen in the next section, and the outcomes, in terms of long-term behavioural change, remain uncertain.

### **The heightened visibility of 'culture' in nursing**

Culture in nursing became visible as 'cultural safety' in 1990 with the adoption of Kawa Whakaruruhau by the Nursing Council of New Zealand. Guidelines were then published to assist implementation of the principles of cultural safety in nursing and midwifery education (see Nursing Council of New Zealand, 1992). Culture was defined in this document as including:

A philosophical base, a way of living in the world, attitudes, behaviours, the individual's role in society and links and relationships with others (Nursing Council of New Zealand, 1992a, p.1).

However, the ongoing discussion focused on tendencies towards ethnocentrism and the effect of the negative attitudes, held by people in power, on the health of those in minority groups.

When one group far outnumbers another or has the power to impose its norms and values upon another, a state of serious imbalance occurs ... creating a state of disease (ibid. p.1).

Nursing's relationship to such "disease" was then explained and supported by statistics which revealed Maori death and morbidity rates to be higher than those of non-Maori (Pomare & de Boer, 1988).

The health of people can be placed at risk by an unaware nursing and midwifery workforce operating from assumptions and stereotypical attitudes. This results in serious impairment to service delivery (Nursing Council of New Zealand, 1992a, p.1).

Thus it was argued that cultural safety:

[M]ust begin with the tangata whenua ... because of the serious health status of the indigenous people of Aotearoa and the real possibility of the disappearance of culture and language under the stress of colonial history and the concept of a 'global village' (ibid. p.4, emphasis in original).

Although cultural safety seeks access to health services for all groups of New Zealanders who are culturally different, redressing the long-term consequences of colonisation and monoculturalism for Maori as indigenous people remains the priority. Since 1989 the Nursing Council of New Zealand has worked with Maori to translate the Treaty of Waitangi into meaningful education and practice outcomes (see Nursing Council of New Zealand, 1996).

### **Cultural safety in nursing education**

Cultural safety programmes focus on attitude change through a process of education that analyses history and power relationships and seeks change where the consequences for health are negative. Although knowledge of tikanga Maori<sup>40</sup> and kawa Maori<sup>41</sup> is recognised to be important, an understanding of the poverty cycle, history, demography, social control mechanisms and other sociopolitical barriers to health is argued to be essential. But, further than this, implementation requires close collaboration between Maori and non-Maori in relation to course content, teaching and evaluation.

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<sup>40</sup> Maori protocols, lore

<sup>41</sup> Maori customs

Education in cultural safety seeks to engender understanding of the pervasive effect of unconsciously held values and attitudes. The course content includes Pakehatanga,<sup>42</sup> revisionist New Zealand history, institutional racism, Maori health initiatives and the international view (Nursing Council of New Zealand, 1992a, p.7). The programmes aim to produce “culturally safe registered nurses and midwives, **not** amateur ethnographers” (ibid. p.10, emphasis in original). Teachers are expected to attend racism awareness workshops and tools appropriate for evaluating culturally safe behaviour are being developed. It is also expected that education in cultural safety should not, “by its very nature ... place the culture of others at risk.... It should be free of threat or guilt” (ibid. p.6). Furthermore such preparation should enable nurses and midwives to “practise safely in any community which is different from their own” (ibid. p.9, emphasis in original). Yet these goals remain idealistic given the controversial nature of the course content and a definition of culture that focuses on Maori-Pakeha relationships.

### **Responses within nursing education to the introduction of cultural safety**

Although many Polytechnic teachers are, and have been, supportive of the Treaty as an essential foundation in nursing education (Murchie & Spoonley, 1995), several have expressed concern. Sherrard (1991) suggests that confusion is evident between the two different, albeit related concepts: the Treaty of Waitangi and the notion of cultural safety. The Treaty, as an agreement between sovereign nations for their mutual benefit (Reid, 1988), had been re-interpreted by political developments since the 1980s to outline the parameters for a bicultural relationship. Although health was not specifically mentioned, the critical issues of governance, authority, culture and equity were argued by Reid (ibid.) to be central both to the Treaty and to Maori wellbeing. Within the notion of cultural safety, wellbeing refers to both Maori patients and Maori nurses. Maori patients must receive nursing care as Maori and Maori nurses should have a sense of worth both individually and as members of their whanau, hapu and iwi where appropriate. Not only are Maori values to be accepted and understood but the effects of colonisation on health must be appreciated.

While acknowledging the need for nurses to understand the effects of colonisation, Sherrard expresses concern that the creation of a burden of guilt may adversely affect students' capacity to be culturally safe when nursing Maori. Furthermore, the principle that cultural safety be assessed by those from the culture at risk (ie. Maori) is

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<sup>42</sup> Pakeha culture

recognised as problematic. Nurses acknowledge that all people require culturally appropriate care and, moreover, that such care needs to account for individual differences. As with all holistic assessment, the evaluation of nursing care is therefore argued to best take place within the context of that care. Thus, there is concern about the Council's intentions to use the State Examination to assess the cultural safety of nursing candidates (Sherrard, *ibid.*) because correct theoretical answers cannot guarantee the provision of a culturally safe nursing service.

A group of 14 tutors from Waikato Polytechnic published additional concerns in the New Zealand Nursing Journal in 1992. The group had written to the Nursing Council of New Zealand about a perceived lack of consultation and concern that open debate was being hindered for fear of being labelled racist or part of a Pakeha backlash. The Council responded by speaking of the positive feedback it had received thus far and reiterating its support of open debate. However, no action was taken to help resolve the concerns expressed.

Another development which followed the introduction of Kawa Whakaruruhau was that of the PARALLEL programme at Waikato Polytechnic (O'Connor, 1993). After considerable consultation and debate involving Maori communities, the polytechnic, Maori students, the Area Health Board and other health agencies, a parallel comprehensive programme, for nursing students identifying as Maori, began in 1993 with the approval of the Tainui Maori Trust Board. Having experienced hostility and misunderstanding in relation to the implementation of Kawa Whakaruruhau, the tutors involved sought to totally integrate Kawa Whakaruruhau philosophies throughout the programme. They envisaged that Maori graduates would have modern nursing skills balanced with Maori skills and thus be acceptable to their own people.

The philosophy is not one of a separatist nature as some would deem it, but it is a real attempt to have other areas of knowledge recognised as having equity with the mainstream paradigm commonly practised within Aotearoa for the past 152 years (O'Connor, 1993, p.17).

At a critical point in New Zealand's history many in nursing education were attempting to move from rhetoric to action, but they were ill prepared and minimally supported in this vision. Despite government policy encouraging institutional moves towards biculturalism, the position of Education Officer in Maori Health was dis-established in 1989, a decision argued by Ramsden (1997) to seriously jeopardise the ongoing development and monitoring of national teaching and evaluation standards. The

announcement (in 1993), that 20% of the State Examination would relate to culturally safe nursing practice drew angry student response and a hostile media reaction.

### **Cultural safety becomes synonymous with 'political correctness'<sup>43</sup>**

Cultural safety had catapulted nursing into the headlines. At a time when employment opportunities for nurses were lessening, because of needs to curb health expenditure, the education of nurses was being challenged. The balance between the theory and practice components of nursing education had remained controversial since the transfer of nursing education from hospital apprenticeship to the tertiary sector. The inclusion of cultural safety in education was thus perceived to preclude and reduce other more essential curriculum content (David Wills, national director of the Nurses Society, as cited in Forrester, 1993) and some students perceived their visions of registration and employment to be in jeopardy.

For many in nursing, the distinctions between the personal and the political were confusing. There was uncertainty about how to act in the face of Maori political aspirations and the media responses to cultural safety further contributed to this confusion and divisiveness. Regarded as threatening to traditional values, the curricular changes in nursing were described as being 'socially engineered' by a group of 'Maori radicals' who stood to gain financially from developments of this type (Du Chateau, 1992). Defined by the media as a 'politically inspired campaign of subversion' (Ramsden & Spoonley, 1993), being culturally safe was portrayed as requiring sensitivity to Maori but not to people from other cultures. Moreover questions about the relative importance of being safe in a medical and physical sense were being pitted against the need to be 'politically correct' [read 'culturally safe'], as if this was an either/or proposition in nursing.

The following statement, in Metro magazine became one of several catalysts for a torrid debate that spanned a number of years:

[T]he fact that many new graduates have never learned how to put in a catheter and some are possibly medically unsafe to practise is not as important to the crusaders as politically correct attitudes (Du Chateau, 1992, p.97).

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<sup>43</sup> The term 'politically correct' can be traced to the counter-cultural movements of the American 'new left' in late 1960s and 1970s (Cameron, 1994). In the New Zealand context, it has been used by certain journalists, amongst other things, to dismiss anything that is culturally sensitive.

Soon after, Anna Penn, a nursing student who had failed the culture and society section of her programme, distributed a letter to the media that attacked the teaching of cultural safety at Christchurch Polytechnic. The issues were complex and complicated by inaccurate information and a partial understanding of those reporting the issues. The difficulties were suggested to be behavioural on the part of the student, and procedural on the part of the polytechnic (Brett, 1993), but the numerous letters to the editor and the feature articles that followed focused almost entirely on the adverse effects of 'race' related issues in nursing. Referring to the introduction of cultural safety in nursing, one editorial stated:

Political correctness is the antithesis of free speech and a democratic society, yet its tentacles reach into the very heart of New Zealand society through government departments, quangos and places of learning (Editorial, 1993a).

Another editorial, entitled "Nurses must think again" (1993b) similarly challenged the Nursing Council's approach, its use of the terms "crusade", "unfortunate experiment" and "cultural cleansing" exemplifying the intensity of negatively held prejudices. In 1994, Frank Haden reported in the Sunday Star-Times, that "Maori activists were infiltrating and subverting New Zealand's schools of nursing" (Haden, 1994) and, in 1995, another of Haden's editorials prompted further criticism of "the racially biased tutors and politically correct whimpish bosses of that Council" (Colclough, 1995). Yet paradoxically, some members of the fourth estate do not comprehend that they too can be accused of subversion. In most media reporting, the term 'culture' was synonymous with the term 'race'. 'Culture' had meaning in relation to groups of people whose physical characteristics differed, usually in a negative sense, from the majority of New Zealanders. Moreover, in most cases the references concerned Maori. Thus the contribution by Maori to health, via nursing, was being interpreted as a 'take-over' rather than as evidence of Maori participation and partnership with Pakeha in the interests of improving health outcomes in New Zealand.

Others in the community seemed also to be judging nursing unfavourably. Jenny Shipley, the then Minister of Health and Social Services, delivered the following ultimatum to a workshop I attended in May 1996, which sought to further refine the implementation of cultural safety: "If you don't get this right [meaning cultural safety], you won't get prescribing rights". With revision of the Nurses Act on the government's agenda, the nursing profession was lobbying for limited rights to prescribe medications and this too was a controversial issue.

In his book *Maori: The crisis and the challenge*, Alan Duff, (1993), a Maori author, attacked what he saw as the one-sidedness of Ramsden's view, on the basis that Maori equally needed to take some responsibility if their health statistics were to improve. Horton and Fitzsimmons (1995), as non-nursing educationalists, challenged the Nursing Council's role in relation to the Government's Industry Training Strategy, suggesting that nursing aspirations of professionalism were threatened under conditions of neo-liberal restructuring, and that the inherent tension between standardisation and professionalism was problematic. Again, possibly with the best of intentions, Professor Jensen (1995), as emeritus professor at Waikato University, offered advice to nursing, yet revealed his lack of knowledge both in relation to nursing philosophy and to the process of nursing education. In assuming that Kawa Whakaruruhau focused on classroom learning and the provision of information about other cultures by teachers, Jensen overlooked the fact that 50% of New Zealand's nursing education is acquired clinically. Moreover, ethnic diversity contributes to peer learning as it had similarly in his classes. But overlooked were philosophies of humanism, holism and caring that pervade nursing curricula encouraging engagement with, and the acceptance of, difference.

The points made by these commentators offered insight but, unused to defending their philosophies publicly, nurses found it difficult to create and sustain an informed debate. Why had so many, outside nursing, so much to say about these issues? Was it, as Ramsden (1995, p.2) suggested, that "the idea of the comfortable, trusted nurse being influenced by Maori demanding unreasonable and unrelated input into nursing was all too much for some people"? Had nursing education failed to distinguish between its obligations to tangata whenua under the Treaty and the teaching of a generalised approach to nursing people whose values and expectations were different from the mainstream? Was the New Zealand public not prepared to permit nursing to set and maintain its own professional standards? And, given the statutory recognition of the Treaty of Waitangi (eg, within the Education Amendment Act, 1990; Mental Health Act 1992; Health and Disabilities Act, 1996), why had this innovation caused such vehement debate?

### **Culture and the potential for division within nursing**

The furore over cultural safety had highlighted a divergence between those seeming to prefer the status quo and those prepared to be actively engaged in moves towards biculturalism. Yet the issues were more complex than they appeared on the surface. On both personal and professional levels, the numerous letters to the editor and other



articles published by the media, and in nursing journals, had revealed that both nursing and public opinion was divided (see Fleras & Spoonley, 1999, for thematic appraisal of media themes). The Nursing Council of New Zealand Review by Murchie and Spoonley (1995) found that the major nursing organisations, with the exception of the Nurses Society, were supportive of cultural safety and described those involved in Maori health service delivery as “very supportive” (ibid. p.27). But practising nurses otherwise seemed almost equally divided between being supportive and opposed to the concept. For many, the issue was not opposition to nursing consideration of culture but rather that nursing needed to address multiculturalism instead of, or as well as, biculturalism. Confusion and uncertainty appeared to exist in relation both to the meaning and the implementation of cultural safety.

Furthermore, within nursing education the curricular inclusion of Te Reo and marae<sup>44</sup> visits was being debated. There were concerns about adequate funding and perhaps most important were the questions relating to the assessment of student performance and the evaluation, by students, of course delivery. Some tutors (Sherrard, 1991; Stabb, 1995) had raised their concerns openly. Others had expressed these to the Review Committee. Students had also voiced their concerns, both individually (Penn, reported by Munro, 1993; Teariki, 1993; Davis, reported by Laugesen, 1995) and collectively through a survey conducted by the NZNO Student Unit in 1993. Some students in the survey feared the consequences of openly expressing their opinions. Although most were reported to agree with the philosophy of cultural safety, many believed a multi-cultural framework was more appropriate than the existing bicultural emphasis (New Zealand Nurses Organisation Student Unit, 1993). The survey sample, although small, was believed by Tuffnell, the NZNO student chairperson, to exemplify general trends of opinion and thus it highlighted a potential for further conflict within education.

Yet there were many in nursing who were not about to give up. Having sent press clippings relating to the debate to its international counterparts, the New Zealand Nurses Organisation found Australia, Britain and the USA to be supportive of the preparation of New Zealand graduates. The reply from Virginia Trotter Betts, president of the American Nurses Association, commented specifically that New Zealand nurses were valued in the USA both for their clinical skills and their cultural sensitivity (New Zealand Press Association, 1993). Other efforts to restore balance to the debate were

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<sup>44</sup> the centres of Maori community life

made by the New Zealand College of Nurses and the New Zealand Nurses Organisation. However, getting reasoned arguments into print was not easy (J. Carryer and J. Lumby, personal communications, July, 1995).

The potential to divide nursing over these issues came to a head with the Government's decision to hold a public inquiry in 1995 and the Education and Science Committee was commissioned to do this task. In an effort to avoid divisiveness, the Nursing Council of New Zealand also appointed a Committee to review and evaluate the delivery of the cultural safety component of nursing education. The recommendations made in the Review Committee's Report to Council (Murchie & Spoonley, 1995) were then adopted and given priority in terms of their implementation. Acknowledging the tremendously important role played by nurses in New Zealand society, Murchie and Spoonley (*ibid.* p.3) advocated greater Council involvement with Polytechnics regarding further improvements in the delivery of cultural safety and also recommended that the Council work to increase public understanding and confidence in nursing. But perhaps most significant was the Review Committee's strong support (albeit with improvements) for the continued inclusion of cultural safety in nursing curricula. This report was also accepted by the Education and Science Committee, which suspended their own inquiry on the proviso that the Review Committee's recommendations were implemented by mid-1996. However, the fact that the government's committee repeated its request that the terminology used to describe this curriculum component be reconsidered, suggests a begrudging acceptance of this innovation in nursing.

### **Revisiting the meaning of culture in nursing**

Harshly judged, often by people with an insufficient knowledge of or involvement in nursing education, New Zealand nursing had been chastened by the two inquiries that followed the media furore. The profession recoiled somewhat, yet remained willing to debate and critically evaluate its practices. Working quietly through the recommendations and ensuring that Maori and Pakeha participated together in all phases of development, progress continued away from the limelight and a new set of guidelines was published by the Council in July 1996.

The term culture in the 1996 document is defined simply as "the sharing of meaning and understanding" (Nursing Council of New Zealand, 1996, p.40) and the definition of cultural safety emphasises the recipient's experience of care.

Cultural safety is an outcome of nursing and midwifery education that enables safe service to be defined by those who receive the service (Nursing Council of New Zealand, 1996, p.10).

Cultural awareness and cultural sensitivity are steps in the process towards achieving cultural safety. Although improving the health status of Maori remains the primary focus, the principles of cultural safety are argued to apply in all situations in which there are potential power and status imbalances between the nurse and the patient. Thus culture has meaning in terms of the ways patients' cultural understandings may differ from the cultures of nursing and midwifery. Cultural safety programmes aim to assist the development of attitudes and behaviours that accommodate and show appreciation of the ways that ethnicity, age, gender, disability and socioeconomic position, for example, impact upon a patient's ability to relate to the health care offered. In addition to achieving a shared understanding, culturally safe practice therefore seeks to empower the users of health and disability services (ibid. 1996).

### **The 1990s: an overview**

Cultural safety is a radical, comparatively recent and still evolving concept. Although Ramsden pulled together the reports and recommendations from the various hui contributing to the development of Kawa Whakaruruhau, cultural safety did not begin with the report that named it (Nairn, 1995). Sensitivity to the cultural situations of individuals and families had brought many New Zealand nurses face to face with the poorer health status of Maori, as revealed experientially and confirmed by the Hauora statistics (Pomare, 1980; Pomare & de Boer, 1988). However, a collective and overtly pro-active response had not previously occurred.

The nature of New Zealand nurses' understanding of culture has moved from being well-intentioned but assimilationist, to being anthropologically focused on acquiring knowledge about health beliefs and patterns of behaviour, to a broader sociopolitical comprehension of the consequences of a monocultural health service for those of indigenous or minority status. Maori have been catalysts throughout, yet New Zealand nurses, like their international colleagues (Leininger, 1978a; Lipson & Meleis, 1985; Brink, 1990; Tripp-Reimer & Fox, 1990; Kanitsaki, 1993; Murphy & MacLeod Clark, 1993; Canales, 1998) have also understood cultural differences to be broader than ethnic difference. In emphasising the uniqueness of individuals, nurses recognise cultural difference to include concepts such as gender, age, and class as well as ethnicity. The growing moral and political significance of biculturalism in New Zealand

has resulted in an interpretation of culture as 'Maori first' in the minds of many people, although support for this varies.

Few people ever share power willingly. The history of this country is evidence of how, even with humanitarian intentions, a document was prepared and the Maori invited to treaty with the colonial administration of the day. But the Treaty could not stop the Land Wars, nor the large scale confiscation of land, the alienation of Maori land from Maori ownership ... redress of past injustices will never happen totally ... but in mutual commitment and goodwill on both sides, lies the key to the future of race relations (Kingi, 1989, p.92).

Nursing has responded to a strong movement in New Zealand towards eliminating social inequalities that are racial in origin. The principles of cultural safety are providing valuable guidelines for practice. Nursing's responsibilities in relation to culture have therefore developed, in accordance with re-interpretation of the Treaty of Waitangi, to include the protection of Maori health as taonga<sup>45</sup>. The sudden visibility and the potential for divisiveness created by the cultural safety debate, ensured that the voice of Maori was heard in New Zealand nursing. However, it also raised concerns about the political aspirations of some Maori, causing confusion and uncertainty within the profession. The politicisation of Maori ethnicity has dramatically altered relationships between Maori and Pakeha in Aotearoa/New Zealand (Spoonley, 1993). The situation is complicated further by increasingly significant migration from Asia and recognition that attention also needs to be paid to the health of Tagata Pasefika<sup>46</sup> (Spoonley, Macpherson, & Pearson, 1996).

These are the background horizons of meaning against which the experience of nursing a person from a culture other than one's own is interpreted. Prior to commencing a more ontological exploration of this phenomenon, I need now to discuss the philosophies informing the research approach.

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<sup>45</sup> Treasure; something of value

<sup>46</sup> People from the Pacific Islands

## Chapter Four: From philosophy to methodology

[M]an is an animal suspended in webs of significance he himself has spun ... the analysis of it is therefore not an experimental science in search of law, but an interpretive one in search of meaning  
(Geertz, 1973, p.5)

This chapter begins by reviewing hermeneutics from a philosophical perspective with a particular focus on several of the notions<sup>47</sup> articulated by Hans-Georg Gadamer, Charles Taylor and other commentators. It then discusses the way in which my interpretation of these ideas has influenced the process and outcome of this work.

### **Hermeneutics: origins and meanings**

The discipline of hermeneutics is an ancient, yet modern and also post-modern mode of inquiry (Parse, 1996), derived from the Greek word “hermeneuein” meaning to interpret, express and to translate. In Greek mythology, it was Hermes, the messenger God, who devised and used language and writing in order to change the unknowable into a form that was comprehensible to humans. Historically used during the Protestant Reformation as a method to discover the ‘correct’ interpretation of biblical and legal texts, hermeneutics emphasises the centrality of language as it focuses on the philosophy, theory and practice of interpretation. Recognised in the western world as an important challenge to the contribution of positivism, hermeneutics rejects empiricist accounts of science on the grounds that all human life unfolds in a context of shared meaning. Although there are differing schools of hermeneutic thought, common to all hermeneutic inquiry is a focus on understanding and interpretation as processes (epistemology) and modes of being (ontology) (Reeder, 1988).

Hermeneutic thinkers can be characterised quite generally by their concern to resist the idea of the human intellect as a wordless and timeless source of insight ... hermeneutical theories of understanding argue that all human understanding is never ‘without words’ and never ‘outside of time’. On the contrary, what is distinctive about human understanding is that it is always in terms of some evolving linguistic framework that has been worked out over time in terms of some historically conditioned set of concerns and practices. In short, hermeneutical thinkers argue that language and history are always both conditions and limits of understanding (Wachterhauser, 1986, pp.5-6).

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<sup>47</sup> I have used the term ‘notion’ rather than ‘concept’ because of its speculative and more flexible connotations. Consistent with hermeneutic philosophy, ‘notion’ permits multiple interpretations. For me, ‘concept’ refers more definitively to an object of thought.

**Hermeneutics: understanding, interpretation and experience**

Philosophical hermeneutics argues that the phenomenon of understanding pervades human relations (Linge, 1976). Recognition of the situated nature of human existence encourages exploration of the ways in which understanding and interpretation relate contextually in time and place. In order to understand the use of this approach in relation to the experience of nursing a person from another culture, an examination of the nature of understanding, and the relationships between understanding and interpretation of experience, is therefore important.

For proponents of Gadamerian hermeneutics, understanding is both a process and a mode of being. Born into already existing worlds of meaning, human beings inherit traditions and understandings, both formally and informally, through language and the processes of socialisation. But neither traditions nor understandings are unidirectional phenomena. They are dialectical and dialogic. In learning to speak, an orientation to the world is acquired that is inseparably interwoven with a person's history and culture. Yet cognitive and linguistic capacities also enable reflection on, and the interpretation of, experience. Thus, there is a restless back and forth movement, or 'play' (Gadamer, 1996), between tradition and the experiencing, interpreting person. The person's present, past and future are constitutively involved in the process of understanding.

Experience refers to the totality of a person's perceptions and memories in relation to participation in a particular situation. It includes thoughts, feelings, actions and reflections before, during and after the event (Boud, Keogh, & Walker, 1985). Discussing the relationship between experience and its interpretation or expression, Wilhelm Dilthey (1961) argues that the actions and conversations of others are understood on the basis of one's own experience and self-understanding. Thus, although experiential meanings are interpreted in the present, they are always understood through comparison with that which is already understood. New experiences are checked against those previously encountered and, in turn, these interpretations shape future experiences. Experience therefore structures interpretation and its expression, and interpretation reciprocally structures experience. This infinitely dialogical and dialectical process, known as the hermeneutic circle, is a central tenet of hermeneutic philosophy.

### **The hermeneutic circle: evolving understandings**

For Schleiermacher (1768-1834), an early hermeneutic scholar, the hermeneutic circle was a metaphor for explaining the interaction between parts and a whole when extracting meaning from texts. Such interpretation required an understanding of language use in the form of sentences, as an essential part of explicating the whole meaning of a text, the aim being to reconstruct the original thinking of the author (Palmer, 1969). Schleiermacher similarly understood every structure of thought as a part in the total context of a person's life (Gadamer, 1996). But his hermeneutic circle of understanding did not include an awareness of the prejudgements brought by the interpreter. It was Wilhelm Dilthey's (1833-1911) emphasis on historicism that facilitated the recognition that the interpreter's horizon also constituted part of the hermeneutic circle. At this time, however, the influence of Descartes remained strong within philosophy and Dilthey's focus was epistemological rather than ontological. Emphasis was placed on self-recognition and self-knowledge (Reeder, 1988).

For Husserl (1859-1938), Heidegger's predecessor, the notion that one's pre-understandings could be transcended or bracketed was still dominant (Thompson, 1990; Crotty, 1996). Focusing on intentionality (inner-time consciousness), which reflects the convergence of past, present and future (Reeder, *ibid.* p.211) and the logical structure of consciousness, Husserl continually sought to establish the "objectivity in the very heart of subjectivity" (Spiegelberg, 1982). Experiencing was therefore primarily an epistemological or 'knowledge affair' (Bernstein, 1971; Ricoeur, 1981).

In the twentieth century, however, challenged firstly by Heidegger, and then by Gadamer, the hermeneutic circle became a metaphor for describing the existential nature of interpretive understanding.

In the circle is hidden a positive possibility of the most primordial kind of knowing, and we genuinely grasp this possibility only when we have understood that our first, last and constant task in interpreting is never to allow our forehaving, foresight, and foreconception to be presented to us by fancies and popular conceptions, but rather to make the scientific theme secure by working out these fore-structures in terms of the things themselves (Heidegger, 1927/1962, p.153).

Heidegger did not conceive understanding to be a way of knowing. Understanding was a "mode of being", and a "fundamental characteristic of our being-in-the-world" (Ricoeur, 1981, p.20). Through the phenomenological analysis of "Dasein" in *Being*

*and Time*, Heidegger demonstrated that questions about how people 'know' are secondary to those of how people 'are' in everyday existence (MacLeod, 1996). The concept of Dasein, which roughly translated means existence; 'being-there' or 'being-present', radically de-psychologises the notion of understanding (van Manen, 1990). Although, on the surface, it may seem that the human mind can be consciously directed towards objects, Heidegger argues that this is only possible because understanding exists in a context of social and historical meaning. The impossibility of separating 'person' from 'world', means that human understanding is a mode, or "fundamental characteristic of our being-in-the-world" (Reeder, 1988, p.198). Thus, a turn from consciousness to existence is evident (Koch, 1995) and the new hermeneutic focus emphasises ontological rather than epistemological theories of interpretation.

Extending Heidegger's work, Gadamer and Taylor emphasise the existentially intersubjective and dynamic nature of human understanding. Individuals shape and are shaped by the traditions in which they live. Knowledge arises through the dialectics of history, culture and language. Thus the capacity to understand derives from personal involvement in circular and contradictory processes of interpretation (Rowan & Reason, 1981) which are inextricably linked to one's being-in-the-world.

We are always situated within traditions (Gadamer, 1996 p.282) ... we ... participate in the evolution of tradition and hence further determine ourselves. Thus the circle of understanding is not a "methodological" circle, but describes an element of the ontological structure of understanding (ibid. p.293).

Within this study, the nurses' interpretations of experience are shaped reciprocally through the interaction of past and present traditions. The nurse experiences each encounter with a person from another culture in light of the whole of his/her previous experiences. This part-whole dynamic also has relevance in the present, simultaneously at interpersonal, professional and societal levels. The nurse, as an individual with personal attributes, is part in the sense of relating within the wider community in which he or she practises and is also a part within the whole of the nursing profession. In each of these part-whole relationships, provisional understandings develop, but the meanings are only partially apparent and it is by relating each to the other and to the whole that understanding develops more fully.

Understanding, in this thesis, therefore has meaning in terms of the circular relationships between the phenomenon itself and its wider context. It also has meaning deriving from the relationship between the 'knower' and what is known and between



the known and the unknown (Rowan & Reason, 1981). But if circular implies a rotational movement that begins from one point in a circle and returns to the same point, then the relationships being referred to are descriptively more spiral and open ended than they are circular in nature. Because understanding is revealed under different conditions, a potential always exists for things to be interpreted in different ways and thus for understandings to be taken beyond the present or known differently in the manner described by T. S Eliot in "Little Gidding".

We shall not cease from exploration  
And the end of all our exploring  
Will be to arrive where we started  
And know the place for the first time  
(Eliot, 1963, p.222).

Bearing in mind that I too, in drawing on certain philosophical notions for the purpose of research, am adapting and pushing meanings beyond the purpose for which they were originally intended (Lawler, 1998), I need now to present my interpretation of the hermeneutic notions that have informed this study.

### **Understanding and historicity**

The first lesson of hermeneutics is that we are historical beings and that our understanding is an historical process (Rowan & Reason, 1981, p.132).

Both Gadamer and Taylor support the view that, as humans, we are pre-cognitively aware of our cultural and historical situatedness. Taylor (1995) uses the term "home culture" to describe an understanding that is woven deeply into our lives and, for Gadamer (1975), the terms "horizon" and "prejudice" refer to the historically and culturally produced pre-understandings that influence interpretation and thereby contribute to understanding. In this sense, horizon metaphorically represents one's "range of vision" or world-view, and is inclusive of "everything that can be seen from a particular vantage point" (Gadamer, 1996, p.302). Horizons comprise pre-understandings or prejudices that enable us to understand or make sense of events and people. Our horizons are contributed to by our culture and position in society. They are acquired pre-reflectively through language and constitute traditions that are not themselves the object of understanding but the conditions of their occurrence (Linge, 1976).

According to Gadamer, having a limited horizon means not seeing far enough, or over-valuing that which is most familiar. Yet having a horizon also means that it is possible to “see beyond” (Gadamer, 1996, p.302) what is close at hand because the temporal nature of human existence ensures that we are never completely bound to the present. Horizons are not static. They may be limited but they are fluid and can “change for a person who is moving” (ibid. p.304). Thus Gadamer suggests that although we always understand others from our own standpoint, this standpoint is not fixed in the person who is trying to understand or who is prepared to engage reflexively with other understandings.

The related term “prejudice” refers similarly to background horizons or frames of reference, and acknowledges that “long before we understand ourselves through processes of self-examination we understand ourselves in a self-evident way in the family, society and state in which we live” (Gadamer, 1996, p.276). It is essential to note that Gadamer does not use prejudice to infer something negative or needing elimination. Prejudices are the conditions whereby something is experienced as having meaning. Prejudices constitute the understanding through which interpretation becomes possible. They are not necessarily erroneous or unjustified, but rather “constitute the initial directedness of our whole ability to experience” (Gadamer, 1976b, p.9). In defining prejudice as “a judgement that is rendered before all the elements that determine a situation have been fully examined”, Gadamer (1996, p.270) challenges the negativity associated with this term and argues that adequate understanding needs to include positive and negative meanings.

The current dictionary meanings of prejudice partially support, but do not emphasise, Gadamer’s interpretation. The acknowledgment of prejudice as “opinion formed beforehand” is immediately qualified as being “unfavourable” with further explication mentioning “intolerance of, or dislike for, people of a specific race or religion” and “disadvantage or injury” accruing from such opinion (Collins Dictionary of the English Language, 1986). The etymological sources cited include the French *prejudice* and Latin *praejudicium*, a preceding judgement or disadvantage, yet the latter receives emphasis in spite of the meanings of the component parts; *prae* meaning before and *judicium* meaning trial, from *judex*, a judge. Thus the possibility of a positive prejudgement is denied.

Although there is evidence of differing interpretations within both academic and lay writing, the negative meaning similarly predominates. Within the literature pertaining to

cultural issues in nursing, prejudice is associated with ethnocentrism and the stereotyping by nurses of patients according to race (Bonaparte, 1979; Leininger, 1983; Thiederman, 1986; Ramsden, 1990a). In New Zealand's sociological literature, prejudice is closely linked with racial discrimination and colonialism (Pearson, 1990; Spoonley, 1993), and within current media reporting the association of prejudice with minority group disadvantage is common (recall discussion in Chapters Two and Three).

Distinguishing between the meanings of prejudice is important because both positive and negative interpretations are relevant in this study. If prejudice is interpreted in terms of the dichotomy - I am prejudiced or I am not prejudiced (Gudykunst & Kim, 1992) - not only is priority given to the negative meaning, but there is also a tendency to overlook the existence of its multiple dimensions. Individuals vary in the strength of their preference for interacting with people who share similar values and expectations, for example. They also vary in their willingness to engage with difference and their capacity to adjust when confronted with the unfamiliar. Acknowledging that all people are to some extent, racist, sexist and ageist, Gudykunst and Kim therefore argue that it is more useful to think of prejudice as varying in strength from high to low and from very positive to very negative.

Gadamer's appropriation of the term prejudice, however, assists an understanding of the way in which particular prejudices come about. It also encourages the consideration of other possible prejudices and recognises the potential for understanding to change and increase. The process by which prejudices contribute to developments in understanding and practice is thus made more visible. Differentiating between the false prejudices that prevent us from finding truth in a situation and true prejudices which assist to enlarge our understandings, Gadamer therefore argues for the need to develop an awareness of the ways in which our horizons and prejudices are projected in the effort of understanding.

The notion of 'effective historical consciousness' (Gadamer, 1975) or 'historically effected consciousness' (Gadamer, 1996) further explains our inability to consciously or unconsciously deny our historicity. To be engaged in a situation means to be doubly influenced by tradition because we are simultaneously " 'affected' by history, and also ... brought into being [or] 'effected' by history" (Weinsheimer & Marshall, 1996, p.xv). We exist in the present affected by tradition and, in reflecting on events, we look backward from that present position. Our awareness of the effect of historical events influences

our interpretations of those events. Historical consciousness refers to an awareness of the prejudices governing our understandings, and effective historical consciousness acknowledges that the effect of history influences our interpretations (Hekman, 1986). Successful completion of the act of understanding therefore requires not only a consciousness of one's historical horizon but an appreciation or examination of its effect.

In insisting that prejudice and effective historical consciousness are necessary contributors to all understanding, Gadamer also argues that "the recognition that all understanding inevitably involves some prejudice is what gives the hermeneutic problem its real thrust" (Gadamer, 1996, p.270). In relation to research generally, effective history determines what is deemed worthy of investigation (Bernstein, 1983). In this study, the denial of an interpreter to a non-English speaking patient violated my expectations in relation to patients' rights. It also rekindled an awareness of the disparity between theoretical ideals and the reality of nursing practice. This, and other events, brought to consciousness certain prejudices that prompted me to inquire further. What was shaping my horizon? How had my understandings evolved and how were they the same as, and different from, those of other nurses? The notion of prejudice, as articulated by Gadamer, could facilitate exploration of the prejudgements enabling and limiting understanding of the phenomenon in question.

### **The modern sense of self, understanding and emotions**

Exploring another dimension in the hermeneutic relationship between understanding and historicity, Charles Taylor (1985a; 1985b; 1991a) focuses on self-understanding as constituting and being constituted by a background of "distinctions of worth" (Taylor, 1985a, p.17). He suggests that in a sense, the 'self' is a modern phenomenon because certain powers of reflexivity have become a crucial feature of the person in modern Western culture. We scrutinise our thinking and regard ourselves as having 'inner', partially explored, capacities and potentialities. Although we are beginning to see 'self' in relation to history, we have yet to recognise that our self-understanding essentially comprises seeing ourselves against a background of differential values.

Taylor therefore extends the hermeneutic claim that human beings are self-interpreting on the basis that feelings, values and understandings are inextricably related. People are beings for whom things matter. The notion "strong evaluations" is used to distinguish the qualitative worth of our different desires (ibid. p.16). Yet the meanings we derive from our experiences are not only constituted rationally. We respond

affectively to situations. Our emotions happen beyond our control and thus can reveal what matters to us prior to our interpretive effort. Experiencing an emotion therefore means experiencing a situation as having some significance or “bearing a certain import” because, if it were neutral, we would be indifferent and unmoved by the experience (ibid. p.50). The import gives the grounds or basis for the feeling and, because we make differential judgements about the importance or relevance of the feelings we experience, our emotions incorporate a sense of what is important to us. Thus, there is a connection between feeling and judgement.

Understanding our emotional responses therefore entails making explicit the significance of the situation experienced. Again, referring to one of the events that led to my involvement in this project, it was the emotions of anger and confusion engendered by the denial of an interpreter that had prompted me to seek clarification from those responsible for making the decision. This was an issue that mattered to me, as a person, as a nurse and, as a nurse teacher. In Taylor’s terminology, it was a strong evaluation or evidence that certain values had become embodied in my understanding. Why had this event announced itself as important to me? What was the basis of my anger and confusion? The Gadamerian notions of prejudice and horizon could assist exploration of the origins and meaning of these “strong evaluations” and enhance understanding of the phenomenon in question. Chapters Two and Three have commenced discussion of several significant issues.

### **Language and understanding**

Both Taylor (1985a, 1985b) and Gadamer (1996) place a heavy emphasis on language, arguing that it is through language that we develop understanding. According to Gadamer (1990) “language is the fundamental mode of operation of our being-in-the-world and the all-embracing form of the constitution of the world” (p.147).

Language embodies tradition by transmitting meanings pre-reflectively to us. It also enables reflection on past experiences and is the medium through which the past and present interpenetrate and fuse. When making sense of the situations in which we find ourselves we engage in “dialogue” with our past experiences (Gadamer, 1976, p.66). We pose questions and fumble for answers, interpreting our present situation both in relation to previous understandings and according to embodied anticipations, purposes and concerns. It is having a language that enables us to express feelings and understandings (Taylor, 1985a). Furthermore, it is through language that we reflect on the adequacy or otherwise of our interpretations and in accepting, rejecting and refining

our articulations we are able to move from inchoate experiences to ones that more clearly define and facilitate ongoing understanding and expression.

Taylor (1985b) describes hermeneutic interpretation as “an attempt to make clear, to make sense of, an object of study” and suggests further that:

this object must, therefore, be a text or text analogue, which is confused, incomplete, cloudy, seemingly contradictory - in some way or another, unclear. The interpretation aims to bring to light an underlying coherence or sense (p.15).

My purpose, in this study, is to illuminate the taken for granted practice meanings embedded in the experience of nursing a person, or people, from cultures other than one's own. The texts in this study primarily comprise nursing accounts of practice experiences. Yet, in order to comprehend these experiential accounts, other texts in the form of nursing literature, media reportage, sociological writing and New Zealand history, art and literature also contribute to the interpretation by way of contextualising the experience. How does nursing's specific language disclose the experience of nursing a person from a culture other than one's own? How is theoretical expression in the literature similar to and different from experience as lived by practising nurses? In order to understand comprehensively the phenomenon of concern, I need to work between the nurses' stories and the discourses dominant in society and the nursing literature. I need to ask questions that can reveal the relationships between experience, tradition and language.

In addition to arguing that language is the medium by which we come to understand, Gadamer (1996) uses 'conversation', 'play' and 'game' as analogies to describe the structure of understanding. Language, like conversation and play, is something we enter into and are encompassed by. It is a shared or social activity (Hekman, 1986). It is dynamic and its outcome is not always predictable. Gadamer, in comparing hermeneutic understanding with the acts of dialogue and play, suggests that the processes of question and answer, listening and speaking, talking at cross-purposes and seeing the other's point of view enable us to reach new understandings. “Questions always bring out the undetermined possibilities of a thing” (Gadamer, 1996, p.375). Thus it is through questioning, or laying open our surface experiences, that our horizons are enlarged and enriched.

When referring to textual interpretation, Gadamer emphasises the need to pose questions in a way that explores both positive and negative judgements. As in the Socratic method, the art is in seeing what can be questioned for “the art of questioning is the art of questioning ever further” (Gadamer, 1996, p.367). Through dialoguing with texts and responding to the questions raised, we test possible understandings and, when a text asks questions of us, we ourselves begin to ask questions and thus are taken beyond the horizon being presented.

To reach an understanding in a dialogue is not merely a matter of putting oneself forward and asserting one’s point of view, but being transformed into a communion in which we do not remain what we were (Gadamer, 1996, p.379).

### **Understanding as fusion of horizons**

The notion of “fusion” is used to further Gadamer’s assertion that “all understanding is interpretation” (Gadamer, 1996, p.398). Used as a metaphor for understanding, “fusion of horizons” refers to the coming together of differing vantage points through language. New understandings are constituted by the fusion of two perspectives, that of the phenomenon itself and that of its interpreter (Rowan & Reason, 1981). Significantly, the term does not mean that all differences coalesce but rather that the new understanding, although different, possesses elements from its contributors. We can, for example, learn to think and write in a different language without losing the ability to speak and write our own (Zuckert, 1996). Gadamer (1997) contends therefore, that “the otherness of the Other is not overcome in understanding, but rather preserved” (p.41). What eventuates is a broader and more complex understanding. Moreover, because horizons are essentially open, the fusion is ongoing.

When one enters into a dialogue with another person and is then carried further by the dialogue, it is no longer the will of the individual person ... that is determinative. Rather, the law of the subject matter is at issue in the dialogue and elicits statements and counter-statements, and in the end plays them into each other (Gadamer, 1996, p.347),

and thus:

those who understand a text ... not only project themselves in an effort of understanding toward a significance, but acquire through understanding a new liberty of the mind (Gadamer, 1979, p.110).

However, the fusion that is occurring is not only between one party in a conversation and another. It is also between past and present, and between what is said and what is not said. In the research situation, fusion occurs between the researcher’s horizon and

those of the participants. Researchers bring their own interests both to the creation of data through dialogue with those participating and to the subsequent interpretation of that data. Meaning is therefore neither located in the subjective intentions of the participants nor is it solely produced by the interpretive methods and pre-understandings of the researcher (Thompson, 1990). In relation to the generation of text analogues, a fusion occurs between the horizons of the storyteller and the listener. Then, in the process of analysing or interpreting such analogues, a further fusion of horizons happens in front of the texts to produce an understanding that mediates between the recounted experiences and their interpreter at an historical point in time. Moreover, as I suggested earlier, when outlining the assumptions underlying the study the research findings are interpreted again by readers who are also situated within a culture and history. The process of fusion is ongoing. The present and the previous are always combining. Thus inherent in the notion of understanding as an event of fusion is the ever-present possibility of coming to a different understanding.

### **Extensions/challenges to Gadamerian philosophy**

Gadamerian hermeneutics has been challenged on several accounts (Zuckert, 1996). Because Gadamer, unlike Heidegger, emphasises the continuity of history, he is charged with being too conservative. Yet because he maintains, with Heidegger, that truth changes with the passage of time, he is also accused of relativism. Perhaps most significant however, is the criticism by Habermas (1985; 1987) that the emphasis on historicism is too idealistic.

Gadamer's philosophy is essentially positive in outlook. Human beings can potentially come to agreement because they have a universal capacity for language and the dialectic of question and answer is a never-ending process which all perspectives can be included (Zuckert, 1996). "Hermeneutic philosophy ... does not understand itself as an 'absolute' position but as a path of experiencing ... there is no higher principle than ... holding oneself open to the conversation" (Gadamer, 1997, p.36).

Although supportive of the notions of self-reflexivity and the analysis of language dialectically with tradition, Habermas claims that Gadamer neglects the critical powers of human reason (Zuckert, 1996). In placing greater emphasis on questioning the authority of given meanings, Habermas argues that power relations should be permeable to hermeneutics. The critical scholar must therefore "slacken commitments to tradition" in order to "critically examine cultural practices" (Thompson, 1990, p.261).



In what has been labelled ‘the Gadamer-Habermas debate’ (Ricoeur, 1981), Gadamer reiterates the claim that belonging to tradition does not preclude such a critique because “questioning reconceptualises the historicity of our thinking and knowing” (Gadamer, 1997, p.35). Although able to accept the reality of dominating interests, Gadamer asserts that these can only be understood through language and thus he cannot comprehend the possibility of speaking from a position outside what Habermas refers to as linguistically constituted consciousness (Hekman, 1986).

The debate, although unresolved in my opinion, highlights the need for rigorous and disciplined attention to interpretations that privilege certain voices over others. I found Ricoeur’s (1981) appropriation of the terms ‘faith’ and ‘suspicion’ helpful in this regard. Faith focuses on “the restoration of (lost) meaning [and] is motivated by the will-to-hear” (Ihde, 1971, p.141), while suspicion aims to remove illusions and emphasises the need to demystify or go behind given meanings. Throughout this study, my aim has been both to listen in order to understand the experience and to critique taken-for-granted meanings. Further discussion of the specific ways in which I have endeavoured to achieve this methodologically will be presented in the next chapter.

### **Cross-cultural understanding**

Discussion thus far has centred on the ways in which ‘texts’ and ‘text analogues’ are interpreted across historical distance within the same culture. But both Gadamer and Taylor also intimate that this model pertains to cross-cultural interpretation. For example, Gadamer (1992) anticipates that Japan will produce readers in Greek philosophy for the same reasons that Westerners will engage with Eastern writings: in order to understand each other’s philosophies of science, and Taylor (1995) argues that ethnocentrism can be overcome through engagement with difference. When “we place the strangeness opposite some piece of our lives, ... we can go to work on it and make sense of the difference” (p.152). On the basis that experience of the world is bound to language, each presupposes the possibility of common understanding. Even when different languages are spoken and communication seems impossible, hermeneutic understanding remains within reach because “the possibility of communication between rational beings can never be denied” (Gadamer, 1997, p.29).

Lampert (1997) suggests however, that it is cross-cultural interpretation that makes historical interpretation possible. Also acknowledging the importance of language, Lampert argues that, in every human contact, cross-cultural interpretations are already happening. In addition to definitions of culture that involve shared understanding

between members, culture is argued to have meaning “as a system within which differences can be negotiated” (ibid. p.354). Not everyone in a culture shares everything commonly with every other person. Thus there are spaces within cultures for engagement with other forms of understanding. Being in a culture also entails interacting with other cultures because each culture’s history develops through a dialectic of transmission, resistance and recognition with other groups. Thus cultures are identified and differentiated through the large-scale fusion of interpretive horizons.

A recognition that both common sense agreement and points of disagreement exist underpins Lampert’s emphasis on the development of understanding through contact with difference. On the basis that “mutual learning contains a dialectic of reception and resistance” (p.359), conflict is argued to be valuable “as a form of communication” (p.360). Moreover, making cross-cultural interpretation more explicit is believed to be essential in the development of “multiperspectival self-understanding” (p.363). If emphasis is placed on understanding the relationship between agreement and conflict in interpretation, there is an increased possibility that future understandings will surpass those of the present. Others’ objections to our ideas and our objections to theirs provide the potential for understanding to expand towards implications previously unimagined, thus widening the horizons of possibility.

### **Understanding and the research question**

This study seeks to uncover, interpret and thereby understand the experience of nursing a person, or people, from cultures other than one’s own. In defining understanding for the purpose of this study, my aim is to provide an account of nurses as agents by articulating their self-understandings. But, as Taylor (1985b) argues, this requires more than describing their points of view. A discursive understanding makes the experience (or phenomenon of interest) clearer to the participants by exploring and challenging the meanings derived from experience. Such understanding involves articulating the effects of history and culture on present thoughts, actions and feelings. The notions of prejudice, strong evaluation, historically effected consciousness, and play are therefore centrally important to description of the phenomenon of nursing a person, or people, from cultures other than one’s own.

Hermeneutic experience is concerned with what is transmitted in tradition both linguistically and in terms of human action (Gadamer, 1996). Experience refers to being in a world, at a point in time, dynamically influenced by history and culture.

Experiences are interpreted both during their happening and after the event. Thus interpreting experience requires attention to the interplay between ontology and epistemology.

The nursing experiences referred to in this study derive from nursing in the professional sense of being employed and recognised as a 'nurse' by patients and society. Numerous cumulative learning experiences, both formal and informal, conscious and unconscious, have contributed to the meanings derived by the participants from their experiences. But more specifically, the experiences that comprise the interview data are those that these nurses have chosen to share. For various reasons, certain experiences have been remembered and selected. Yet they also always exist alongside other experiences which are not communicated.

Experience consists not only of "*Erlebnis*" (Gadamer, 1996, p.64): or 'an experience' from some reflective or anticipatory distance, but also as "*Erfahrung*" (Gadamer, ibid. p.346): 'as experiencing' or living through: a reflexive process which, in its happening, is more primordial in nature. This exploration thus seeks to illuminate the ways in which the experience (of nursing a person whose culture differs from that of the nurse) is revealed and has meaning in nursing. Attention to what is said, what is implied and to what is not said is therefore required. The interpretation is inclusive of the participants' prejudices and necessarily also includes the prejudices or pre-understandings that I, as researcher, bring to the research process. 'The experience of nursing' described therefore refers to my interpretation of other nurses' expressed experiences.

Use of the definite, rather than indefinite article, acknowledges the experiences collectively as a phenomenon yet it does not imply that the description is entire or absolute. The experience being referred to is situated, partial and is dynamically related to past and future experiences. It does not preclude other possible interpretations and yet it argues its point. For, in addition to the persistent posing of questions, nurses need a sense of what is currently "feasible", "possible" and "correct" (Gadamer, 1996, p.xxxviii).

## **Conclusion**

In this chapter, a brief overview of philosophical hermeneutics and the relationships between understanding, interpretation and experience has been given. I have focused on describing the nature of these concepts, what they comprise and how they come into being. Their dialectical interrelationship, as epistemological processes and as

ontological modes of being, is complex and infinitely ongoing. In describing the specifically selected hermeneutic notions and relating these to the proposed study, I have sought to establish their relevance and suitability for exploring and revealing the phenomenon in question. As interpreters of experience, each of the participants, including myself, constitutes, has been constituted by, and will continue to constitute the cultural and historical horizons central to human existence. Moreover, our relationship with others also means that the temporal nature of understanding coexists dialectically with cross-cultural interpretations. The meanings interpreted from experience are not only diverse they are constantly changing. Yet their plurality and dynamism are strengths, rather than weaknesses, because of the potential for understanding to change and increase.

In the following chapter I will outline how the inquiry was undertaken, providing both an audit trail and descriptive details of the interpretive process.

## Chapter Five: From methodology to method

Hermeneutics is above all a practice, the art of understanding and of making something understood to someone else (Gadamer, 1997, p.17).

The search for 'true' understanding directly contrasts with the techniques and processes of method (Gadamer, 1996). It is not the development of procedures for understanding that is important in hermeneutics but rather making explicit the conditions under which such understanding takes place. Of prime concern therefore is the maintenance and demonstration of an open attitude or orientation towards the "hidden prejudices that make us deaf to what speaks to us in tradition" (Gadamer, 1996, p.270). In the context of research, this means being open both to the processes of researching and to the phenomenon in question.

The process by which I came to decide upon the research question and methodology was, in itself, hermeneutical. Reflective journaling, as a teacher of students in the clinical setting (recall Introduction), had alerted me to a personally held prejudice. The difficulties and apparent injustices inherent in nursing people from other cultures had niggled at my conscience and raised questions that I felt demanded further investigation. There seemed to be high levels of confusion and antagonism, both within nursing and in the public arena, and wondering whether the associated negativity might be an effect of history (Gadamer, 1975) rather than necessarily 'true' to the experience, I decided against using the highly charged term, 'cultural safety'. Although I suspected that the issue might be raised by the participants, I wanted the experiential meanings to emerge and develop through the research process.

Hermeneutic phenomenology had been selected initially, as both a philosophical approach and research method, because of its emphasis on understanding meanings in context. Looking back on my first interviews, I know now that, in the words of my supervisor (J. Christensen, personal communication, March 1997), I had interviewed with 'phenomenological intent'. I focused on experience as lived, encouraging the participants to reflect on their feelings. But I also asked questions that sought to contextualise these experiences. My first attempts at analysis focused on identifying themes in the data. The nurses' values and attitudes seemed important. They seemed to be trying to be culturally appropriate in their actions. Environmental factors seemed

significant and there was evidence of tension and conflict. Yet, in trying to write separately under headings such as 'values and attitudes', 'nursing actions' and 'environmental influences', I became increasingly frustrated by their overlapping nature. I was also having difficulty differentiating 'experience' in the thinking, cognitive sense from 'experience' in a more affective and precognitive sense. Returning repeatedly to the literature relating to phenomenology and hermeneutics, I found the guidance I needed in the writings of Gadamer (1975; 1976; 1985; 1996), Bernstein (1983), Linge (1976), Hekman (1986) and Taylor (1985a; 1985b; 1991a; 1995).

Lincoln and Guba (1985) suggest that the term "emergent design" describes the indeterminate nature of interpretive research. They acknowledge, like Heidegger and Gadamer, that the interpreter begins with tacit knowledge relating to a phenomenon and that methodological understanding becomes clearer as salient meanings and insights emerge from the data.

I believed that the approach selected needed to recognise and enable exploration of the complex and situated nature of experience and it was Gadamer's assertion that the human capacity for reason could never be freed from its historical and linguistic context (Bernstein, 1983) that inspired a shift in my understanding. The Gadamerian notions of prejudice and effective historical consciousness seemed to apply both to everyday interpretations of experience and to the hermeneutic analysis of written texts. They also seemed particularly relevant to the phenomenon in question.

The nurses' values and attitudes are 'prejudices' that constitute 'the horizons' from which they interpret their experiences. But the temporal nature of these notions ensures that understandings are always in motion and that an ongoing tension exists between the past, the present and the anticipated future. Analysis using a Gadamerian framework demands exploration of the effect of history on consciousness. This means that attention is paid to the way in which the temporal nature of understanding contributes to the nurses' experiences.

Gadamer, in discussion with Ricoeur (1982, as cited in Hekman, 1986, p.141), suggests that "deciphering and understanding a text is very like encountering reality". The ongoing processes of question and answer and the fusing of horizons that characterised my search for an appropriate methodology exemplified the phenomenon of understanding generally. I came to recognise that, in trying to understand the nurses' experiences my horizon of understanding was intersecting with theirs. Thus, in

addition to understanding the nurses, in both their immediate and past contexts, I knew I needed to understand myself in relation to the stories being told. As I began to see the cumulative, interactive and partial nature of understanding, I felt more able to let the process of researching evolve. The ongoing reflective and questioning stance which characterises this study therefore presumes an openness both in relation to my prejudices and in terms of the way in which these interact and fuse with those of the participating nurses.

Thus the hermeneutic processes used in this study were not specifically formulated beforehand. However, this does not mean the study was without form (MacLeod, 1996). Always in the back of my mind was the need to maintain a questioning stance in relation to decisions about method and when interpreting data. In seeking to establish the plausibility of this study, I need therefore to incorporate an account of the reflexive processes that characterised the crafting of this project (Koch & Harrington, 1998).

### **The issue of rigour in hermeneutic research**

The value of any research depends on the reader's certainty that the processes, findings and implications stated are trustworthy or rigorous (Koch, 1994; Gasquoine, 1996). But how can such certainty be achieved when hermeneutics argues philosophically that 'truth' (or genuine knowledge) and method may be antithetical? If knowledge is the result of a dialogical process between the self-understanding person and that which is encountered, be it a text or the expressions of another person, then decisions regarding the rigour or otherwise of a work are expressions of agreement or commendation, rather than accurate depictions of the interpretation as 'correct or right' (Smith, 1990). Van Manen (1990) suggests therefore that rigour has less to do with adhering to rules and procedures than it has to do with remaining faithful to the spirit of qualitative inquiry. Particular criteria can be stated but they can only be loosely applied because they are ultimately tied to the social practices of dialogue and negotiation (Smith, 1990; Sandelowski, 1993).

On the basis that interpretation is an unavoidable part of all research, Koch and Harrington (1998) propose that researching is a "reflexive exercise" (p.882). The researcher brings "generated data, a range of literature, a positioning of this literature, a positioning of oneself and moral sociopolitical contexts [to the] research product" (ibid. p.887). Furthermore, if a project is to be judged rigorous then the work should possess "an internal logic achieved through the detailing of each interpretative, reflective turn of its makers" (ibid. p.889). Keeping a reflexive journal that documents

ongoing self-critique and self-appraisal in relation to the research process is therefore advocated. Then, in relation to the creation of the text or 'research product', the following suggestions by Denzin (1996) regarding skilled writing, are argued to assist this "reconceptualisation of rigour" (Koch & Harrington, 1998, p.882). The strategies recommended for enhancing rigour through writing include treating facts as social constructions, emphasising showing rather than telling, using multiple viewpoints, differing narrative strategies and explicating one's moral position vis a vis radical societal change. Of utmost importance however, is the notion that incorporating reflective accounts into the 'research product', enables the reader to decide whether or not the research is believable or plausible.

One of the basic tenets of philosophical hermeneutics is that a dialogue takes place between researcher and text, or reader and interpretations, acknowledging that the researcher brings to the analysis his or her own pre-conceptions ... Readers may not share the author's interpretation but they should be able to follow the way in which the author came to it (Koch, 1994, p.977).

The strategies used in the discussion thus far have commenced explication of the prejudices that I bring to the study. Their use will now continue as the decisions taken regarding the method and the processes of interpretation are laid open for scrutiny.

### **Laying open the audit trail**

#### **Ethical approval**

The study received approval from Massey University's Department of Nursing and Midwifery Ethical Review Committee, initially as a Masters thesis, in 1994. The first round of interviews had illuminated the complex and contradictory nature of the phenomenon of interest. In order to understand adequately the participants' experiences, I therefore needed to enlarge the study's frame of reference to include exploration of the cultural and historical contexts. In 1995, the proposal was resubmitted and accepted as a doctoral study by the same Ethics Committee. Then, when funding was sought to support writing time at the end of 1996, UNITEC's Ethics Committee also reviewed the proposal.

At this point, a Maori member of the UNITEC committee expressed concern about the two participants whose background included Maori ethnicity. Approval was granted with the proviso that their views would not be interpreted as generally representing a



Maori perspective. Hermeneutic research does not seek to generalise and, in this inquiry, a comparative analysis based on ethnicity was neither appropriate nor planned. The study did not aim to explicate Maori or any other ethnic group's perspective. It was being a nurse and experiencing the nursing of people from cultures other than the nurses' own that was the focus of interest. Upon contacting the two Maori participants again to explain the concern raised and check their wishes, I received assurance that they wanted their contributions included.

### **Selecting the participants**

The participants were selected using professional networks. I attempted to include as much variation as possible in terms of employment settings and canvassed support from widely varied areas of nursing practice through intermediary nurses. Preliminary information was provided verbally and in the form of an information sheet (see Appendix A) to the intermediary nurses who, in turn, approached colleagues whom they believed might wish to be involved. A number of nurses telephoned me directly, offering to participate while others gave their telephone number to the intermediary person for me to follow up. It was an effective process in that I had no difficulty finding participants. Moreover, none of the nurses was known to me, thus any conflict of interest between the roles of researcher, teacher and clinician was avoided.

### **Gaining consent and maintaining anonymity and confidentiality**

Prior to commencing the first interviews, written consent to research participation was obtained (see Appendices A and C). The participants were informed that they were free to withdraw from the study at any time. Consent for audio-taping, further telephone contact and publication of findings was gained, with ongoing verbal processes of negotiation characterising the data collection and preliminary analysis phase. All participants received copies of their interview transcriptions. They were informed of the study's progression from a Masters to a Doctoral thesis and additional written consent was obtained at this point (see Appendix B).

Ethnicity, educational qualifications, present employment and details of previous work experience were obtained at the second meeting. In the interests of anonymity, pseudonyms were used when transcribing the interviews, in all subsequent writing, and discussions with thesis supervisors, study group members and colleagues. Interview tapes and computer disc transcriptions were kept locked in two different locations with demographic information stored separately from the interview data.

### **Criteria for participation**

Because everyday experiences were the focus of the inquiry, I required all participants to be nursing people from other cultures throughout the planned period of interviewing. I excluded registered nurses in their first year of practice on the basis that they needed time to establish themselves and gain clinical confidence. I did not want to further burden these nurses during this period of transition. Aware too, that 'culture' had not been formally included in nursing curricula prior to the mid-1980s I began by selecting nurses educated in New Zealand within the last decade. I expected these nurses to have a greater awareness of such issues, but this thinking was challenged when a nurse, who had trained in the 1970s, wanted to participate and argued that ongoing study had provided the opportunity to reflect on cultural matters. As data collection proceeded, I also became more aware of the cumulative way in which experiential learning contributes to nurses' understanding of practice. On the basis that experience was experience as lived and interpreted by the participant, I therefore decided to include nurses regardless of when and where they received their nursing education. If I was focusing on illuminating practice experiences in the context of their happening, the nurses' undergraduate setting could only partially contribute to this. As a nurse educator, I seemed to be valuing formal learning ahead of knowledge acquired through practice post registration. Yet I knew the value of experientially acquired knowledge. I was not evaluating an educational programme but I was becoming more aware of the effect of my recent history as a nurse educator on my consciousness!

### **The study participants**

The nurses in the beginning series of interviews were all Pakeha except one. Wondering whether this was because I was Pakeha and wanting to challenge my early interpretations, I decided to extend and use different collegial networks to recruit participants from ethnic backgrounds other than my own. The final sample included seventeen registered nurses. Twelve described themselves as 'Pakeha' or as 'New Zealanders of European descent'. Two participants said that they were 'New Zealanders of Maori/Pakeha descent', one stating that she had Irish ancestry and the other mentioning Nga Puhī<sup>48</sup> heritage. One participant was Samoan. Another was, in her words, 'Eurasian, from Singapore', and the final participant was born and schooled in England but had received her nursing education in New Zealand as a mature student.

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<sup>48</sup> Nga Puhī are a northern tribe of Maori descendant from Rahiri and based in the Hokianga region (McKinnon, 1997).

The New Zealand-educated participants had received their nursing education at eight different polytechnics or schools of nursing. Nine were undertaking further university study. All were women working full-time, their patients having a range of ethnic backgrounds. In addition to Pakeha New Zealanders, their patients included people who were Maori, Samoan, Tongan, Niuean, English, Dutch, Chinese, Indian, Somalian, Bosnian, Thai and Vietnamese. The participants' employment settings included acute care medical and surgical wards, district nursing, the public health arena, paediatrics, midwifery, mental health, the private sector and practice nursing. Aware of the 'politics of location', I was seeking diversity in the field of representation (Koch & Harrington, 1998). I wanted responses from people "positioned differently" (Marcus, 1994, p.572) in terms of work place culture.

Although not seeking to generalise across cultures, the nurses' ethnic and workplace variability seemed important because of its potential to increase the diversity of the parts within the whole of this hermeneutic circle of understanding. I expected the diversity of the participants to potentially expand the contributing horizons of meaning and thus to enhance interpretation of the phenomenon.

The decision to limit the number of participants to seventeen was based on a sense that the data were sufficient. The interviews had generated rich and appropriately focused data. Colaizzi (1978, p.70) suggests that "there are no external or pre-established criteria for determining when to terminate the approach phase". He speaks also of "a certain 'empty but distinct' feeling of being satisfied" with the adequacy of the data. Following the second phase of data collection, this too was my experience. I was also concerned that data overload could prevent me from doing justice to the participants' experiences. Their stories had such depth and there was so much to be unravelled (Smythe, 1998). Yet paradoxically I knew that, given the dynamic nature of understanding, there would never be sufficient data.

### **Data collection**

Although the literature contextualising the nurses' experiences was an important data source, the major source of data derived from interviews which generated stories of practice experiences. I had decided that it was inappropriate to observe the nurses' practice for several reasons. I was concerned that the presence of a third person would increase the nurses' anxiety and alter their experience. Furthermore, I believed that it was neither ethical nor feasible to do this and ensure the protection of the patients with

whom the nurses were interacting. Gaining consent would have been difficult and could have added to the likely anxiety being experienced by the patients. The lack of opportunity to observe and check the embodied practices, perhaps overlooked by the nurses, is thus a limitation of this study.

### **Interviewing as a means of collecting nursing experiences**

The interviews took place at times and venues selected as convenient by each participant. Efforts were made to ensure tape recording happened in quiet, uninterrupted surroundings. I offered hospitality as a way of showing appreciation and establishing rapport and, when not in my own home, took muffins or something similar each time I visited. Moustakas (1990) suggests that such measures facilitate a sense of comfort, encouraging openness and self-disclosure. I remember my husband commenting, with surprise, at the nurses' willingness to 'give up their time'. However, it was apparent from the nurses' responses that participating in the interviews was an enjoyable and supportive experience. It seemed, as Hutchinson, Wilson and Skodol-Wilson (1994) suggest, that benefits such as catharsis, self-acknowledgment, increasing self-awareness and empowerment may be gained through participating in research. The politicisation of cultural issues in New Zealand nursing had polarised views and many nurses were feeling vulnerable. As well as facilitating a re-learning, by me, of the value of listening and being present for others (Benner, 1984), the interview process seemed also to provide a "voice for the disenfranchised" (Hutchinson et al. *ibid.* p.164).

Loosely structured interviews using broad, open-ended questions were recorded on tape. The nurses were asked firstly, to describe a recent situation in which they had nursed a person from another culture. Subsequent questions probed the feelings they experienced and sought to clarify their interpretation of the experience. In order to minimise the intrusion of my own horizon I tried as much as possible to frame questions using the participant's language and to encourage uninterrupted self-expression. Most nurses described three or four experiences quite specifically, with other instances being touched on in a more general or collective manner. Then, acknowledging the need to explore cultural and historical traditions and ideological understandings as part of the questioning process, three further topic areas were introduced.

The nurses were invited to reflect on the aspects of their personal and educational background that they believed influenced the ways in which they nursed people from

cultures other than their own. The degree to which the nurses believed their present working environment influenced their capacity to provide culturally appropriate care was raised and, towards the end of the interview, two definitions of cultural safety were presented for interpretation and comment (see Appendix D). Although interested in the level of political awareness and its effect on practice experiences, this question was placed last because I did not want the definitions offered to 'flavour' the participants' spontaneous descriptions of their experiences.

Audio-taping enabled me to listen supportively. I wanted to minimise researcher-participant power differentials and believed that interacting with the nurses as partners and professional colleagues would enhance their capacity to talk freely about their experiences (Moustakas, 1990). Field notes describing the interview setting and timing were recorded as soon as possible after each interview. I also commented on the congruence between verbal and non-verbal communications and noted any difficulties encountered.

All interviews were transcribed personally. With the conversational experience freshly in my mind, I clearly remembered how particular statements were made and this helped to capture more accurately the nuances of emphasis, hesitation, silence and humour. Then, as each transcription was completed, a copy was mailed to the appropriate participant for verification and additional comment. Transcriptions of several early interviews were also sent to my supervisor for comments regarding interview technique, the style of questioning and the transcription layout.

Nine of the first ten participants were interviewed a second time. One nurse withdrew, for reasons unrelated to the study, but gave permission for her initial interview to be included in the analysis. The second interviews served two purposes. Wanting to capture recent, and perhaps more detailed experiences, I had invited each nurse to keep a small journal between interviews. These were used to record examples of practice perceived to have cultural relevance together with any associated thoughts or questions. The journals were used in varying degrees at the second interview, but were considered to be personal property and were kept by each participant. Second interviews were also used to clarify and extend understandings gained from the previous interview. There were times when I also cross-checked common and different experiences. In one interview I asked, for example:

*Some participants have talked about how they draw on personal experiences of being in a minority situation where they felt vulnerable and frightened. Is this similar to what you are saying? I wonder if your experience of “changing high schools and temporarily going crazy” in the bigger, more diverse environment might similarly help your understanding of a person of coming from a quiet island to the ‘big smoke’?*

And on another occasion:

*Another point made has been that of feeling the brunt of client or visitor anger. Some nurses have talked about that. What is your experience?*

A group interview involving seven of the nurses completed the first phase of data collection. Several of the participants had asked whether others in the study had had similar experiences and the suggestion that we might get together for dinner, followed by an audio-taped discussion, was enthusiastically supported. Although not originally planned, this forum provided further valuable cross-checking and clarification. I prepared myself by reading several articles on the subject of focus group interviewing (Basch, 1987; Kingry, Tiedje, & Freidman, 1990; Carey, 1994), and began the discussion with a brief summary of my beginning interpretations asking: “Does this seem real? Is this what the experience is like?”

Feelings of camaraderie and trust were evident and there was little need to prompt the discussion. I encouraged conversation across the group rather than to and from myself by averting my gaze away from the speaker on many occasions, although there were also times when eye contact was important as a means of encouraging the speaker to continue. Mostly people spoke one at a time and everyone contributed openly. Basch (1987) suggests that relaxed group situations often facilitate the sharing of concerns that individuals may otherwise find difficult to communicate. Often the stories told confirmed and augmented one another. But there were also challenges and sometimes a counter story would be told which in turn triggered recall of other experiences. Transcribing was easier than I had anticipated and again the transcriptions were mailed, with stamped addressed envelopes, to each of the nurses.

The second phase of data collection took place after attendance at a phenomenological workshop facilitated by Max van Manen at Monash University in December, 1995. With an increased understanding of the value of rich anecdotal description, I intensified my focus on the phenomenon of interest ‘as lived through’. I worked harder during interviews to explore the private feelings, motivations and expectations embedded in the nurses’ interpretations of their experiences. A further

four nurses were interviewed individually and three more chose to make their contribution via a group interview. I also invited several of the participants to elaborate further, in writing, specific experiences contributed during our discussions. Providing the guidelines that I had received in preparation for van Manen's workshop, two very valuable stories became data in this way and two additionally similar contributions were received from other nurses inspired through informal meetings.

When second interviews were completed, the transcripts of both interviews were colour coded for each participant and kept together. Wide margins and double spacing enabled comments to be made and the use of only one side of the paper ensured there was plenty of space for elaboration and the clarification of meaning. In total, data collection relating to the nurses' experiences, comprised thirty-nine interviews and four written anecdotes.

### **Collecting data to contextualise the nurses' experiences**

#### Nursing literature

Driven by the need to "clearly define the cultural and historical horizon of the actors involved in this event" (Hekman, 1986, p.150), I searched the literature for nursing's philosophical underpinnings, placing particular emphasis on the evolving interpretation of culture. Reviewing both local and international literature, I sought to explicate the values, beliefs and assumptions that were likely to have informed both the nurses' practice reflections and the pre-understandings or prejudices influential in my interpretation.

#### Curricula documentation

The collection of educational documents pertaining to cultural aspects of curricula was undertaken to provide contextually grounded information to situate further the hermeneutic analysis. Nursing's educational philosophy constituted a significant part of this study's context because every participant including myself had, by virtue of being in New Zealand, experienced the notion of 'cultural safety in nursing education' in one form or another. It was essential to explore the way in which these meanings were being interpreted against the background 'whole' of nursing's philosophical horizon.

I tracked the progressive inclusion of matters 'cultural' in New Zealand's nursing curricula both nationally, in the form of Nursing Council policy and procedural documents, and locally in terms of polytechnic programme documentation. I also

reviewed the cultural content of New Zealand's national examination for nursing registration between 1986 and 1990.

### Media material

Throughout the study, sixty-three newspaper clippings and eight articles from popular magazines were reviewed. In the middle of 1995 when a ministerial review of cultural safety was instigated, I also taped and transcribed a television programme and two radio documentaries on the subject. Most dealt specifically with cultural safety in nursing, some with biculturalism in health care and others with race relations issues.

The reviews commissioned by the Nursing Council of New Zealand (Murchie & Spoonley, 1995) and the government's Education and Science Committee (1996), which followed this publicity, also became data for the study.

### Other sources

Exploring the historical and cultural context of the experience of nursing someone from another culture necessitated reading sociological and historical material about New Zealand. Upwards of three hundred professional journal articles and texts specifically relating to the Treaty of Waitangi, New Zealand identity, ethnicity, racism, biculturalism and multi-culturalism were reviewed. I looked, too, at the way in which New Zealanders presented themselves through their art and literature. The medium of photography was particularly revealing of ethnic diversity and group separateness. I found poetry and story helpful in terms of understanding the context constitutive of both my horizons and those of the participants.

### **Laying open the interpretive process**

According to Gadamerian philosophy, the goal of interpretation is not simply to retell events as they happened. The interpreter/researcher enters a dialogue with the texts, not only asking certain questions but also listening critically for questions that arise from interpreting the texts. A willingness to work between the "familiarity and strangeness" of texts is required in this form of inquiry because "the true locus of hermeneutics is this in-between" (Gadamer, 1996, p.295). At the same time that meaning is given, meaning also remains hidden. Thus analysis requires reflexive engagement within the hermeneutic circle of understanding (Koch & Harrington, 1998).



Hekman's (1986) discussion of the methodological implications of Gadamer's hermeneutics for the social sciences proposes that analysis should begin with the researcher seeking to define the cultural and historical horizons of the participants. She argues secondly, that there needs to be an awareness that the researcher necessarily imposes his or her own understandings on those of the actors or text and, thirdly that in choosing to focus on a phenomenon, the researcher is aware of, and thus makes explicit, the effect of his or her knowledge on the interpretation. Although listed sequentially, the recognition that these processes interrelate and overlap with each other is important. The focus of exploration in Chapters Two and Three addressed the first of these recommendations. Attention will now be given to explaining the ways in which Hekman's second and third recommendations were implemented.

### **Surfacing pre-understandings**

Prior to submission of the research proposal, a colleague had interviewed me in order to clarify a number of issues relating to the study. This also served to assist the identification and documentation of the assumptions and expectations that I held in relation to the topic. The aim was not to 'bracket' or set these aside, but rather to bring them to the surface in dialogue so that they became more amenable to scrutiny. I needed to clarify, as much as possible, the direction and limitations of my guiding interests.

Another way in which I sought to increase understanding of my 'horizon' and 'prejudices' was in talking with people and interacting with texts outside my circle of familiarity. Recognising the limitation of self-reflection when trying to surface my prejudices, I consciously sought non-female, non-nurse, non-teacher and non-Pakeha sources of dialogue. Of particular value, in this way, were my business-oriented husband, a Maori woman with whom I shared an office and one of my supervisors, a male sociologist.

### **Ongoing exploration of prejudices**

Throughout the study, I documented my experiences as a researcher in a journal. I recorded, along with the rationale, the decisions made regarding method. I described my reactions to the participants' stories, the literature I was reading and the media events relating to cultural issues. I took the journal to work. Locked in my brief case, it accompanied me to seminars and conferences, meetings with my supervisors and my

study support group. Using Peshkin's (1988, p.18) notion of "warm and cool spots", I wrote about situations and ideas that encouraged me, as well as those about which I preferred not to hear. There were times, for example, when I noted my disappointment at the seeming inability of participants to see patients' points of view. In relation to one transcript I jotted:

*Nurse X mentions client vulnerability but does not see this as a reason for nurses to take more responsibility or make effort in terms of compromise and flexibility. It's hard trying to avoid being judgmental about nurses' attitudes and their ability to be culturally sensitive.*

Although knowing the difficult circumstances in which this person worked, I found myself expecting that she should be able to overcome these in order to meet patients' individual needs. This was a 'cool spot'. I needed to explore the origins of this bias or prejudice in order to be able to see beyond it. The purpose was not to necessarily discount the prejudice but to engage with it in a way that extended, rather than restricted, understanding. Further exemplification of the ways in which such 'cool' and 'warm' responses influenced the thesis findings will be provided in Chapter Nine in relation to the stories selected to illustrate the over-arching theme: working with prejudice, paradox and possibility.

Also documented was any personal action taken beyond the role of researcher. An entry, in July 1995, recorded a discussion with colleagues that resulted in my drafting a series of letters to the Members of Parliament involved in the debate over cultural safety. I was concerned by, what I perceived to be the one-sided and destructive nature of media reporting and felt obliged to contribute another view of the issues involved. As someone whose understanding was increasing through involvement with the topic, I was taking action beyond that required for the purposes of research. The response was important in demonstrating my moral position in relation to the sociopolitical context and again its influence on the interpretation needed to be recognised.

At a mid-point in the analysis phase, my colleague interviewed me again, the aim being to record and clarify the nature of my changing understandings in relation to the topic. Each time a journal was completed (there were four in total), I reviewed and wrote notes tracking the progress of my understanding. Regular conversations with fellow interpretive researchers also served to clarify both methodological and substantive interpretations (Smythe, Spence, & Gasquoine, 1995). Other important challenges

came from clinical colleagues. For example, it was a comment from a friend that not all nurses can or do attempt to meet patients' cultural needs, that led to my asking: "What about the times when nurses do not seem to make an effort?" Wondering what 'not striving' might look like, thus helped me to see the possibility of different directions and intensities within striving. It also prompted reconsideration of the contradictions inherent in this notion (this is discussed in Chapter Eight).

Isabelle Sherrard<sup>49</sup> provided a valuable critique of the chapter that explored the meanings of culture in nursing. I also met with academic staff from the University of Auckland's Department of Philosophy and was, of course, often challenged and guided by my own research supervisors. Such action is illustrative of the ongoing self-critique and self-appraisal argued to characterise the 'reconceptualised rigour', proposed by Koch and Harrington (1998).

### **The hermeneutic creation of texts**

In hermeneutic study of this type, texts are co-created through dialogue. During our discussions the nurses and I, through the processes of question and answer, disclosed and created meanings that, in this interplay, extended beyond the original horizons. The text analogues thus represent another layer or second level of interpretation, the first having been the nurse's recollections of the phenomenon in question.

In the following excerpt, Sue and I were discussing media use of the words 'sensitivity' and 'safety' in relation to cultural issues in nursing.

*Me: I know these terms have been bandied around a lot, but do you feel essentially OK about the ideas behind them - for nursing?*

*Sue: ... Oh dear ... Yes, in way I do and in a way I don't. Sometimes I feel there are double standards; that we are expected to be culturally sensitive towards clients, but what about our own culture?*

*Me: Can you tell me about the double standards? Is it that our culture is not acknowledged? Is it our nursing culture or is it our cultures as individuals?*

*Sue: Our cultures as individuals. We come from different cultures. Our nursing culture - I suppose people expect nurses to be culturally sensitive and culturally safe ... And the minute we step out of line there's a big hue and cry about it. But we're human.*

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<sup>49</sup> At that point, Acting Head of UNITEC's School of Nursing: a nurse with long-standing interest and involvement in cultural issues in nursing education.

*Me: Mmmm ... So you would like to see more of a two way process?*

*Sue: Yes. There's too much cultural safety on the Maori side ... on the Polynesian side. What about cultural safety on the New Zealand kiwi side. This is where I think there are double standards.... [There are people], who are European, that get very irate about this.*

This discussion had taken place towards the end of our conversation. In raising the issues of sensitivity and safety, I was seeking to understand the context influencing Sue's practice experiences. The beginning question raised a topic of interest to me. Sue's response then decided the direction of the ongoing exchange but was contributed to by the questions I asked when seeking clarification. Thus the interview transcript is co-created. It represents an understanding that is contributed to by both parties but which differs from the original view of either party.

The interviews were informal in nature. My intention was to make them more like discussions between colleagues. I focused on the natural expression of thoughts, ideas and feelings, encouraging the participants to respond in whatever way they felt most comfortable. For example, having begun Jo's interview by asking her to think of herself in a situation with a person from another culture and then to describe what that experience was like, Jo preferred to begin differently:

*Jo: OK, what it's like to nurse someone from another culture. Once I get started I'll be fine. I just have to think. ... Do you think I could start off with what it's like nursing someone from my own culture?*

*Me: Mmmm, that will be a good idea*

*Jo: It might get me started, OK...*

The next six pages of transcript were focused in this way.

An attitude of gentle probing also characterised my interviewing. The questions used sought to clarify the nature of the experience. Further into the above discussion, I asked:

*Me: OK ... Can you move now to talk about how it is different when you are nursing someone from a culture that you are less familiar with?*

*Jo: Mmm ... How is it different? ... I suppose there are a lot more things that I don't take for granted. There is a lot more learning, not that I take every Maori person for granted, but there are things that sort of naturally come ... Yeah. So it's taking a longer time to get to know the person. You've got to have a lot of respect for people just to build any kind of rapport, and just always checking their needs and watching, you know,*

*getting signals from them. If they're not talking, you are watching their body language, what they do, trying to pick up how they're feeling, their behaviour.*

*Me: So your brain's actually working to assess all the time, and to interpret?*

*Jo: Yes. That's right.*

There were times when personal experiences were offered to affirm and assist further disclosure. Interested in clarifying the meaning of the previously used term 'driving me nuts', the following excerpt from a second interview provides an example:

*Me: Now ... this business of having a patient who is driving you nuts. I'm interested in what sorts of things drive you nuts. What is it that makes you feel like this?*

*Theresa: ... I don't know about the driving me nuts bit ... It seems a bit harsh in hindsight.*

*Me: Mmm, ... But things do drive us nuts at work don't they?*

*Theresa: Yes they do ... I think one of the biggest stresses that I find is ...*

More than a page of enthusiastic, uninterrupted and vivid description ensued and Theresa's relief at being able to pour out these pent up feelings was palpable. Located towards the end of our second conversation, this excerpt demonstrates the developing level of trust between Theresa and myself. In this instance, the shared nature of our nursing backgrounds appears to have facilitated empathy for each other's experiences.

In order to check the accuracy of my interpretations, I often sought clarification of the words used by participants. When Anne talked of enjoying her experiences in the community during our first conversation, she explained that:

*[G]oing into their home ... you're a visitor and I think that's really nice because they have the power. You're not lording it over them. You wait for them to say "Would you like a seat?" That sort of thing keeps the balance (Anne, 1:75).*

During the second interview, I checked my interpretation:

*Me: Now, about balance and power. I've interpreted that as balance of power. Is that correct?*

I received the following assurance:

*Anne: Yes it is, the balance of power, definitely.*

There were also occasions when such clarification illuminated differences in understanding. Tara had been talking about her constant feelings of guilt and the need to apologise to patients and relatives in an accident and emergency setting.

*Tara: I spend a lot of time apologising. What else can I say? Sometimes I say to parents, "There's no use apologising to you is there?" They know. But yes, I do. I spend a lot of time apologising.*

*Me: That's not necessarily a cultural issue is it? Perhaps it's because of the system and the delays?*

*Tara: No, in our culture you have to apologise.*

*Me: So you do that more than other nurses?*

*Tara: Well ... maybe? ... Well I notice other nurses doing it too. Even though it's not our own fault. I suppose it's the only way we can make them feel a little happier.... It's usually nurses who do that.*

In this interchange, I had initially interpreted the setting to be more influential than the nurse's cultural background and then, knowing Tara to be Samoan, I had wondered whether cultural values contributed to her behaviour. In asking whether she apologised more than her colleagues did, I was asking her to reflect on the influence of personal difference relative to other nurses. Yet this seemed only partially true from Tara's perspective. Her use of the words 'we', 'nurses' and 'our' suggests a common experiencing related to being a nurse. Thus my understanding of culture in this context was extended to encompass the culture of nursing.

### **Hermeneutic interpretation of the experiential texts**

In the same way that interpretation influences the options taken and not taken during the construction of text analogues, the researcher continues to participate in the interpretation through ongoing interaction with the interview data. Researcher interaction with the experiential texts collectively thus constitutes another layer or level of interpretation.

Van Manen (1990) describes the dynamic interplay of turning to a phenomenon, investigating it, reflecting on themes, describing the phenomenon, staying oriented and continually considering parts and the whole. The processes involved are those of reading, thinking, questioning, writing, re-reading and re-writing. It is the data that

drives this hermeneutic circle of understanding but the overlapping and dynamic nature of the processes makes description of the method difficult.

After transcribing the interviews and re-reading each participant's interviews together, I wrote a description of 'overall impressions' to gain a sense of their whole. Returning to the transcripts, I then began highlighting 'significant statements', writing interpretations in the margin and earmarking 'gems for preservation'. The questions that I asked of the texts at this point were: "What does this mean?" "What seems to matter most?" and "What must I not forget?"

A list of interpreted statements and the description of overall impressions for each participant thus constituted the beginnings of analysis. This was sent with the transcribed interviews to their various owners for validation and further comment. Telephone conversations with each participant then served to clarify and prioritise these interpreted meanings.

As soon as I discovered some initially understandable elements, I began to sketch meanings for the texts collectively and from this point on, the interpretations that developed were my own. Although concerned to achieve a fair and trustworthy account, I decided against further member checking (Lincoln & Guba, 1985) for the following reasons. Within the framework of philosophical hermeneutics, experiences are recognised to be time-bound and situation-specific. I had been reminded of this fact during the earlier pilot study when one of the participants decided she could not continue, because having re-read her transcript, she had come to understand her experiences differently. A fusion between past and present understanding had resulted in a new and different understanding.

Sandelowski (1993) suggests furthermore that the representation of multiple realities requires greater abstraction than is necessary when interpreting individual member's realities. This is congruent with Gadamer's explanation that the interpretation is about the subject matter and not the reliving of another person's experiences (see earlier discussion re Schleiermacher, Chapter Four). Bringing the texts together generated more questions and it was through reading, questioning, re-reading, and experimenting with structure progressively, that the interpretation developed. Thus, as individual statements are crafted into themes and sub-themes in hermeneutic analysis, the identification of specific contributions becomes problematic (Koch & Harrington, 1998).

By drawing the reader in, and at the same time prompting the reader to reflect, texts create a questioning that opens new directions of meaning. Searching the data thus focused on finding descriptions of experience, focusing on what was said, yet also wondering about what was not said. In questioning the texts further, I asked: “What am I not seeing?” “Who am I not hearing?” “What appears ordinary because it occurs so often?”

The interpretations were continually modified and replaced by more adequate ones. However, the preceding interpretations were not cast aside. They were the means through which new understandings gained entry and came to the fore. At times these new interpretations extended the old but on occasions they denounced the previous interpretation (Gadamer, 1979).

Understanding meanings in context also involves examining how ideas are expressed. In addition to noting emphasis and tone, it means noticing the words selected and exploring the ways in which word meanings may have evolved, changed or been used differently in other contexts. Tracing etymological sources and searching idiomatic phrases (van Manen, 1990) helped extend the interpretation. The repeated reference by participants to “relationships”, “establishing rapport” and “nursing holistically”, for example, required that I explore the meaning and significance of these concepts. Comparing the variable and the not so variable usage of the term ‘culture’, in both the nursing and sociological literature, was a necessary part of the process of formulating the theme “encountering difference” (see Chapter Six). In a similar way, examining the situated meanings of ‘conflict’ and “dilemma” contributed to, and prompted, exploration of the notions of “tension” and “paradox” (see Chapters Seven and Nine).

### **The contribution of literature to the interpretation**

The literature which contextualises the experience of nursing a person from a culture other than one’s own forms another major part of this hermeneutic circle of understanding. Repeated movement to and from the interview and literature data sources (see earlier section entitled: “Data Collection”) assisted the developing interpretation and provided insight into the qualities and themes constitutive of the experience.

When reviewing literature I documented how the work of others might relate to my developing ideas. While re-reading Truth and Method, the following entry on 11 July 1996 is typical:



*I like the positive feel of Gadamer's writing. I like his understanding of the enabling possibilities of prejudice. This helps me see what makes nursing a person from another culture possible. I also like the way he pieces together aspects of his predecessors' thinking, by exploring and emphasising the different ways they contribute to his current thinking. It is also intriguing that he uses the terms 'striving' and 'in between' and that he draws on Aristotle in relation to moral understanding when discussing issues of 'application'. This has similarity with Taylor and the idea that 'things matter' to human beings. It is also congruent with some of nursing's literature (see Paterson & Zderad, Travelbee, Bishop & Scudder).*

On one occasion, when feeling enthusiastic about the usefulness of Cyprian Smith's "The Way of Paradox" (Smith, 1987), I made extensive notes about the way in which many of Smith's notions seemed congruent with the nurses' experiences. I also noted that the style of his discussion might help me when trying to convey, in my own writing, the tensions inherent in the experience. Then, more specifically, in relation to the interview data, I asked on January 7 1997:

*Is being open the way forward? Jane (2:2) states: "It is more important to be open as a person than to go into a situation with your only mantle being, 'I'm from this ethnic group". This seems congruent with Gadamer and I need to re-read Leininger with this in mind.*

Thus the practices of reading, thinking, questioning, writing and re-writing were used to situate, clarify, challenge and refine the ideas being generated through interaction with the experiential data.

### **Crafting the research product**

The process of textual interpretation is one of constant elaboration and synthesis through questioning, exploring words and their meanings and confronting contradictions. Through acquainting myself with other people's perspectives, situating myself in relation to these and reconsidering my own interpretations, I delved, surfaced and extended my understanding.

Writing and re-writing were an integral part of the interpretive process. Rather than being the final act in the research process, writing is an essential way of giving appearance and body to thinking (van Manen, 1990). It facilitates the reflective activity that a hermeneutic interpretation requires. In my early attempts at writing, I was often frustrated by what seemed to be blind alleys. Yet these were important precursors of thematic ideas. Attendance at the van Manen workshop, (1995) inspired the writing of

vivid experiential anecdotes from the excerpts I had previously identified as ‘gems for preservation.’ Then, moving between the transcripts, the literature and my interpretations, the themes and their relationships came to the fore more explicitly through writing and re-writing.

I also drew pictures and diagrams to help clarify the relationships between my ideas. Having wondered about the notion of a matrix, and attempted to draw data findings in this way, I noted in June 1997:

*The matrix has merit in terms of accommodating the complex interrelationships between the themes but it still seems too structured. It's too tight and too linear in organisation. A matrix does not adequately represent human understanding or experience.*

Aware also that rushing interpretation risks premature closure (Morse, 1994), I spent time ‘intuitively dwelling’ with the data and ‘letting the interpretation be’ when facing a seeming impasse. Like the participants in the study, I too learned to live with uncertainty and paradox and gained considerable insight through patient engagement in the processes of reflection and reflexivity.

The manner in which ideas are communicated in writing also has important consequences in terms of meaning. In selecting and using words, I have tried to achieve congruence with hermeneutic philosophy. For example, when discussing the importance of articulating the differences between our “home understandings” and those of another person for the purpose of “correcting distortive understandings” (Taylor, 1995, discussed in Chapter Nine), the word ‘correcting’ seemed to imply the existence of right and wrong answers. The term ‘re-evaluate’ was therefore selected as being more appropriate because of its greater openness towards possibility.

In an effort to stay close to the phenomenon, I have tried to ‘show’ more than to ‘tell’ when presenting my work. Yet I know also that I live paradoxically with the expectation that the thesis does in fact ‘show *and* tell’. Thus I am reminded of the limitations of dichotomies. Words like “perhaps”, “suggest”, “may”, “seem” and “appear” have therefore been used to create a tentativeness that is consistent with hermeneutic openness to other possibilities and the terms “yet”, “although”, “but” and “at the same time” assist to convey the contradictory and paradoxical nature of the phenomenon as interpreted.

Questioning within the text has similarly been used to convey a sense of tension between that which is known and that, which may yet be known. Congruent with philosophical hermeneutics, this strategy also serves as a reminder of the effective historical consciousness that I bring to the analysis. The questions are a way of illuminating the interplay of multiple viewpoints and possible understandings. They reinforce the notion that understanding is socially constructed. Moreover, in an effort to write *matically* (van Manen, 1997), narrative descriptions, interview excerpts, literature, poetry and researcher journal entries have been used to produce a text that vividly portrays the experience of nursing a person from another culture. In addition to providing a rigorous and coherent description, I seek to share a sense of living the experience through arousing feelings, stirring memories and stimulating further questions. Furthermore, as much as is possible within the parameters of a doctoral thesis, I have sought to communicate in a manner comprehensible to clinicians.

### **Judging the rigour of this study**

Numerous authors have challenged the claim that hard and fast rules are an appropriate means of judging the 'goodness' of qualitative inquiry (Smith, 1990; Schwandt, 1996; Emden & Sandelowski, 1998; Koch & Harrington, 1998). Of greater importance than adherence to criteria is the demonstration of a study's congruity with its ontological and epistemological roots. The intent of this chapter (and indeed of the work in toto) has been to provide evidence that hermeneutic philosophy has underpinned decisions regarding method and the process of interpretation.

The use of a hermeneutic approach necessitates the comprehensive description of context both historically and in present terms. Throughout the study, I have focused on situating both the participants' experiences and my interpretation of these in this way. I have also sought to explicate the methodological decisions, the progression of theoretical insights and the analytic choices that have contributed to the interpretation. On several occasions during the study, I used the opportunity of conference and seminar presentation, both internationally and locally, to 'test' my evolving interpretations more widely. My role as a teacher of registered nurses has provided an avenue for ongoing discussion and challenge and a six-month return to clinical practice during the latter stages of the study also provided an invaluable opportunity for further reflexive evaluation. The interest and affirmation generated within these contexts, has been both rewarding and stimulating.

### **Conclusion**

In laying open the audit trail and process of interpretation, I have begun to describe the events, influences and rationale for the actions taken throughout this study. Yet this, in itself, is insufficient. The interpretation must provide answers to the stated research question. The reader needs raw data that demonstrates the connection between presented findings and the real world. The findings need also to stimulate further questions and thinking (Marshall, 1990). Evaluation of this study's value and plausibility will therefore continue as analysis of the phenomenon progresses. Interpretation of what it is like to nurse a person, or people from cultures other than one's own, commences in the following chapter.

## Chapter Six: Encountering Difference

Human beings draw close to one another by their common nature, but  
habits and customs keep them apart  
(Confucian saying, cited in Gudykunst & Kim, 1992, p.41).

Having glimpsed the cultural and historical horizons that constitute the phenomenon of interest and gained insight into the manner in which exploration of the topic has been approached, attention now turns to the interpretation of everyday practice experiences.

Imagine that you are a nurse working clinically. You are about to meet a patient for the first time. It is likely that the contact has already been initiated and that certain information has been documented. You therefore know the person's name but may not know how it should be pronounced. You know the diagnosis and have expectations about what this will mean in terms of nursing care. You also have details about the history of the illness or trauma. You know the person's age, their address and their country of birth. A picture is forming in your mind. You wonder if they will speak English. You wonder how easy it will be to communicate. You wonder whether they have people who will support them through this experience and you remember the frustrating time you had last week with a patient whose background was similar. You sigh. You knock on the door and enter.

This chapter describes what 'from another culture' means to the nurses in this study. The terms 'encountering' and 'difference' are used because the participants encounter people from other cultures as different from themselves. Questions arise about the relationships between identity and difference, but more importantly for practical reasons, 'encountering difference' when nursing a person from a culture other than one's own, also has meaning as difficulty.

### **Difference is 'different from me'**

Nurses understand people from other cultures in relation to themselves ie. as different from me, in both a personal sense and in terms of group membership. Such understanding also has a temporal relationship. Difference may be anticipated. It is

experienced in the moment of happening and can also be understood more deeply on reflection. Beverley notices cultural difference before she sees the patient.

*I think the first thing I notice when I get a referral is the name and immediately I know it's someone from another culture (Beverley, 1:3).*

Often the name announces the person as different in the written form. Perhaps this is because it differs from those with which Beverley is more familiar? Does this recognition signify a sensitivity and awareness of the person's culture? The story continues:

*The thing I find frustrating is that I find it very difficult to identify where they come from. So many referrals are incomplete ... and I find it very embarrassing to have to go to them and ask. I mean, I'd never go and say "What race are you?" ... but I need to find a tactful way of finding where they come from so that I can put into perspective how I should be working.*

Frustrated by the lack of referral information, Beverley's response suggests that "race" is a difference that matters. What is the basis of this judgement? What, in Taylor's (1985a) terms, is the significance of this "import"? Asking the clarifying questions seems difficult and the embarrassment felt suggests that 'difference' has meaning as difficulty. The statement that she would never ask "What race are you?" also suggests that past horizons are operating in the present. Exploration of the meaning of 'culture' in Chapter Three revealed media reportage to use the words 'race' and 'culture' synonymously, yet in nursing, the adoption of Kawa Whakaruruhau has heightened awareness of nurses' racist attitudes and practices. Is this what prompts Beverley's search for a "tactful way of finding where they come from"? Beverley's use of the term 'race' seems to have meaning in terms of the person's origins. Does it mean country, ethnicity, nationality, perhaps? Are the associated feelings positive or negative and does having such information necessarily mean knowing how, in her words, one "should be working"?

Jane compares her experiences as a public health nurse with experiences gained previously in an acute hospital environment.

*The first thing for me is not a person's colour or the way they dress. It's language ... Often the first thing is - that nothing comes out because they don't speak English. Or they will say something in their own language, or say "no", which indicates they don't speak English. Then, once I've heard a voice, I put the rest of the picture together. This is a very multicultural society. We all wear different clothes and there are so many different types of coloured skin. So once I've heard a voice I can*

*think, notice little indicators, maybe a scarf worn a certain way, or jewellery, the way they stand, whether they make eye contact, those sort of non verbal things ... Often I think, "Oh no. I'm going to blow my manager's interpreting budget", which I do all the time (Jane, 1:9).*

Jane values being part of the patient's world because it provides her with much more information than was available in her previous role in a hospital ward. She can simultaneously see, feel, hear and thus contextualise her patient's situation. Yet Jane begins by discounting colour and dress as the main indicators of difference and focuses instead on language. Is Jane seeing, but not seeing, dress and skin colour because she regards being able to communicate to be more important? She concentrates very specifically, firstly on whether or not anything is said, then on what language is used, and finally on how much English is forthcoming. Cultural difference seems to be being interpreted as a potential difficulty in terms of communication.

Perhaps Jane's focus on language is pragmatic? Her mention of the interpreting budget suggests that she needs to decide early whether or not to arrange for an interpreter. In the ensuing conversation, Jane explains that the first step is "*just making contact with the family*" and that often she is unable to get information even if she tries. Yet there is an awareness of more than verbal language. Jane also notices and specifically identifies, what she calls, "*little indicators*". She mentions "*non-verbal things*" after having looked beyond seemingly significant factors like dress and skin colour. Perhaps "*clothes*" and "*coloured skin*" seem stereotypical when contrasted with the very individual differences recognisable to Jane? Or perhaps she has learned through nursing that understanding cultural difference begins with finding sufficient language? Although their experiences are different, both Jane and Beverley anticipate that it may be difficult to acquire the information needed in order to tailor appropriate nursing care.

Sue's first encounter with cultural difference, after immigrating and finding work in New Zealand, is experienced more dramatically.

*I must admit my first encounter with a Polynesian patient was quite hair raising. I had to go and do a blood pressure on a very psychotic and paranoid young man. He was big - about 20 stone. He was a gang member with patches on. And he had dreadlocks. I mean dreadlocks to me is Rastafarian and in England that sort of population brought fear to me. It was a nightmare. I had never encountered anything like this before. My hands were clammy. I had to keep telling myself "Look this is within your professional capacity. You'll be all right. If anything happens there'll be other staff who will come to your rescue." I kept telling myself, "It'll be fine. It'll be fine. Just remember your psychiatric skills. Talk to the*

*person.” In my mind’s eye I recalled telling my son that when he came into contact with a growling dog, “Don’t show you’re afraid”, and I kind of related to that. “Don’t show your fear. Just get on with it”. But I didn’t feel safe. I wanted to be a million miles away. It was very hard.*

*I suppose the charge nurse thought I’d get on better with him because I had a brown face and maybe for him my brown face was OK. But the moment I opened my mouth, with this really prominent English accent, the poor man was quite confused. “There’s somebody speaking. It’s not your voice.” And a job that should have taken 5 minutes took more than half an hour.*

*I explained the procedure, sort of jabbering along to cover up my fear and hoping he wouldn’t pick up that my hands were trembling. It took a lot of encouragement and persuasion. Then later, after we had built up a rapport, he told me how confusing it had been for him and when he improved he came up to me and said, “Hey Sue, You’re a bit staunch, but you’re all right.” It was really nice and my biggest accomplishment when I first started nursing here.*

In this story, cultural difference announces itself in a very physical manner. Size, hair and patches vividly conjure a scene that is threatening. Sue’s sense of danger is palpable. Fear is evident in her uncontrollably clammy hands, her jabbering speech pattern and her attempts to talk herself through the situation. The man’s colour is not mentioned yet it is implied when Sue suggests her own brown face may have been the reason she was assigned to this patient. The dreadlocks seem to engender more fear than the man’s psychotic state, which she is able to manage using her nursing knowledge and skills. Thus Sue’s prejudices are both ‘a help’ and ‘a hindrance’. She draws on professional knowledge and expertise in order to approach and successfully work through this challenging situation. A previous, ordinary life experience also helps her to cope. However, other experiences contribute in an oppositional way. The Rastafarian association exacerbates her fear, a fear that, despite her efforts to the contrary, may well have been communicated to the patient and adversely affected the situation. Her gender, her relatively smaller size and her lack of specific cultural knowledge contribute to her feelings of vulnerability. Yet, she tolerates this discomfort because her motivation to persevere is strong. Knowing that this is her role and that she has something to offer, she also anticipates that her colleagues will help if necessary, and is able to continue. Nursing as a culture has prepared Sue to be more comfortable and confident with a person who is psychotic than with someone who appears Rastafarian. After all Sue, who is a mental health nurse, is with this person because of the psychosis not his association with Rastafarianism. Perhaps ‘culture-as-gang-membership’ presents greater difficulty than ‘culture-as-race or ethnicity’?



Is it not also true that, in the midst of the unfamiliar, differences are more noticeable than similarities? In highly charged situations, our senses are heightened and the differences seem greater. Fear, moreover, can be a common bond and this commonality may have contributed to the positive outcome. The fact that both Sue and the patient had pre-conceptions of each other that were not sustained also suggests that, in addition to feeling vulnerable, the realisation that each had prematurely judged the other may have provided the basis for beginning rapport.

Thus co-existing with the differences are emotions that are commonly experienced. Perhaps the degree of difference is also relevant? Having to deal firstly with strong emotions means that more time is required for the development of trust. Concerned for her personal safety, Sue is initially unable to engage with this man as a person. But later, as her own tenseness lessens, she begins to see more of the individual. Perhaps the eventually successful outcome is due in part to the opportunity for continued interaction when compared with other time-limited situations in health service delivery? Closely allied to this are capacities, within both Sue and the patient, which enable each to come to know and respect the other's differences.

In these stories, difference means difference from me both individually and professionally. Using themselves as referents, because as "self-interpreting animals" (Taylor, 1985a, p.45) they cannot do otherwise, each of the nurses notices aspects with which they are not personally familiar. Name, the language spoken, skin colour, dress and gestures stand out as different. They are noticed, not taken for granted or passed over as they might be in encounters with people from one's own culture. Moreover the noticing is immediate and, because the differences demand attention, they momentarily interrupt the business of nursing (ie. 'getting nursing done'). Is this what matters? Is this the meaning of noticing difference?

Perhaps difference-from-me is being interpreted racially? Yet, the term 'race' is conspicuously absent in the nurses' conversations, possibly, as previously mentioned, because of an enhanced awareness of racism? 'Culture' is the word most commonly used by the participants. The term 'ethnic' is mentioned occasionally and there is frequent use of labels describing ethnic group membership and nationality. Are these the differences that matter to nurses?

### Encountering 'difference as ethnicity'

When I asked the nurses to tell me about nursing people from other cultures, they immediately focused on patients whose ethnic backgrounds differed from their own. Theresa began by talking specifically about a "Samoan lady", Angie of a "Samoan man"; Donna, Amanda, Elisabeth and Pam talked first about Maori clients; Alice of a "Lebanese gentleman and his family", Meg of a "Korean girl", and Lara of a "lovely, Niuean lady". The responses from Bobby, Jane, Anne and Sue were initially more general. They began by speaking of nursing "Polynesian people, Maori and Pacific Island families" [and] "people from Somalia, Bosnia, Iran, and Iraq". Beverley referred to "all sorts of cultures - Vietnamese, Chinese, Maori". Tara, who is Samoan, mentioned "a variety of patients from different races" and included "Pakeha, Asians, Indians etc". Yet, given that people from most of these countries may belong to one of many ethnic groups, the array of descriptors reveals that culture also means nationality. Moreover, when compared with experiences earlier in their careers and other parts of New Zealand, the range of differences seems more overwhelming in Auckland. Anne comments:

*I was talking to my sister in Whangarei about the huge number of ethnic groups here. For my brother-in-law, a school teacher, the main ethnic group besides Pakeha is Maori. So Auckland is unique I think in its diversity (Anne, 2:49).*

Discussion with the head of Auckland's Interpreter Service during the time of data collection revealed the availability of interpreters for "seventy-five languages, including dialects" (R. Wikaira, personal communication, May 1998). Between 1991 and 1996 the European/Pakeha population of Auckland and Northland had dropped from 73% to 62.3% and only 70% of the European/Pakeha population were born in New Zealand (Walker, 1998).

When asked about their own ethnicity a number of the participants described themselves as being 'Pakeha New Zealanders'. I too, use this descriptor for myself. How many New Zealanders now describe themselves in this way? The word 'pakeha' is Maori. Does this mean that 'different from me' in the context of being a New Zealander is inclusive of Maori in some way? With renewed understanding of the Treaty of Waitangi, an increasing acknowledgment of identity in relation to Maori and decreasing identification with British ancestry seems more evident. Yet also prevalent in the general population is the view that 'we are all New Zealanders'. Discussing the issue of ethnic labels, Bell (1996) notes that in the 1986 census, over 36,000 people in a population of 3.3 million rejected the option to self-ascribe their ethnicity, by either not

responding or by substituting the word 'New Zealander'. Is the issue one of confusion between nationality and ethnicity? A 1993 publication, which discussed classifications of ethnicity, revealed that many New Zealanders objected to being called European and a "slightly greater" number objected to being called Pakeha (Department of Statistics, 1993, p.16). In a letter to the editor in the same year, Harrison-Smith (1993) argued that all New Zealanders had immigrated at differing points in the country's history and, within the media context of 'political correctness', Bauld (1993) suggested that intermarriage had ensured that most New Zealanders had "the blood of many races running through their veins."

In the context of this study, the nurses' recognition of difference as ethnicity demonstrates awareness that cultural practices and beliefs differ between groups in society. Yet this raises questions about the relationships between 'race', 'culture' and 'ethnicity'. In sociological terms, the group members define who is included in an ethnic group. "Ethnicity is essentially an identity that reflects the cultural experiences and feelings of a particular group" (Spoonley, 1995, p.36). The positive feelings of belonging to a cultural group are emphasised and ethnicity is contrasted with the term 'race' in which membership is specified by other, usually dominant, groups in society. While on one hand it is possible that the nurses have established their patients' nationalities through asking or reading referral information, on the other it is possible that they are ascribing group membership. Thus questions can again be asked about the bases of these judgements. Do the nurses feel superior in the relationship? Is this the meaning that matters?

*Anne, who works frequently with new immigrants, talks of realising how lucky she is ... being in their house, their territory, with their permission. She also acknowledges that, because they live in my culture, I have the power. I am comfortable. If I were in their culture, I would be the powerless, disorientated one (Anne, 2:35).*

Anne acknowledges her more powerful position but she also feels privileged at being invited into these people's homes. Rather than being interpreted as superiority, her position of power is accompanied by feelings of responsibility towards the inhabitants. The significance of the power differential is that the person's difference from Pakeha culture is perceived to render them more vulnerable in some instances. Thus the nurses' use of descriptors does not necessarily imply racial superiority or prejudice in a negative sense. Recognising difference whether as race, nationality or ethnicity can be enabling in nursing. For many nurses the ultimate call is the call to care (Bishop & Scudder, 1996).

Gudykunst & Kim (1992) suggest that initial impressions of strangers are largely abstract and categorical because of the lack of available information. Sometimes the nurses' descriptors derive from data available through already existing documentation regarding place of birth or self-identity as recorded by the patient. On other occasions, the nurses draw on their previous experiences in order to decide upon the person's 'cultural' background. Coupled with each of the ethnic/nationality labels above, are other defining labels: 'lady', 'gentleman', 'girl' and 'family'. Perhaps these are differences that matter also? The distinctions seem to communicate an understanding that health beliefs and practices differ between and within groups. Does this demonstrate that nurses are alert to 'assessing' and gathering as much information about variability as possible? Or are the descriptors just stereotypical forms of generalisation?

Differentiating within Pacific Island and Asian cultures is not easy. The nurses do not always distinguish between Niuean and Samoan or Vietnamese and Cambodian people, for example, and the terms 'Pacific Islander' and 'Asian' are frequently used in an all-inclusive sense. Occasionally, the pause or correction made in relation to the descriptor demonstrates awareness of this lack of knowledge, but most often, the main point of the story is that the person is perceived to be vulnerable because of their different background. Thus race, ethnicity and nationality, although significant, only partially describe the meaning of cultural difference in nursing.

### **Other differences that matter**

In addition to ethnicity, difference has meaning in relation to gender, age, social class and occupation. Jo notices that Indian males are less receptive to female nurses.

*In my experience they get on much better if they have a male nurse. If you're female they're not going to tell you anything. Its just 'Get down there woman', 'I want my lunch' ... That's not to say they're all like that. It's just that I've found it works better with a male nurse. They'll talk on a deeper level (Jo, 1:124).*

These are practice observations from a psychiatric setting and Jo's generalisation suggests that similar situations have been experienced previously. Although the patient's responses differ from that to which she may feel entitled, Jo is neither offended nor does she expect all Indian men to be the same. In addition to considering ethnic difference, Jo is taking the man's illness into account. Of utmost importance is this person's need to relate therapeutically to someone. Jo knows that challenging or

rejecting the man's behaviour might compromise his progress towards health. She therefore accepts that it is in his interest to be nursed by a male. Thus, although inclusive of gender, nationality and illness, the difference that matters is that of the person's vulnerability.

Cultural variations relating to rural and urban socialisation experiences are also recognised:

*I notice quite a difference in people who are brought up in Auckland. This is really generalising, but people who live in Auckland seem to be more forward about asking for things or telling you something is not right ... whereas I've found people who are from the little towns, in the middle of nowhere, sort of just sit there quietly (Jo, 1:7).*

The concern again is that the care of those who are less assertive may be compromised. Even within the same city, differences are acknowledged to exist. Comparing district nursing in South Auckland with experiences in central Auckland, Beverley explains:

*Epsom has a culture of its own. They expect you to be there at 9am and if you're not there by five past, they're on the phone finding out where you are. They have quite rigid expectations of you (Bev, 3:54).*

This comment is offered by way of explaining the reluctance of some of Beverley's colleagues to fill her South Auckland position when she is temporarily required to assume a managerial role. Epsom is an upper middle-class and predominantly Pakeha residential area. South Auckland's population comprises greater numbers of Polynesians and people of lower socio-economic status. What are the differences that matter?

When pondering the definition of culture, Anne asks whether it is "*familiar territory ... where you feel comfortable*" reflecting further that "*I don't know if that is a personal or a general thing?*" (Anne, 1:169). Perhaps it is both personal and general, but always situationally specific? In Chapter Four, the variable willingness of individuals to engage in cross-cultural interaction was mentioned. The constant fusion of past and present experiences and the place of cross-cultural contact and conflict in the progression of human understanding were also explained. Neither people nor societies are static and the recent diversification of New Zealand's population has again challenged historically

embedded notions of egalitarianism. A poll of 750 randomly selected adults in October 1995 concluded that “Kiwis”<sup>50</sup> were becoming “more racist”

51% say there are too many Asians here compared with 42% last October and 57% say there are too many Pacific Islanders here compared with 53% last year (Hunt, 1995, p.1).

The president of the New Zealand Federation of Ethnic Councils and the Auckland Refugee Council recently referred to “friction everywhere”, yet the manager of Auckland’s Race Relations Office noted that New Zealanders “are increasingly aware of what is called “oversive racism”, our recognition of our own unconscious responses in the way we view the world” (Reid, 1998, p.15). Thus positive and negative signs coexist within contemporary race relations (recall the section in Chapter Two entitled: “Glimpses of Possibility”). An increased opportunity for cross-cultural contact exists alongside the human predilection for engaging with familiarity rather than strangeness.

Most people prefer to interact with others who are relatively similar (Gudykunst & Kim, 1992). However, contact with people who are different can be regarded positively as a novel form of interaction (Rose, 1981). In the context of a group discussion, Beverley’s (3:54) comment that some of her colleagues “*feel more comfortable in their niches in Epsom etc.*” prompts the following responses from Bobby and Theresa:

*Polynesian people are so welcoming (Theresa, 3:55)*

*And they’re so grateful for whatever you can do for them ... You’re welcomed in, “Would you like a cup of tea love?” (Bobby, 3:56)*

*Yes, you feel special to be there, don’t you? (Theresa, 3:57)*

*You do, and they’re really glad that you’re there and they’re getting the help. If you’re there for them, that’s the important thing. Yes, it’s very rewarding (Bobby, 3:58).*

The pleasure inherent in such encounters is clearly evident. The cultural differences are valued and important for their positive reinforcement. But more important, for these participants, is the patient’s perception that he or she is receiving nursing assistance. Being “*there for them*” is something these nurses believe is important. However, ‘being there’ is not always straightforward.

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<sup>50</sup> The Kiwi is a flightless bird indigenous to New Zealand. In this context it is used colloquially to mean ‘New Zealanders’.

Beverley enjoys the more relaxed atmosphere in South Auckland. She challenges her colleagues' perceptions of its *"social problems and the high percentages of Maori and Pacific Island people"*. Yet she is also aware of the frustrations inherent in her working environment. *"You can go to someone and they know you're coming, but they'll still go out. You can make the effort to ring and say, 'I'll be there between ten and eleven" and you get there and they're still not there"* (Beverley, 3:60).

The conversation turns to consider this paradox and other examples are offered in a somewhat humorous vein. Reference is made to *"the ones you bend over backwards for, like going to the funeral, and get absolutely nothing in return.... Then the people you don't feel you have been able to do much for, they're the ones who put something in the paper"* (Beverley, 3:65).

The nurses are talking about the unpredictable nature of patients' appreciation for their work. What seems to be common, in terms of nursing experience generally then, are the numerous differences that engender uncertainty, surprise, reward and disappointment. Perhaps the issue is one of degree or accumulative difference?

Socioeconomic status is also recognised as a significant cultural difference. Jane remembers attending a community meeting in which discussion centred on ways of breaking the poverty cycle occurring among Maori.

*Ultimately it came back, not to a specifically ethnic culture, but to the culture of where you live. It might be, that in the area you live, everyone is unemployed, that they are on benefits and that there is that dependency cycle.... Often that's a stronger culture than someone's ancestral roots* (Jane, 2:9).

Anne draws on similar experiences to distinguish between poverty-stricken Pakeha and new immigrants:

*We're not dealing with the middle class. If we're dealing with Pakeha New Zealanders, we're dealing with the mother who is addicted to drugs ... you know. I mean she's a neat person to go and talk to, but she's got lots of problems. You see, the people from other cultures are usually immigrants. They're people who, back home, would be leading their lives just fine, whereas the Pakeha New Zealanders (and this might sound a bit judgmental), are the ones who are trapped - generations of patterns that haven't changed. I drive away feeling more depressed. A lot of the Samoan and Somalian people I see are 'together' people. I admire them. There's a 'wholeness' about them. I think you expect more from your own culture and your own kind* (Anne, 2:45).

Both Jane and Anne work in communities where their understanding of the socio-economic contributions to health is heightened through their exposure to people's life situations and chances. Confronted daily with difference in terms of poverty, they have come to see commonness among those who are different because of their social disadvantage. Thus, alongside the recognised differences within and between groups, similarities are known to exist. Furthermore, they seem to be valued for their assistance in establishing relationships, as can be seen in the next story.

Amanda recalls nursing a Pacific Island family:

*They were a really well educated family.... It was really positive for me. It breaks down a lot of those sorts of judgements. It was easier for me because I could speak at a higher level and explain things more technically (Amanda, 2:10).*

Because of previous difficulties communicating with people from the Pacific Islands, Amanda had assumed that she would need to simplify information in order to communicate effectively. Throughout our conversations, Amanda repeatedly mentioned her concern that patients who spoke English as a second language were compromised on issues of informed consent. Her positive feelings in the above situation relate to her knowing that this family more fully understands their situation. She also feels positive about the challenge to her assumptions. In addition to language barriers and differing education levels, Amanda recognises the influence of the negative expectation that she brought to the encounter. The story illustrates an understanding that various differences can deny a person access to adequate information. It also hints at a belief that nurse-patient communication directly influences the quality of care. These are differences that matter.

### **Interpreting difference to mean Maori**

Despite the burgeoning ethnic diversity of Auckland's population, interactions with Maori patients feature prominently in the nurses' conversations. Most nurses have specific stories to tell about their experiences nursing Maori patients and those who do not often mention Maori when comparing their experiences with patients from other ethnic backgrounds. Several nurses specifically acknowledge their greater awareness of the needs of Maori.

*Usually when I stop and analyse myself transculturally, it's in terms of me nursing a Maori patient. For some reason that seems to have higher priority for me, so that is probably most of what I will talk about (Amanda 1:3).*



*Where I work, if you talk about cultural safety, it's assumed you're talking Maori (Pamela, 1:35).*

Interpreted within a context of increasing bicultural awareness amongst nurses there is a sense that, in addition to meaning different from me, being 'culturally other' invariably means being Maori. Are Maori perceived to constitute the greatest number of persons nursed from another culture? Is it that Maori are recognised by these nurses as having indigenous rights in New Zealand? How is difference-as-Maori encountered?

In the Northern region, which comprises the provinces of Auckland and Northland, Maori constitute 14% of the population, in comparison with 62.3% Pakeha/European. A further 9.8% identify as being from the Pacific Islands, 8% are 'Asian' and a further 6% 'other' (Walker, 1998). Thus, the 23% of the population who are neither Maori nor Pakeha/European are higher in number than are Maori. The nurses' greater emphasis on Maori would therefore suggest that being Maori is a difference that matters.

In almost every conversation, unprompted reference was made to either, or both, the Treaty of Waitangi and biculturalism. Discussion often centred on educational experiences, mostly those within undergraduate programmes but also through post-registration in-service opportunities.

Speaking of their undergraduate educational experiences, the nurses recall:

*It was not multicultural, it was bicultural, basically Maori and that made me angry because, dealing now with nursing, I realise that there is so much more than just Maori culture out there (Theresa, 1:72).*

*[I]n my nursing programme ... We looked at history. We looked at the Treaty of Waitangi, and issues surrounding that ... quite a good history (Lara, 1:74).*

*Attitudes, ... I think that was useful.... It wasn't until I went to Tech and studied the Treaty that I gained a glimpse of things important to Maori (Pamela, 1:7).*

*At Tech they seemed to focus mainly on the Maori culture and that's fine but what about the Asians? .... I think that we're more multicultural, not just bicultural. OK the Maori are the native people, but the greater proportion of patients is probably Samoan, or Pacific Island, not Maori. They seemed to focus just on Maori (Gail, 1:65).*

*The culture classes we had at Tech. I don't actually recall them being specific to other cultures apart from the Maori. I think they mainly outlined being able to deal with issues that came up that were related to*

*different cultures ... I think that was helpful because although perhaps when you were dealing with them in the class they were about Maori or Pacific Island settings, there were issues that you could relate to any other culture. It made you more aware of what to look for, the non-verbal and the verbal signs and family structure and that sort of thing (Bobby, 1:75).*

*I personally believe that if you can't deal with the main culture of the country that you live in then how do you expect to relate to people from other cultures ... so although, at the time, it seemed like we were getting the Treaty of Waitangi rammed down our throat and some classes you sort of thought 'what are we doing here?'... some of it was really quite good (Bobby, 1: 79).*

Having already been exposed to Maori issues at university, Lara is enthusiastic about the effect of the cultural component of her nursing programme on some of her classmates:

*It really changed some attitudes ... I found it quite exciting; that someone who was intolerant or narrow-minded ... you could really see that ... There were obvious changes in attitude and that was really good (Lara, 1:70).*

Comprehensive exploration of the nurses' educational experiences is not the focus of this study. Yet educational background has clearly influenced the participants' interpretations of their practice experiences. Although attitudes towards Maori are recognised to be centrally important, of major concern is the prioritising of Maori health when other similarly disadvantaged people are perceived to be missing out. The difference that matters here is the perception that health-funding allocation may not be equitable. In the next chapter, I will discuss the tension between bicultural and multi-cultural discourses in more detail. The significance of the excerpts, at this point however, is that difference as Maori ethnicity matters in nursing but that interpreting culture in this way is not without its difficulties.

Difference from me personally has thus been extended to include the variations recognisable between groups. Difference has meaning as race, as nationality and as ethnicity. It also has meaning as class. Moreover, against a background in which the nursing meaning of culture has become increasingly associated with biculturalism, there is heightened awareness of the need to redress the differences experienced by Maori in terms of health inequalities. Although education has contributed some theoretical understanding, being 'out there' in practice is often difficult. Noticing the differences between groups seems to engender a 'thinking' and 'worrying' kind of experiencing. How can nurses know all these differences? What are they expected to

know and do? The focus is inward. It is centred on the nurse and his or her capacity to respond in the moment. The interplay between difference from me as an individual, and the differences noticed between groups, is constant. The variety of differences also, at times, seems overwhelming.

### **Considering Identity and Difference**

What then is the meaning of cultural difference? Can a person's uniqueness as an individual be identified separately from who they are culturally and historically as a group? If individuals are so different, what is cultural identity?

Anne asks, "*Is it belonging to a certain culture?*" (Anne, 1:133). Then, having attempted to explore what she means by culture in her journal, she reads:

*Mores, attitudes, beliefs, habits, world-view, spiritual beliefs, attitudes towards women and men, children, childbirth? (Anne, 2:35).*

Yes, but there is more and, from a nursing perspective, she decides:

*I would put well being above everything, like self-esteem, not disempowering a person. Cultural identity is part of that. Sometimes it's very hard to know what cultural identity is. How do I know what a Somali's cultural identity is? I might read a lot about them and that may help but when it comes to communication between you and the person, you can have all the knowledge in the world and be absolutely hopeless (Anne, 1:133).*

Cultural identity is being tentatively defined to include the beliefs and practices generally adopted by those from the same country. However, specific sub-groupings are not referred to. Anne knows that she is unlikely to ever possess the relevant knowledge. Furthermore she believes that nursing relationships with people from other cultures need to be based on more than cross-cultural understanding of this type. Although she recognises knowledge of others' cultural practices to be helpful, she also knows that such knowledge is useless in the hands of nurses who are not respectful of patients as individual persons. The other person's cultural identity is also important to her because of its contribution to self-esteem. Anne therefore focuses on ensuring that her interactive efforts do not disempower the other person. Of greatest importance is an attitude that acknowledges and respects difference.

*I try to get through to the essence of the person, transcending cultural barriers. Most of it is an overall sensitivity that tries to foster respect and openness. Only part is cultural (Anne, 2:35).*

This statement hints at the elusive complexity of human identity and the, perhaps universal, tendency for perceived difference to obstruct cross-cultural communication. It also suggests that a person's cultural identity comprises more than differences that are ethnic in origin.

Asking the same question, from the perspective of the other person, Jane points out that people are often unaware of their cultural identity:

*A lot of people are not aware of their cultural identity or of being a person who belongs to a culture. It doesn't exist. Families under stress just exist day to day (Jane, 1:102).*

In Jane's experience the needs of many such families are those of adequate food, clothing, and access to affordable health care. Is conscious self-identification within an ethnic group partly a luxury dependent on wellbeing, education perhaps, and the relative absence of hardship or threat? Jane seems to be suggesting that daily life circumstances may either constrain or enable such identification and that there may be other priorities. The underlying assumption is that the impact of poverty on wellbeing is greater than cultural group membership.

The inextricable relationship between individual and cultural identity is thus a constant source of tension in the nurses' practice reflections. Nurses are continually confronted with culture in both its agential or individual sense and in terms of collective or social meaning. On balance their conclusion is that individual identity is greater than, but inclusive of, one's socially prescribed cultural identity.

*I don't think you can separate them. A person's culture is part of who they are. You have to deal with all aspects together (Bobby, 1:113).*

*Your culture is part of your being. You can't let go of that. It's been indoctrinated in you since you've been a child and even further back than that. It goes back centuries, generations (Angie, 1:170).*

*Culture is your very being.... It's not just what a person is at that time. It's their past and their future and what they are (Elisabeth, 1:1).*

Thus, that which constitutes a person's culture is perceived to endure as an inseparable part of each person's being. But in 'being always with us', its multiple aspects are not always recognisable. Is this why the nurses continually try to

distinguish these forms of identity? Is it that, by coming to know aspects of an individual, nurses are better able to nurse the whole person? Or is there recognition that such knowledge can only ever be partial? A tension seems to exist between the reductive view of a person as comprising definable characteristics and a more practical moral view which is reflexively open to matters of significance that are culturally embedded (Taylor, 1985a).

Pamela's reflection illustrates an awareness of this paradox:

*Some say 'You should know', but then, if they're an individual person, how can you know? ... unless you've lived with them and even then, how much do you know anyway? (Pamela, 1:102).*

Cultural difference is not fixed or static. It evolves historically, spatially and temporally for each individual. Jane refers to herself when grappling with the impossibility of trying to articulate cultural values that are constantly changing. *"I'm not a cultural identity. I can't say 'I'm this', because it changes"* (Jane, 1:93). She then presents evidence of similar processes occurring in others:

*People who have grown up in New Zealand but who have origins elsewhere have kept some of the values that they brought from overseas, but they've grown up in a Kiwi society and also have those values on board (Jane, 1:104).*

Not only does Jane understand people to be uniquely different, she knows a person's identity evolves continually throughout their life. How is a person's culture knowable by another when it is always changing? How can nursing do justice to such a diverse and elusive phenomenon? Does the uncertain and complex nature of difference ensure that difficulty is an inescapable part of encountering difference?

### **Encountering difference as difficulty**

Encountering cultural difference has a very practical meaning in nursing (Chapter Eight provides further explication). Many nurses try to understand and respond to the multiple dynamic needs and expectations of those for whom they care. However, in addition to differences in personal values and background, the nurses' working environments significantly influence their perceptions of cultural difference and, very often, difference announces itself as difficulty. Many of the problems associated with

cultural difference relate to communication yet the barrier of language, although significant, is not the only obstacle.

### **Communication difficulties**

Language difficulties often present the patient who is 'other' culturally in terms of a communication 'problem'. How is difference encountered as problematic and for whom is the problem 'a difficulty'?

Beverley finds it difficult to *"know how much they're taking in"* (Beverley, 1:8). Lara worries *"that they lie there frightened and not understanding"* (Lara, 1: 36), and Amanda explains that when the language barrier is greater she has to simplify things more. This is difficult because she wants *"to treat people equally"*. Her concern is that information giving is compromised. *"I think 'Gosh, Is this giving them all the information in a really informed way? That's the difference that seems greater'"* (Amanda, 2:2).

In each of these statements the nurses speak in the plural form, the terms 'they' and 'them' implying that communication difficulties are frequently experienced. In each of the examples the nurse's concern seems focused more on the consequences for the patients than on the difficulties they experience personally during such encounters.

Another 'problem' mentioned in association with language difference is interpreter use and the difficulty establishing relationships through such means. Amanda's experiences trying to communicate through an interpreter do not come up to expectation:

*It went fine, but I didn't get to form any sort of relationship with the client. The communication goes through someone else. It's not a two-way thing (Amanda, 2:4).*

Then similarly, in another situation when using a family member to interpret, Amanda believes that she formed a closer relationship with the daughter-in-law who interpreted and that this precluded her from giving *"as good a service to the patient."* The importance of the nurse-patient relationship was mentioned in Chapter Two, as part of nursing's cultural horizon. The establishment of a human-to-human relationship (Travelbee, 1971) seems important to Amanda. But this one-to-one relationship, highly valued in Western systems of nursing, is more difficult to establish when the nurse and the patient cannot communicate in the same language. Thus cultural difference is encountered as a communication problem because of the associated difficulty, from

the nurses' perspective, of maintaining expected standards of care. Yet questions are not asked about whether or not such relationships are appropriate in all cross-cultural situations.

Another difference experienced as difficulty in relation to communication is the variable interpretation of words commonly used in nursing. Theresa is aware, for example, that the word 'sick' in the sentence 'Do you feel sick?' is likely to mean being spiritually unwell to someone from Samoa, rather than feeling nauseated as it may to the nurse. The term "pain" also risks being misinterpreted.

*Someone from the Islands may think of pain in terms of hurt because they are separated from their family, whereas a European patient would think of it in a more physical sense (Theresa, 2:44).*

Thus, even when the nurse and the patient use the same words, misunderstandings are possible. The significance, once again, seems related to the potential for miscommunication to adversely affect the adequacy of the nursing response.

### **Difficulty as competing demands**

Two immediate concerns for nurses, especially in acute care settings, are those of accommodating extended families and religious differences. The focus here is on culture in the anthropological sense of behavioural norms and mores. Cultural difference shows itself as difficulty in terms of practices and expectations that are not well catered for within the institutional setting both physically and in terms of conflicting values.

Theresa recognises the ways in which her working environment fails where cultural values differ.

*There was a Maori gentleman and trillions of family were spilling out into the corridor ... I left a note for the charge nurse about it. The whanau room<sup>51</sup> was being renovated, but that's difficult anyway. It's just too far away and I can understand that. I mean if someone's dying ... (Theresa, 1:136.)*

Theresa's frustration is associated with unaccommodating physical space. She understands a family's need to be close to their dying relative and that, in the case of Maori families, the numbers of visitors can seem overwhelming to staff because of the institution's lack of facilities. The need for space also relates to group prayers, Sunday

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<sup>51</sup> A room with facilities made available, by the institution, to family supporting their ill relatives.

visiting and the blessing of rooms following a person's death. Yet what seemingly presents as difficulty is not necessarily insurmountable. Despite the constraints of their physical environment, the nurses often manage to accommodate such differences.

*It comes up time and time again, that adjusting of duties around things like this. I think we do it unconsciously. Yes. No, it's not a problem (Theresa 2:4).*

Some of these difficulties are short-lived and, at times, go unrecognised because they are attended to as a matter of course. Referring to the death of a Cambodian woman, Theresa provides another example:

*It was their family culture that she should go down to the mortuary dressed in her own clothes. I knew that the mortician was quite likely to make a bit of a stink about it, if he didn't know what was going on, so I said "Yes that's fine" to the family and made a note of it being 'family culture' for the mortician (Theresa, 1:125).*

Hospital protocol relating to care of a body after death requires that the person be dressed in a shroud and Theresa anticipates, probably in relation to previous experience, that the mortician may be irritated by departure from this norm. The patient's own clothes may be more difficult to remove and/or they may get damaged or lost. Yet Theresa does not attempt to explain the protocol relating to shrouds, or make excuses, to the family. She accepts and respects their beliefs and simply writes the mortician a note. For her, the accommodation of cultural difference is essential to the family's wellbeing and, acting as a patient advocate within the 'system', she encourages the mortician to be similarly accommodating.

It is possible that, in this story, Theresa does not see the patient's difference as difficulty. It is also possible that her anticipation of the mortician's dissatisfaction compels her to shield, or protect, the family from further distress. Perhaps Theresa is determined that the family do not feel their difference as a difficulty for others?

There are also occasions when health priorities differ:

*For a small section of the community I work with (predominantly Maori and Pacific Islanders), there's an apathy towards health care. I've looked at it from the view that it's not a priority for them. School sores, for example: Often the family have lived with those for a long time and can't see the importance of treating them (Jane, 1:56). They know they will heal eventually and they don't worry about the scarring (Jane, 2:39).*



Jane understands that what may be interpreted as apathy, by a health professional, may be seen very differently by the person with the health problem. For some, the sores and the scars are normal and the possibility that other people could become similarly affected is not considered. Jane has also learned, through experience, that there is little point in imposing her values on others. Thus difference is presenting as difficulty because she knows that finding solutions that meet diverging expectations is far from straightforward. She talks of “*treading the fine line*” of always having to consider who else is affected by the decision and what the outcomes might be.

Thus in addition to experiencing difference-from-me, both in a personal, idiosyncratic way and as a member of a cultural group, difference has meaning as difficulty in nursing because of its potential to restrict communication and its challenge to institutional mores. At issue here is the anticipated impact of such differences on the health outcomes for people from other cultures. But also significant is the responsibility the nurses feel in terms of making extra effort. Encountering difference as difficulty is therefore recognised to have implications for both the nurse and the patient.

### **Encountering Difference: bringing the meanings together**

#### **‘Encountering’**

Encountering, in the sense of ‘meeting’ or ‘coming together with’ in the context of nursing, implies a relationship of some sort. Nurses encounter numerous people, on numerous occasions, and strictly speaking, even when meeting a person again, never have the same experience twice (Gadamer, 1996). Continually present is the potential for ‘coming across’ the unexpected. There is always the possibility that one’s expectations may or may not be upheld.

The understandings deriving from cross-cultural encounters vary according to the intensity, depth and duration of the encounter. Previous encounters may increase the familiarity with which the nurse engages with a person from another culture. Contact provides learning opportunities that can reduce the levels of anxiety often associated with new experiences and time contributes significantly in terms of ongoing development and depth of understanding.

Encountering in the sense of 'contending with' or 'colliding with' implies the possibility of conflict and for experiencing encounters in negative ways. The nurse's lesser familiarity with the horizons of people from other cultures increases the likelihood of misunderstanding. Yet, because there are also ways in which the nursing horizon can contribute to successful encountering, prejudice, as both a positive and a negative prejudgment (Gadamer, 1996), is an integral part of encountering.

### 'Difference'

Difference means 'unlike' and, in the context of this study it means being unlike the nurse. Difference also means 'out of the ordinary' or 'unusual' and is therefore not only related to differences between the nurse and individuals from other cultures, but to variations from the expectations and practices dominant in society as a whole, particularly in relation to health care. Thus difference has meaning simultaneously at both personal and group levels.

Difference as 'having distinguishing characteristics', in the context of cultural difference, is initially most noticeable in terms of language and physical appearance. It is also interpreted as meaning different values, beliefs and behaviour. Yet as the encounter progresses and the nurse comes to know the person better as an individual, more subtle differences become known. The nurse comes to understand particular expectations, attitudes and preferences. Thus difference as 'not identical' or 'not the same' encompasses the notion that there can be different differences, that there is variation within groups and that, because difference is contextual and relational, it is, like encountering, a dynamic phenomenon. Moreover, inherent in the uncertain nature of cross-cultural encountering is a happening beyond the will of those participating in the encounter.

When asking the initial interview question, I deliberately refrained from defining the term 'culture'. Some nurses explored its meaning through the use of rhetorical questions, but most took its meaning for granted, their responses assuming culture to mean ethnicity and nationality. Furthermore, although a number of different groups were specifically named, there was a tendency for culture to be interpreted most often as pertaining to Maori. A lesser emphasis was also placed on other characteristics such as gender, age, social class and recreational group membership.

But what is lost in describing the meaning of cultural difference in this way? Does focusing on these aspects, or 'parts', provide sufficient understanding? Is it 'culture' or

is it 'difference' that is significant? Perhaps it is both? What matters most to the nurses, and why? Is there a more important underlying meaning that pervades 'the whole'?

### Partial and whole meanings

In the beginning phase of analysis, I had unconsciously passed over the meaning of 'from another culture'. Following the nurses' stories, I responded instead to their emphasis on finding ways to communicate and build trust. Nursing is a purposeful and people-oriented activity and building rapport and gaining trust are essential to the purpose of achieving a working relationship with patients. Beverley, for example, talks of having "to form a relationship in order to achieve things for that person to get better" (Beverley, 2:118), and Jane succinctly states:

*It comes down to the basic thing about whether you can develop rapport and whether nursing care gets given. You don't get very far if you can't get in the door (Jane, 1:115).*

In the nursing context, difference is anticipated prior to the meeting of all persons. Then, in most instances, because the nurse and patient are together for a purpose, each seeks to feel more at home within this 'new' situation (Gudykunst & Kim, 1992). However questions, such as whether cross-cultural relationships might be the same and/or different from other encounters in nursing and how nursing relationships might be similar to or different from social cross-cultural interaction, prompted exploration of the meaning of cultural difference in the literature. Simmel (1950), Schutz (1971), Ogletree (1985) and Gudykunst and Kim (1992) each refer to the 'other' as a stranger, as someone who is different because they are lesser known or unfamiliar in the context. Thus, in linguistic terms, why 'encountering difference' and not 'encountering strangers'?

Nurses interact with people and the words 'client', 'patient' and 'stranger' refer to persons whereas 'difference' may also pertain to objects. Perhaps my use of the word 'difference' seems dehumanising? Yet the word 'stranger' conveys a sense of dislike, often in relation to that which is unusual. A stranger is a person who is regarded as being 'foreign', 'alien or 'peculiar' in some way and the term 'stranger danger' engenders fear for personal safety. Thus there is a tendency to reject or seek to avoid the person as stranger. Not only is the word 'difference' less judgmental, its associations with separateness and distance are fewer.

In nursing, the philosophies of humanism, holism and caring motivate the nurse to come to know the patient as a person (Tanner, Benner, Chesla, & Gordon, 1993). Thus priority is placed on reducing distance and the phenomenon of strangeness. Nurses learn the importance of individual acknowledgment. They also know that emotional states influence health outcomes and that respect for others' differences contributes to the reduction of anxiety. The meaning of 'encountering' as 'being faced with' in the context of the nurse-patient relationship can be further interpreted in relation to nursing's moral imperative towards others. Paterson & Zderad (1988) describe nursing as a reciprocal call and response lived between nurse and other (ie. the patient). In addition to not being able to avoid encountering, nurses have a professional responsibility and social mandate to engage with patients and to provide nursing assistance. Receptivity to difference is therefore essential. Although nurses may perceive 'strangeness' in those whom they are nursing (remember Sue and the man whom she perceived to be Rastafarian), the predominant focus is one of becoming dialogically involved with the person who is other so that the phenomenon of strangeness is short-lived.

Furthermore, the nurses' knowledge of human development, socialisation processes and pathophysiology contributes understandings that may be commonly experienced across cultures. However, all patients bring differing understandings of their illnesses and expectations for care. Like each patient, nurses are uniquely different individuals who, at the same time, have beliefs in common with the groups to which they belong. Thus differences and similarities not only co-exist they interpenetrate. The multi-factorial nature of difference means, therefore, that the issue is one of degree and that strangeness may on occasions be a part of difference. More importantly however, is the likelihood that strangeness closes options down, whereas difference engenders possibility. When contrasting differing points of view, for example, for the purpose of understanding each perspective, variations can be evaluated and new understandings can arise (Taylor, 1985b). Also significant is the potential for such understanding to distinguish the patient from the nurse in a way that also acknowledges their similar humanness. In summary then, how do nurses encounter difference? What is fundamentally significant about this aspect of nursing a person from another culture?

### **Conclusion**

Encountering is relational. Encountering difference means experiencing one's self as a nurse in relation to a person who is 'culturally other'. It means noticing the patient as different from me, yet similar to other patients in terms of the need for nursing and

respect as an individual. Paradoxically then, it means simultaneously engaging with familiarity and difference.

Nurses experience greater uncertainty when nursing people from other cultures than when encountering people from their own culture. Thus difference potentially has meaning as difficulty because, when encountering a patient from another culture, the nurse cannot assume that the person will share, or be able to understand, the background horizons that inform nursing practice. People from other cultures are also often perceived to be more vulnerable by nurses. Thus a greater need to communicate and establish trust exists alongside the increased difficulty of doing so.

Specific factors within the patient, the nurse, and the setting are also significant. From the nurses' perspective, perception of cultural difference diminishes with the acuteness of a patient's illness in the same way that ethnic difference diminishes with increasing poverty. It is not that cultural differences do not matter, but rather that nurses must prioritise their responses. Perceptions of difference are also lessened where there is opportunity to be continually in relation with people who are culturally different and when the nurse, as a person, feels able to engage with such people. Encountering difference can be a welcome divergence from the usual and the familiar but it can also engender variably intense feelings of anxiety. The nurse-patient relationship is a two-way phenomenon occurring within a dynamic and, to some extent, unpredictable context. Moreover, theoretical preparation for cross-cultural interaction, although helpful, cannot foreshadow the ontological experience.

Encountering difference describes, in part, the experience of nursing a person or people from cultures other than one's own. Encountering difference has meaning prior to, in the moment, and on reflection. It is difference that is pivotal. Culture is important but difficult to define because of its evolving nature. Differences are more immediately tangible and although their form varies, they invariably have meaning as difficulty. This meaning is significant because differences are anticipated to constrain the establishment of the nurse-patient relationship regarded by nurses as so fundamentally important in the delivery of nursing care. The following chapter describes tension and the tensions experienced upon encountering difference.

## Chapter Seven: Experiencing Tension(s)

Persons are embodied beings related to each other through the medium of space. We are separated and joined by our different perspectives, educations, backgrounds, organisations, group loyalties, ideologies, socioeconomic class interests and temperament. These social 'things' that unite us are, by the same token, so many things, so many social figments that come between us  
(Laing, 1967, p.20).

### Introduction

Tension is an ever-present part of the experience of nursing someone from another culture. Born out of a moral imperative to willingly engage with others and to help those in need (Henderson, 1966; Bishop & Scudder, 1990), nurses experience tension intra-personally, interpersonally and in their relationships with the wider community.

In the previous chapter I have shown that, although nurses expect all patients to differ to some extent, when the patient is a person from another culture the perceived degree of difference raises the nurse's level of anxiety. Not only are people from another culture likely to respond to illness differently, but their whole way of being in the world is largely unknown to the nurse. The fact that nursing care is often intimate and intrusive in nature (Lawler, 1991) further increases the tension for both parties in the encounter. Placing the "problem of the body" centrally in nursing, Lawler suggests that nurses must know about the taken for granted rules that govern the body in society. But when nursing a person from another culture, questions arise as to which rules? Whose culture? More than the body is at issue. This chapter describes how nurses experience such tensions.

### Experiencing tension: how I came to this theme

Early in the analysis phase I had drawn a picture of the nurse, sometimes together with and at other times quite separate from the patient, trying to negotiate a path littered with obstacles. For the nurse, the way forward seemed tension-filled and paradoxical. When I examined the pages on which I had summarised the nurses' experiences and their ways of 'being' when encountering people whose cultural backgrounds differed from their own, the array of contrary descriptors was bewildering. Yet it confirmed my initial impressions. The nurses had talked of experiencing conflict, fulfilment, success

and failure and I wrote about vacillating, hesitating and choosing, using phrases such as 'being in two minds', and 'knowing but not knowing'.

Formal educational experiences in nursing had not prepared me to encounter such contradictions. I had been taught what to do and why. As a nurse, I expected, and was expected, to carry out duties in a certain way and yet I also knew that the tensions being described were genuine descriptions of nursing experience. The 'ifs and buts', the 'ups and downs' and the 'good and bad' experiences in nursing seemed more intense in cross-cultural encounters. In exploring both the linguistic and literature meanings of words like 'but', 'conflict', 'dilemma', 'tension' and 'paradox', I came to see a relationship between encountering difference and experiencing tension. The following story, told by Amanda, reveals the tensions inherent in introductions and thus illustrates the interrelated nature of these ideas:

*For me nursing someone from another culture begins with an introduction in an acute care setting that I know isn't going to be very relaxed or welcoming. I introduce myself and speak specifically to the patient and whoever is with them, asking their names. But, even that can be difficult. The other day I met a woman whose husband said 'Call me Uncle Pene and call her Aunty Mere', and much as I loved that, like my heart felt it was glowing, that they had allowed me to do that, I didn't feel as if I could. Part of it was concern that my colleagues would disapprove and part of it was that it felt disrespectful. Yet I also felt I was totally ignoring their request. I was desperate to call them 'uncle' and 'aunty'. I thought it was gorgeous.*

*Then as I potted along telling them what would be happening and what to expect, the next thing I'm aware of, is my name. It's clearly written on my badge but they aren't using it. I've made a conscious effort to remember their names and to learn their daughter's name and I've told them my name and it's written here and I don't like being called 'nurse'.*

*I know they can't remember all of our names but I'm disappointed.*

Amanda immediately notices the couple's difference as a difficulty. The fact that she believes hospitals limit the quality of nurse-patient interactions suggests that prior experiences may have contributed to this anticipation. The family is Maori. But are such experiences not similar for all patients? It is possible that Amanda, affected by history, is being influenced by a discourse that says hospitals are Pakeha institutions and therefore alienating to Maori. Yet this interplays with other discourses and values.

Establishing a relationship is important and Amanda respectfully introduces herself in a way that she hopes will put these people at ease. Nursing encourages her to focus on

the person as an individual and thus to invite the self-disclosure of identity. Yet, although complimented by the reciprocal invitation to use what she perceives to be a very personal form of address, Amanda experiences conflict. Wrestling with divergent notions of respect, a tension or play exists between her personal and professional expectations. Amanda recognises that other nurses may not share her views and may not be supportive. She is also younger than those whom she is addressing. Her feelings of disrespect may therefore relate to having been brought up to use more formal titles in such circumstances. The influences of nursing's cultural practices seem less visible. The relatively recent practice of asking patients how they would like to be addressed is likely to be more straightforward when the nurse and the patient share similar backgrounds. Amanda may have found the Christian names easier to use had the titles 'Uncle' and 'Aunty' not been added. The meaning of these terms differs depending on one's understanding of the concept of family.

The hiatus of "*pottering along*" seems to provide temporary relief from these internal strivings but all too soon Amanda faces another dilemma. She notices, and is disappointed, that the family are not using her Christian name. Having felt the warmth of their invitation, she wants to be able to relate on a more personal level. Yet Amanda does not appear to recognise that the difficulties she is having using "*Uncle Pene*" and "*Aunty Mere*" may well be the same reasons these people are calling her "*nurse*" and not Amanda. Unable to break through the roles of 'nurse' and 'patient', their apparently mutual hope for reciprocal understanding is ironically thwarted by the inability on both their parts to achieve this goal.

This story reminds us that something as seemingly simple as an introduction may not proceed as expected when the participants come from different cultural backgrounds. The pleasure at having been invited to use a warm and informal form of address is only fleetingly experienced. Amanda has to contend with the voices of others within her that present conflict and which ultimately preclude her from responding to the offer. Perhaps partially embodied is the expectation that a nurse needs to maintain professional distance in order to do her job well? Beverley Taylor (1994) suggests that a somewhat aloof politeness is standard behaviour in most people-oriented professions. It is possible that Amanda's colleagues might "*disapprove*" for similar reasons yet it may also be that the perceived lack of collegial support has ethnocentric undertones. In a more covert sense, such attitudes may derive from the hierarchical notion that formal titles announce and maintain an established order of power relations between health care professionals and their clients.



Amanda experiences tension between her personal identity and her professional role. She seems to want acceptance as a person as well as a nurse and to be acceptable to patients, peers and to herself. Her use of the term “conscious”, when talking of the effort to learn the patients’ names and relationship details, suggests that the names and titles may be more difficult to learn or pronounce. But having made the effort, Amanda hopes for reciprocity from the family. Taylor (ibid. p.234) refers to the tendency of many professional people to “forget, dismiss or otherwise reject, their everyday genuineness as humans”. Thus, although Amanda struggles intra-personally, in relation to her colleagues and within her workplace to negate some of the alienating influences of the health system, she unwittingly perpetuates the situation that she seeks to change.

Interested in the simultaneous and contradictory nature of the nurses’ feelings, the next stage of analysis was prompted by Taylor’s (1985a) claim that our emotions offer insight into our lives as subjects. The nurses experienced feelings of frustration, disappointment, embarrassment and guilt. But there was also joy, laughter and hope. Early in our conversation, Theresa remembers nursing a Samoan woman who was dying:

*It was really nice because we have a lecture room outside our ward. We had her in there so her family could come and go as often as they pleased. But it was also difficult. There was so much family that often you didn’t know who you were speaking to. I felt quite frustrated. I had been going in regularly and asking if she was comfortable. “Shall I turn her over? She’s been on her back most of the day”.... But the family said, “No, no”. They didn’t want me to move her or wash her. She was expected to die quite quickly but she actually held out.... She was waiting for family from Samoa ... and then I was speaking to one of the other nurses and learned that someone had said, “Nothing’s been done for her” ... and I think they were quite annoyed. The person who we had all thought was the spokesperson had gone home and one of the daughters who had come over from the Islands had taken over the role (Theresa, 1:2).*

Theresa is pleased that her working environment is able to accommodate this woman’s need for space and she has willingly assisted the family to be present in their own way. However, she is also concerned about the medical complications that can arise when a person stays in one position. The family’s refusal to allow the woman to be washed or moved denies Theresa the opportunity to assess and monitor such possibilities. Yet she accepts and upholds what she believes to be the family’s wishes, only to find out that other family members appear dissatisfied. Again there is tension between the concerns of the family and the concerns of nursing. The family’s emotional, cultural and

perhaps spiritual needs are prioritised and Theresa takes a risk in waiving the latter in favour of the former. Yet, for other unforeseen reasons, this decision presents a problem. The experience is therefore described as “*really nice ... but also difficult*” and, later when reflecting more generally on her work with people from other cultures, Theresa states:

*I really enjoy working in South Auckland because of the opportunity to work with people from other cultures. It can be very challenging at times. But it's really interesting (Theresa, 1:152).*

Anne speaks similarly of her experiences: “*one minute, you're thinking you're making great inroads and then suddenly something happens ... it's difficult to assess*”.

Her efforts to organise a health camp opportunity for a child, who was being ostracised at school “*because she smelt and didn't have her uniform*”, had failed.

*It would have been a great experience for her.... It was hard to get the parents to agree and they went out and brought her home after three days. I think there were lots of reasons, some cultural, some not. They didn't want her to be away from the family. She did a lot of work around the place ... that responsible role was needed in the family to look after brothers and sisters. They couldn't let her go (Anne, 1:30).*

However, alongside the disappointments are experiences that are cherished. Anne talks about “*something lovely*” when working with Samoans that she finds difficult to express:

*I can't put it into words. A richness and gentleness that they have. When I go and sit with a Samoan woman, talking about her child, it can be a magical thing (Anne, 1:83.)*

Once again the summary reflection is similar:

*What I feel in the end is that it's quite difficult nursing people from other cultures but it's incredibly rewarding (Anne, 2:50).*

These nurses feel able in some situations and frustrated in others. Feeling accepted by some patients does not preclude feeling rejected by others in the same way that being delighted in some situations, is counteracted by being saddened by others. The tensions are part of a constant interplay of values and expectations inherent in the nurse, the patient and the context of the encounter. There is also variability in the level of the nurses' consciousness of this interplay. The tensions as they are experienced in the moment are only fleetingly acknowledged because the nurse must act. Yet they are

carried forward to other encounters and may also resurface as questions needing resolution.

Working then to understand the distinctions between 'experiencing' as "*erlebnis*" (experience that you have and which is therefore connected with a subject) and 'experiencing' as "*erfahrung*" (something that you undergo, in which subjectivity is overcome and drawn into an "event" of meaning) (Weinsheimer & Marshall, 1996. p.xiii-iv), the relevance of these two interrelated aspects became more apparent. Like 'encountering difference', experiencing tension had meaning as lived through in the moment (*erfahrung*), as well as being anticipated and reflected upon after the event (*erlebnis*). The nurses simultaneously experienced tension in each of these ways. Tension is lived through in encounters. It surfaces in the form of questions and is experienced as horizons in conflict.

### **Experiencing tension as lived through in encounters**

Our emotions are "affective modes of awareness of situation" (Taylor, 1985a, p.48). "They are the language of embodied intelligence" (Benner & Wrubel, 1989, p.96). They signal what matters to us prior to conscious interpretation and thus alert us to our prejudices. In the context of this study, they also illuminate the contradictions and inconsistencies inherent in the experience of nursing people perceived to be culturally different.

When Anne summarises the experience of nursing people from other cultures by saying: "*there is a whole gamut of experiences, rich and frustrating*" (Anne, 2:162), she is describing the demanding, challenging, frustrating and rewarding nature of this work. Although many 'felt' experiences are affirming and serve to encourage the nurse, these positive feelings are encountered paradoxically with less positive experiences. Frustration, ignorance, embarrassment, injustice and concern, doubt, anger, guilt, rejection and powerlessness are interspersed with feelings of privilege, admiration, pleasure and joy.

Aware of the increased vulnerability of many persons from other cultures, nurses often feel concern on behalf of these patients. They worry about them and want the best for them. Yet, when the client's values differ from those of the mainstream, the nurse can

feel torn or 'played' by both the social views predominating and those of the patient. Tension is experienced in the form of the ongoing dilemma of how best to accommodate everyone's expectations.

### Experiencing frustration

*I think the biggest stresses that I find are situations like the man down the far end of the ward with troops and troops and troops of visitors before visiting hours. Kids everywhere - all about two feet high with lovely hard shoes on and it gets to the stage where, as much as you want to be culturally sensitive, you are being insensitive to everybody's else's needs, and that's the sort of situation that drives me nuts.*

*The families get angry and agitated. They say, 'Oh, but I've come from up north and my Dad's sick,' and I think, 'But everybody else in the ward is sick too and your children are running up and down the corridors' and I do feel like tearing my hair out because no matter how sensitive I try to be, sometimes it feels like a kick in the face.*

*I think, 'Here we are helping your Dad. We've let you come in before visiting ... and I feel abused and taken for granted (Theresa, 2:53).*

This story does not describe an isolated experience. Theresa is generalising as she recounts "situations like the man down the far end of the ward" and openly acknowledges the stresses they induce. The extra people, their noise, the length of the ward and the demands being made seem overwhelming and, in trying meet the cultural needs of some clients, Theresa risks undermining the needs of others who require rest in a well-managed environment. There is a sense that Theresa feels she is losing control and that there is little chance for improvement. The layout of the ward does not support its users' needs. It has long corridors, no carpets and there are rules that must continually be explained and either enforced or relaxed. Anxious and frustrated, Theresa hopes, but does not communicate her expectation, that the visitors will understand and appreciate both her situation and that of the other patients. Thus achieving a reciprocal understanding is unlikely.

This is an acute hospital ward. Theresa, in her second year post registration, is the nurse in charge on this shift. The responsibilities she feels create tension, the intensity of which is exemplified in her language. The word "troops" is used repetitively to describe the visitors, and kids everywhere, "two feet high" adds vividly to a picture of disorder. Her cynical use of "lovely, hard shoes" reveals feelings of frustration and the quite violent metaphors; "driving me nuts", "tearing my hair out" and "a kick in the face" suggest significant levels of emotional stress and negative tension. Yet they may also constitute carefully expressed negative prejudice.

Shaped culturally and historically, both as a member of the nursing profession and as a nurse employed in an acute care setting, Theresa has embodied the need to prioritise the physical safety of her patients. Yet she also wants to meet their health needs more holistically and to do so in a way that is equitable. Theresa accepts responsibility for the patients' wellbeing. In charge of the ward, her role is that of ensuring the smooth delivery of nursing care to everyone. But tension is inevitable where values and priorities differ (Gudykunst & Kim, 1992) and it is exacerbated when decisions are required as to whose values and which priorities take precedence. While it is possible to provide a broad range of nursing interventions more in accordance with notions of holism in a well-staffed and philosophically supportive working environment, this is problematic in the present climate of cost containment and medically dominated health care. New Zealand's restructured health delivery system is "dominated by corporate interests and sustained by the power of a select group of providers, notably physicians" (Tilah, 1996, p.20). Englehardt (1985) suggests that the position between doctors, patients and employing institutions creates difficulties for the nurse. Do Theresa's feelings of tension relate being 'caught in-between' in this way?

Associated with similar interpretations of practice is the notion that nurses have their own legitimate area of authority and expertise. The clinically focused research of Benner (1984) and Benner and Wrubel (1989) describe, very specifically, how nurses can make a critical difference for patients and their families. Bishop and Scudder (1991) argue therefore, that in addition to being 'in-between' in the negative sense described by Englehardt, it is also possible for nurses to use their situation to advantage. These authors conclude that "practising nurses experience nursing primarily as a moral and personal human endeavour" and, that "the in-between stance" can also be construed as a position of "privilege" from which nurses can "foster the team decisions required in health care ethics" (ibid. p.28). Can Theresa become an advocate for patients in the manner suggested by Bishop and Scudder? Is it possible that, when living through dilemmas in the moment, feelings of frustration and anxiety may be related to the tension between feeling caught and being unable to liaise and negotiate an outcome that satisfies everyone's needs? Do nurses simultaneously experience both forms of 'in between'? Is this the meaning of tension?

Although nurses can, to some extent, control their contribution to each new encounter they cannot predict the patients' contributions nor can they easily control the environmental influences on their situation. Tension therefore exists between the hoped for positive effects and the known, and unknown, barriers and constraints.

Feeling frustrated takes differing forms. The nurses frequently experience tension in relation to their anxiety about how best to respond when in unfamiliar situations.

*Things like with pre-schoolers. One family that I visited today, as soon as I arrive, they want to take everything out of my bag because I've got things like blocks and pens. You know, they're fiddling with me all over, taking everything out of my diary because it's something to play with. And I say to the Mum, "Haven't they got any toys?" And she says, "Oh, well, they'll just make a mess" and I think "perhaps I could bring them some toys?" But I've talked to other public health nurses and we agree that they have a different attitude towards children and toys ... and what you find is that they put them up on shelves just to look at. They don't actually play with them. So there's that real dichotomy. You want to be able to.... You see these kids grabbing at your things. They want to play, but their parents don't think it's really important. So all you can do is.... Yes there are lots of lovely Samoan people who obviously didn't have toys when they were kids and they're fine. So I suppose... (Anne, 1:20).*

Anne is grappling with a difference in child-rearing practices. Her professional background has contributed an understanding of the developmental need to manipulate objects and, in her culture, children's toys are commonplace and likely to be regarded as essential. The experience of tension as frustration in this story is one of being baffled, of searching for possible answers and feeling 'left up in the air', still uncertain about what to believe and how best to respond.

Tension as frustration is also revealed through uncertain expectations with regard to levels of cultural knowledge. Yet nurses do not necessarily accept that they should be fully conversant with the beliefs and mores of each patient's ethnic group. In the context of a group discussion Angie explains:

*I don't think it's so much that you can learn about them. It's that the resources aren't there when you come to the situation of needing to know. That is what is so frustrating (Angie, 1: 230).*

Alice is similarly frustrated by a lack of information that could provide an entree to discussion and further learning.

*There should be something that I could hone into, just to get my thinking around what the person might expect ... some basics so you don't go stumbling in (Alice, 1: 160).*

Also contributing to experiencing tension are other environmental factors that preclude the assessing and following through of patients' individual requirements. Lack of time is

a frequently cited source of frustration. Such tension is inherent in the following apology from Lara:

*I hate saying this, because it's a bit of an excuse, but sometimes it's so busy you honestly don't have time to be as aware or to get that awareness as much as you like and I find that really frustrating (Lara, 1:44).*

Lara begins by blaming herself. Yet she knows that this is unreasonable. Her feelings of frustration derive from the tension experienced between the ideal of how she ought to be, and the reality of how she can be, given the constraints of time.

The nurses are grateful for the availability of the various patient support services, and mention is made, in particular, of the interpreter service, cultural liaison personnel (eg. Kai Atawhai), and the hospital chaplains. Yet a level of frustration is also evident here. Although the nurses recognise that such services have their own priorities, they experience tension related to the limited capacity of these groups to provide nursing support and feedback about the appropriateness of their nursing responses.

*Sometimes I've asked questions and they've [referring to Kai Atawhai] said, "That's not for me to tell you". So it's not easy to find the information. If I'm never told, for example that the head is sacred, then I'll never know.... I'm aware they don't want to be telling me my job, but I think there needs to be some sharing (Amanda, 1: 107).*

Frustration is also expressed in relation to 'being in the middle' in the sense of being between patient and family. On an interpersonal level, allowing a family to deal with a situation "in their own way" is difficult for Beverley (1:32) when she is trying "to be there for the patient" and doesn't believe the family are considering what "is best for him". In a similar way, Meg and Alice remember the frustration of not having family support for a young Filipino girl whose condition required repeated hospitalisation. After several instances of apparent family neglect, the nurses came to believe that the family's ambivalence was the result of gender discrimination.

*She was a girl and not important, so that is why they didn't come and see her much.... It was hard for her. She was dumped. Once, she got really sick. It was explained [on the telephone] that it could be fatal [and that she should come into hospital]. But they got her to catch a bus in and she had to walk over the bridge in the middle of winter ... with a temperature of 40 degrees. I can see where it comes from but it's really frustrating when we're doing everything to help her (Alice, Angie and Meg, 1:115-130).*

The nurses experience tension because they are concerned for their patients' wellbeing, both in terms of illness and their family circumstances. But what are the nurses seeing and not seeing? What do they know of family circumstances and priorities? How can such problems be resolved to the satisfaction of everyone concerned? What are the effects of such disappointments?

Feelings of frustration are, at times, tinged with feelings of hurt. Amanda vividly recalls a situation in which she worked hard with a man whose medical condition made cross-cultural communication even more difficult. Other contextual constraints in the form of shift changes and staff, whom Amanda perceived to be non-supportive, also contributed to inadequate management of the man's pain.

*It was really frustrating and I felt quite hurt. I was the person who got that brunt. I thought I'd tried really hard. It was a difficult relationship but I thought I had persevered well with it and it all came back on me ... I had handed over saying his luer needed to be re-sited. It was 2 shifts before I saw him again.... It wasn't managed satisfactorily for him and we do all need to be accountable.... I just felt my integrity had been challenged and that I didn't have an opportunity to defend myself. He was so angry he wasn't rational. I just had to swallow it and still be professional and cheerful towards him. He expected that. (Amanda, 2:93).*

Experiencing tension in this story relates to Amanda's acceptance of her professional responsibilities at the expense of personal vindication. But the outcome would seem to be a lose-lose situation, given that neither party comes to an understanding beyond their own, particular perspective. The tensions experienced are therefore likely to be carried negatively to future encounters.

### **Experiencing guilt**

Tension can show itself in terms of the feelings of shame and guilt experienced when mistakes are recognised, or thought, to have been made. Travelbee (1971, p.42) suggests that nurses develop a "conscience" or particular type of guilt when unable to fulfil their responsibilities.

Angie remembers feeling "*absolutely shattered*" upon realising that she has missed "*an important religious component of care*" while nursing a Samoan man.

*Six weeks after discharge I learned that Jonah would have loved to have had some religious input into his care. I felt absolutely shattered. It was a huge learning experience. I'd thought I had the skills to nurse somebody who was non-English speaking. But missing his religious*



*needs - that was a real 'biggie'. I'd asked so many times, "Can I do anything more?" He'd never said he'd like to see a priest or minister. I felt I'd given him permission and the space to say or ask, but it was always, "Everything's fine" and "Yes, we're good" from the family too. I discovered that they expected we would recognise his need for religious input.*

*I also learned that Jonah felt disempowered in relation to his dressings. Because the nurses could do this more quickly, he believed they preferred to do it themselves. Initially he had seemed happy to learn to do the dressings. Then he lost interest. When I tried to explore this he had shrugged his shoulders. Like many Samoans, Jonah was very shy and, wanting to respect his privacy, I decided against pursuing the matter further. So we [the nurses] had resumed doing this aspect of his care.*

The nursing omissions in this man's care had surfaced in a post-discharge interview but, despite the patient's assurance that he had been well cared for, Angie feels guilty because she believes he has been spiritually, emotionally and thus culturally compromised. Moreover, the feelings of guilt seem to derive from her belief that Jonah is a worthy human being. She had tried to understand his position and wanted to respect his privacy. Yet, in her eyes, she had still failed him. Charles Taylor (1994) distinguishes between attitudes of benevolence towards others that are fuelled by living up to an ideal or principle and those which are motivated by respect and concern for the other person. The fact that Angie and several colleagues subsequently chose to present their concerns formally at a nursing conference indicates not only that the omissions were distressing for them, but also that they were genuinely committed to ensuring that others did not suffer similarly. Thus also recognisable, in this story, is the sense in which experiencing tension can be enabling. However, when a colleague suggests, at the presentation, that Angie might be being a little hard on herself, the reply "*Probably*" is unconvincing and suggests that the negative meaning persists more strongly. Perhaps the unresolved tension relates to the acceptability or otherwise of learning through one's mistakes in nursing?

Elisabeth, although acknowledging that nurses learn to a certain extent through trial and error, expresses concern about "*learning at the expense of others*" (Elisabeth, 1:21). Believing that people in need of health care have enough to contend with, without additionally being burdened by nursing ineptitude, Elisabeth presents the view that nursing errors should not have to be borne by people from other cultures any more than by any other patient. Yet earlier in our conversation she had remembered, with remorse, a situation in which her actions had been interpreted as discriminatory by the mother of a child whose scabies she had painted. In this situation too, the tensions

experienced had been ultimately enabling. Although difficult in many ways, the incident had prompted a sharing of feelings and differing perspectives that facilitated reciprocal respect and understanding.

### **Simultaneously experiencing fear and hope**

On a more personal level, feelings of tension are experienced in relation to the nurses' own safety. In the community, Anne (2:130) talks of "*not knowing if a burly Hell's Angel will answer the door*", and Jane speaks of the "*security of knowing that out the front there is a hospital car parked, so that if you don't come back out of the house, somebody knows that you've been there.... The police go in pairs into homes that we happily walk into by ourselves*" (Jane, 2:52). In these situations it is the nurses that feel vulnerable. But along with the fear, is an anticipation that all will go well. There is an interplay, or tension, between fear and hope and the prejudices that encourage action outweigh those that are constraining.

Tension is also experienced in relation to the future in a more generalised sense. Sue feels hopeful about the beginnings being made in New Zealand towards the accommodation of difference but she believes there is still a long way to go:

*Perhaps with time this [lip service] will change.... We are after all, a new nation and also in terms of service delivery, it's [cultural safety] a new concept (Sue, 1:37).*

Sue's use of the word "*perhaps*", suggests a fear or doubt that the changes in nursing will be sustained and become an integral part of the health service. Thus there is tension in the hope that the future will be better. Also anticipating a more genuine acceptance of difference in the future, Amanda begrudgingly accepts what seems to her to be an obligatory and thus negative present accommodation of difference.

*We have had a bicultural action group set up, so it does have a high profile but, just in terms of - Well, I think people are aware, even if they're not genuine. It's wicked and I hate it, but the lip service is there for a lot of people. But perhaps if the lip service is there and it happens for long enough, it might be assimilated. People might start taking things on board. So I guess that's positive (Amanda, 1:81).*

Again there is hope that the embodied practices of health professionals will change, yet there is scepticism of the intentions and rationale behind such changes. Pam talks about the recently introduced concept of the 'whanau' room offering space and some facility for families supporting their ill relatives:

*It often feels like it's just a spare room that no one's using, so it will do and there's no input from the people who will be using it (Pam, 1:36).*

Then, in relation to an antenatal clinic with predominantly Maori and Pacific Island clientele, she notes that:

*It's obvious ... because when they walk in at 9.15 for a 9am appointment, the first thing they get is a lecture. The clinic might have one or two posters on the wall but it's European (Pam, 1:70).*

The reflections seem pessimistic yet the nurses' criticisms can also be seen as healthy for their generation of questions and further thinking. Despite the apparent negativity, tension can, in this sense, become enabling.

### **Experiencing tension as questions**

Experiencing tension is illuminated further through exploration of the questions asked by the nurses of themselves. How will I be received by this person? What does he or she need? Will I be allowed to help? What must I do or not do? What does he or she expect from me? How is this the same or different from my expectations? Such questions provide further evidence of tension as dilemma, lived through in the moment, when nursing a person from another culture.

A significant part of the tension experienced when nursing a person who is culturally 'other' relates to whether or not the nurse feels she will be able to appropriately provide care at an acceptable level. In this statement, the term 'appropriate' relates to the patients' expectations and the term 'acceptable' refers to nursing expectations, both personal and professional. The nurse experiences tension in the sense of stretching in anticipation of meeting both requirements.

Nurses feel apprehensive, and are embarrassed, about making errors. They expect to 'know' what to do and believe they are expected by others to know this also. Beverley is unsure of the behaviour expected of her as she enters the home of someone from another culture. She hesitates, asking herself: *"Is it better if I take my shoes off?"* The simple act of entering a person's house is no longer straightforward and Beverley's actions have become visible in their awkwardness. *"I never really know if I should take my shoes off or not and it's really quite terrifying because I don't want to offend people"* (Bev, 1:6). Then, reflecting on past situations in which she has been told not to worry

about removing her shoes, Beverley experiences tension as she works out what the person really means when she says *“Oh don’t worry about it’, when everyone else’s shoes are around”* (Bev, 1:111).

Beverley knows the patient’s acceptance of her is essential to establishing a working relationship. She wants to respect this person’s ways, to do the ‘right’ thing and not to appear ignorant or rude. Is she being treated differently from other guests because of her culture, be it ethnic or occupation? If each wants to accommodate the other’s difference, whose mores should be given priority?

Anne recognises, but is uncertain about, conflicting interpretations of what is acceptable parenting behaviour.

*Sometimes they yell at their kids ... and you think, “What is this? What’s going on?” It is almost abusive and it’s worrying but at the same time, maybe that’s normal for them? It’s hard to say (Anne, 1:22).*

In blaming herself when a family asks if they can say a prayer, Pamela’s questioning is relentless.

*What have I done wrong that they have had to ask? What have I done to make them feel less than comfortable?*

The issue gnaws sufficiently that it is discussed later with her husband. *“What the hell did I do? Fancy them asking me if they could say a prayer!”* (Pamela, 1:75).

The tension is such that it inhibits the consideration of other perspectives. When Pamela’s husband suggests that the family may believe that asking is appropriate in terms of politeness their request demonstrating respect for her as a nurse, Pamela remains unconvinced. How does ‘getting it wrong’ feel and what are the implications for future interactions with patients?

Amanda similarly senses that there are right and wrong forms and ways of communicating and is uncomfortable about her capacity in this regard. She wants to be genuine and sincere but has doubts about being able to say the ‘right things’.

*I probably am able to say the right things, or at least I think I am, but I don’t always have that genuineness. I mean most of the time I am genuine, but then the genuineness in return from the family? I think that unless I get that feedback, I’m never going to be satisfied that it’s any easier (Amanda, 3:20).*

What does Amanda mean by genuineness, hers and the family's? If she means being honest and open, what is stopping her from behaving in this way? Perhaps her uncertainty relates to not really knowing whether or not she is acceptable to the patient? She seems to expect feedback from the family. But how easy is it for patients to give such feedback? Do they necessarily realise it's wanted and, is it always wanted?

How well the nurse-patient relationship will develop is another unknown and, once again, doubt exists alongside positive anticipation.

*She might have just opened the door a little bit and you've managed to get in - you know - Then it's, 'Is she going to close that door again?' (Anne, 3:85).*

When this is said in the context of a group discussion, there are nods of understanding from the other nurses present. If it matters so much to be accepted, what is it like to be so unsure of how you will be received, whether you will be accepted and, if you are, for how long and on what terms?

But trust-related uncertainty also works in another direction. Questions often arise in relation to how much to trust, or hand over, aspects of nursing care to the family. Beverley says of a very ill man being nursed at home:

*I go in and they've done everything, or they tell me they have, but every time I go in he is asleep and they won't let me wake him. I've never seen the guy awake and it really worries me. 'Are these people coping or are they just putting up a front because they're scared I'm going to march in and tell them what to do, or take over?' (Beverley, 1:32).*

The tension here relates to hoping everything is fine, and wanting to believe that it is but not being able to assess this for oneself. The situation is complicated further by recognition that the family's previous experiences may not have been favourable. Thus the tension which Beverley experiences is increased by a consciousness of the past-operating-in-the-present (Proctor, 1997).

Past understandings also contribute to concerns for the future. Anne, who is aware of "the possibility of things going wrong," asks "What about the patient from a different background? Do they know? What do they want?" (Anne, 2:27). Lara's questions are similar and suggest an awareness of further tension in relation to the credibility of the response.

*Have they really understood? They might say 'yes' but I've been concerned they haven't really understood much and have not really known what to do (Lara, 1:171).*

Perhaps this is an issue of pride for the patient? Lara seems to know that admitting that one does not understand is difficult. In challenging the 'yes,' because it seems incongruent with other non-verbal signs of communication, there are risks that the patient's self-esteem may be diminished and that the establishment of trust, so essential to the working relationship, may be compromised. Lara suspects a lack of understanding but does not know the exact nature of this. Perhaps the tension experienced relates to the possibility that further questioning may jeopardise development of the nurse-patient relationship?

Thus far, the primary focus has been ontological. Experiencing tension has been described in terms of *Erfahrung*: as living through or experiencing the act of stretching or being stretched. Tension is revealed both in the nurses' emotional responses and in the form of questions and dilemmas. When nursing people from other cultures, the nurses' minds and concomitant capacity to provide care seems to be stretched more than is generally the case when nursing patients whose backgrounds are more familiar to the nurse. But, closely allied to experiencing tension primordially, in the moment, is the experiencing of tension as competing discourses or horizons in conflict. Description will now focus on experiencing tension in the sense of *Erlebnis*.

### **Experiencing tension as horizons in conflict**

Tensions exist within nursing as a profession, between nursing and society and between nurses and the people significant in their lives. Appropriation of the term *Erlebnis* enables exploration of the competing discourses that influence the nurses' interpretations of their experiences. *Erlebnis* permits the plural *Erlebnisse* and is used by Gadamer in a more critical sense (Weinsheimer & Marshall, 1996). It refers to experience that is anticipated or reflected upon. Experiencing is interpreted as something one has and which is therefore connected with a subject.

### **Tensions between nursing and society**

Nursing has long embraced and sought to impart a philosophy of practice that reaches out to all persons in need of nursing. Yet there are contradictions in an educational

message that appears to favour one group of patients ahead of others. Central to the following story is the tension between bicultural and multicultural discourses.

*I could never understand during my training why there was such a focus on biculturalism and on Maori ... and I was not alone. Lots of students felt this way and we got to the point where we almost resented having to go to class. From our point of view, NZ was a multicultural society and it seemed that lots of people were being ignored.*

*Since then I've done some very interesting workshops on biculturalism and have perhaps gained an appreciation of the process that one goes through to become bicultural. Now my father and I have horrific arguments about the notion that in order to be a multicultural society we first have to become bicultural.*

*So, I swing from side to side. There are times when I believe that Maori, as indigenous people, have rights under the Treaty of Waitangi; that they are deserving of that and then I think of all the other cultures that I have no knowledge of and that I feel are being neglected. So many people from different ethnic backgrounds are growing up in New Zealand and are adopting what I would call a Kiwi or New Zealand, not European culture. I'd like to see more of a focus on that and more of an appreciation of our diverse range of cultures (Jane, 1:59).*

Jane remembers feeling confused and resentful about early educational experiences pertaining to cultural issues in nursing. In a country, whose population is rapidly diversifying in terms of ethnicity, the bicultural focus emphasised in nursing seems unnecessarily narrow to some and Jane expresses concern for those patients whom she perceives are missing out. This view is supported by the literature that relates to multiculturalism in health care. The culturalist approach argues strongly that the educational preparation of nurses should focus upon increasing their awareness of the health beliefs and behaviours of those from minority ethnic communities (Cortis, 1993). Yet this literature also raises questions about the relative merits of ethnic sensitivity models which emphasise professional rather than political solutions (Ramsden, 1990a; Stubbs, 1993). Jane's early understandings seem to have been altered by her more recent educational experiences. A gradual acceptance of biculturalism is replacing her initial resistance to this concept. However, discussion with her father shows this new understanding differs from his and, in arguing her point, she recognises that she still has reservations. On one hand, the reasons for accepting and upholding Maori values seem justifiable. But on the other, Jane fears that a lack of knowledge of other ethnic groups' values may adversely affect the quality of nursing available to these people. Furthermore, her appreciation of the evolutionary nature of cultural beliefs and practices leads her to conclude that examining the diversities within, and perhaps in relation to, the notion of a New Zealand culture may also be necessary. Tension exists between being or becoming a 'Kiwi' and acknowledging and maintaining ethnic and

cultural diversity. Thus nurses are challenged to consider both the extent to which a person is acculturated and the strength of their ethnic identification (Lipson & Meleis, 1985).

An awareness of resurgent Maori issues and bicultural developments in this regard is evident at an interpersonal level in the following excerpt. Differences in the emphases of nursing and society initially create tension. Yet the nursing priority of relationship building helps overcome this tension and highlights the relative insignificance of practices believed to exemplify culturally appropriate behaviour.

*Yes... I am very aware that this person is a Maori woman. I am so aware. Every Maori house that I go to (they are the ones with the biggest problems, I find) I'm aware that I am Pakeha and they are Maori. I'm aware of the political situation and, in a way, I carry that with me. But sometimes, when I'm trying to build a relationship, I don't have time to worry whether I'm being culturally appropriate, although I suppose I'm trying to honour that too. You know, sometimes I haven't taken my shoes off (Anne, 3:38).*

Then, referring to immigrants from other cultures, Anne's insights further illuminate the disparity between society and nursing:

*Yes, part of me thinks "why are we bringing all these refugees into the country?" Yet when I visit a Somali family that doesn't come into it. I'm glad they're here and safe. That one-to-one relationship is where nursing is at (Anne, 2:99).*

Being a nurse seems to enable greater contact and appreciation of people who are different. But this does not mean there is absence of tension.

### **Tensions within nursing**

Several nurses express difficulty coming to terms with what they perceive to be discrimination between ethnic minority groups. Tension exists between the philosophies of multiculturalism and biculturalism because in nursing there is no justification for valuing one person more than another. In the current context it is therefore difficult to accord Maori greater recognition than people from other cultures.

*I mean there is so much going on about biculturalism and a lot is really good. We have to be open to it, but on the other hand, we also have to be open to the other cultures as well (Angie.1:224).*

Biculturalism, within the framework of cultural safety, demands that Pakeha meet their obligations according to the Treaty of Waitangi. Bicultural notions of protection, partnership and participation, when related to nursing, require that Maori health issues



are addressed before those of other groups. From a nursing perspective, accepting this in principle is one thing. Putting it into practice is another.

Then, alluding to another source of tension, Theresa refers to the competing discourse in nursing between respecting the individual and respecting the person's membership within a cultural group:

*The thing to remember is that you've got to treat them as an individual as well. You're looking at their culture and them as an individual.... Maybe in this new wave of cultural sensitivity that can get overlooked. There is a tendency to focus on Maori or Samoans rather than that they are a Samoan person. But they also have individual needs and they're not going to be the same as the next person (Theresa, 1:91).*

Theresa is expressing concern that a focus on group identity may be detrimental to meeting individual requirements for care. Faced with co-existing homogeneity and heterogeneity, a fine line exists between providing care that is tailored according to individual need and stereotyping people from the same region of the world (Lipson & Meleis, 1985).

The potential for conflict also exists when recommended treatments seem to be incongruent with certain cultural values and practices:

*You get into situations where you have quite a large person who has diabetes and they're used to eating lots of taro and other things that make their diabetes unstable. Being sensitive to the fact that these foods are important to them, you've certainly got to find a balance and that's difficult. Or another example might be that the person needs to lose weight and that's not a very sensitive thing to expect of a Samoan person. There are big dilemmas (Theresa, 2:92).*

Working from a background belief that health is a holistic phenomenon, Theresa experiences tension deriving from perceived incompatibility between physiological and socio-cultural requirements for health. Her discussion suggests furthermore, that neither aspect has automatic priority, but that somehow, something will be worked out.

### **Tensions between nurses and their significant others**

Jane's previous admission that she still has arguments with her father and that she swings from side to side in terms of accepting bicultural notions (see p.132), also alludes to competing inter-generational discourses. Beverley, speaks similarly of her father's influence:

*He was very racist. I mean when the Maori news came on he would flick the channel or if anything happened involving Maori it would be 'bloody Maori'. He really ran them down and still does. It really gets on my wick now and I tell him. I think that if I hadn't moved away, that would have certainly shaped the way I developed (Beverley, 1:62).*

Again the reflection is ongoing in terms of change. Beverley clearly disapproves of her father's stance and appears grateful that other experiences have countered his influence. She goes on to explain:

*When I was at school, I worked in a shop and my boss was Maori and he was a really hard worker. He was a great businessman too and we worked well together as a team. I suppose that made me realise that Maori are no different - that there is good in any race (Beverley, 1:62).*

Even though the views of people significant in our early lives may be outgrown, our conversations with them continue within us for as long as we live (Taylor, 1995). However, this does not mean that such influences are immutable but rather that, in existing dialogically with others in the world, tension is an inevitable part of being human.

In the context of one's own generation, Amanda describes the tensions inherent in a personal relationship with a man whom she describes as *part Maori*:

*There's a lot of conflict. Sometimes I can't understand him. It comes down to my nuclear family and possessions. If I generalise, it's that Pakeha attitude of 'What's mine is mine' rather than 'Well, if I've got something and someone else hasn't, then I'm going to share it'. I sometimes find it difficult when someone has worked hard and finally got something, that it's shared. It's a wonderful quality but can't the other person who is asking for it see that it's precious? Usually it's money. It's hard for me to see someone with little money giving it away (Amanda, 2:115).*

For Amanda, the issue of ownership has become problematic. Ways that she is familiar with have become questionable in light of the contradictory values held by someone about whom she cares. The disruption of 'normal' patterns has increased the visibility of her values, demanding that they be re-examined. "Is my way selfish? Is his way better? What are the likely consequences?" Then, there is another tension. On one hand, she respects her partner's generosity and, on the other, concern for his wellbeing means that she is reluctant to see him exploited by others. Amanda is experiencing tension both as mental strain and emotional stress. Perhaps having had such experiences in one's private life facilitates the recognition of and working through

similar tensions at work? Perhaps previous cross-cultural experience reduces or eliminates tension?

### **The possibility of 'no tension'?**

Exploring the notion of tension also prompted my asking what 'no tension' might look like and wondering when this might happen. Receiving praise is both personally and professionally rewarding, although on occasions its acceptance is tentative and played down. Talking about her experiences with refugee resettlement Anne feels rewarded by the positiveness and gratitude of these immigrants: *"Sometimes you get this nice feedback from them"* (Anne, 2:43).

Tara (1:84) laughs, and is perhaps a little embarrassed, but feels good when an Indian man tells her that he likes her; that she is *"a good nurse"* and that he likes coming back. Jo (1:45), in a mental health setting, feels valued when she walks in the door and is greeted. *"Immediately someone's hanging off your arm"* and Theresa fondly remembers leaving the ward one day when *"there were about ten children sitting outside and as I walked past they called "Bye Theresa", all together. I felt quite loved really"* (Theresa, 1:109).

However, there are times when positive feedback from patients is embarrassing. Amanda finds it difficult to accept praise especially when she believes a required nursing procedure cannot possibly have been pleasant for the patient.

*It's 'Thank you nurse' 'Thank you nurse' and I sort of feel embarrassed about that. I don't think I need as much thanks.... Like taking their stitches out.... Maybe they mean it because they are happy they're out but I think, 'Well I've put you to more inconvenience than the other way' and I find myself saying 'You don't need to thank me' or something like that (Amanda, 1:25).*

Do patients from other cultures thank nurses more than do those from their own culture? Do they, because they are grateful for help, sometimes place the nurse uncomfortably on a pedestal? How has Amanda come to conclude that she is unworthy of such gratitude?

Perhaps early and / or prolonged exposure to difference means that one doesn't experience tension? In some respects having a bicultural background means experiencing less tension.

*I've been brought up in two worlds. I can't speak Maori but my Mum always took me around the Maraes when we were younger and then we had Dad's side. He's the Pakeha and we got all the nuclear family stuff with his parents and first cousins. It was strange because when we got a bit older we sort of knew how clear cut it was on Dad's side but on Mum's we had all these cousins and we had never thought to ask how they were related. But it was nice growing up in that way (Jo, 1:5):*

Yet this does not mean Jo finds nursing people, either from her own or other cultures, straightforward. *"It's still hard"*, says Jo (1:95) and she tells of tensions relating to insufficient guidance from interpreters, and of the dilemmas associated with having to set and implement *"ward limits"* when the clients are *"older Maori women. I just feel uncomfortable ... I should be the one listening to them [but] I have to do it"* (1:33).

Jo knows that, within Maori culture, age requires that she defer to the higher status of older women. This is difficult when knowledge of behaviour modification requires that as a nurse she must overrule these women.

Bobby similarly believes that she has been *"fairly lucky, I've had the best of both worlds really, you know, the benefits from the Maori side as well as the Pakeha"* (Bobby, 1:75). But Bobby, like Jo, talks of the difficulties associated with having to compromise when values conflict. Although Bobby could understand a Pacific Island family's expectation that a daughter would be the care-giver when their baby was admitted to the children's hospital, she recognised that missing school was not in the girl's best interests.

*I could understand how that was part of the culture.... At home the child probably did the same thing. But to me she was still a child. You know most of her friends probably had dolls and she had responsibility for the real thing (Bobby, 1:3) ... It was quite hard because the rule is that anyone under sixteen shouldn't be left as the care-giver. So there was that thing about school which in our culture is important.... We actually ended up compromising so that she did get time out and some school (Bobby, 1:9).*

Humour can also reduce tension. Referring to a situation in which a good level of rapport had developed, although she hadn't been able to meet all of her patient's needs, Angie recalls: *"He hassled. He asked me if I'd been to church on Sunday"*. This man had not received the spiritual care he had needed, yet he was able to joke about this and thus had eased Angie's tension.

*I really enjoyed him, although I could see there were things that I'd missed ... and I enjoyed his family as well. I really did (Angie, 1:271).*

The experience had been a positive one, in an overall sense, but Angie remains aware of the things she had missed, the niggling tensions likely to remind her, in future, of patients' spiritual needs.

### **Experiencing tension(s): bringing the meanings together**

'Tension', as the act of stretching or of being stretched, is associated both with mental strain and emotional stress (Collins English Dictionary of the English Language, 1986). Tension shows itself affectively through the emotions, as well as cognitively in the form of questions and dilemmas. From a hermeneutic perspective, there is an ongoing interplay between experiencing tension in its primordial or pre-reflective, embodied sense and experiencing tension in a more consciously reflective or cognitive, sense.

In physics, the term tension relates to 'potential difference in terms of voltage' (ibid.), 'potential' suggesting uncertainty but also implying possibility, and 'voltage' referring to strength of force or charge. Tension in this sense has meaning as a motivational force. It alerts us, through our emotions, to what we regard to be important (Taylor, 1985a), and thus can illuminate our prejudices (Gadamer, 1996). The 'force' or 'charge' in the nursing context seems to be that of feeling morally and professionally committed towards assisting people from other cultures and striving to ensure equality of health care provision.

The meaning of tension as 'unrest' is also relevant. Feelings of concern for and responsibility towards people from other cultures motivate the nurse to reduce the levels of tension experienced through interacting with the person and becoming more familiar with their difference. Thus tension as uneasiness, or anticipation of difficulty, co-exists with tension as necessarily inherent in the call to care.

Gadamer's notion of play is significant in this regard. Gadamer (1986) contends that participants 'belong to the play' and moreover that it is difficult to avoid 'playing along with the game'. But in the context of nursing a person from another culture neither participant fully understands the other's values and expectations and the rules of the game become problematic. Again the questions arise. Which rules? Whose culture? How will the play continue? Being involved in the play has an important communicative aspect because the participants share in the ongoing movement. However, if

restrictions present in the encounter are to be 'outplayed', room is required to establish and pursue common goals (Neal, 1994). The capacity to play and be played, yet still retain one's identity and purpose, seems to aptly describe this part of the experience of nursing a person from another culture.

### **Conclusion**

Experiencing, in this theme, means being in a world of multiple meanings and shaping and being shaped by differing understandings that are never static. Nurses, by the nature of their work, come into closer contact with individual differences than do people from many other occupational groups. Consciously and unconsciously they live with and work through these differences. Experiencing therefore has meaning as looking back, and reflecting on past encounters, as well as relating in the moment to others perceived to be different.

The notions of tension and tensions have enabled description of the subjective and inter-subjective nature of the experience of nursing people from cultures other than one's own. Experiencing tension means being played by one's emotions and ethical responsibilities, both personally and professionally. It means having to make decisions about to whom, when, and how best to respond. Tugged one way and then another, nurses may be certain of their purpose yet uncertain of the most appropriate way of achieving that purpose. Tension is experienced on multiple levels simultaneously. Intrapersonal conflicts are derived from competing social discourses and priorities. At the level of nurse-patient interaction, a lack of knowledge by both parties about each others' expectations contributes to feelings of dissonance and the levels of stress are exacerbated by inflexible and unaccommodating environments and people. Affective, cognitive and behavioural components intertwine and are inextricably linked to their cultural and historical contexts.

This chapter has focused on the constant tension or 'play' between emotional and cognitive experiences. The following chapter, "Striving", will focus on nursing action and the meanings deriving from being actively engaged in nursing people from cultures other than one's own.

## Chapter Eight: Striving

We have to strive to achieve ...  
and the striving should be conscious, deliberate and hard.  
(Gandhi, 1995, p.197)

The previous chapters have illuminated the uncertainty inherent in the experience of nursing a person from another culture. There is frequent talk of wanting to meet patients' expectations but not knowing exactly what these are. An awareness of the adverse effects of monocultural practices on the health of people from other cultures, has increased nurses' levels of anxiety. In asking: "*Am I the right person?*" (Anne, 1:2), Anne is concerned that personal characteristics may jeopardise her capacity to nurse people who are different. In the past, she may not have considered herself to be a 'wrong' person because, as a nurse, she had skills of value. In today's environment she hesitates. Being a nurse seems insufficient.

Throughout the nurses' stories the word 'trying' shows itself in many ways as nurses try to ensure that their care of patients from other cultures is appropriate. They speak, for example, of "*trying to be as unthreatening as possible*" (Anne, 1:2), "*trying to learn Maori protocol*" (Sue, 1:406) and "*trying to be there for the family*" (Jane, 1:67). Amanda mentions repeated efforts to pronounce unfamiliar names. Beverley tries to get good information and Bobby speaks of trying to find balance and a compromise. When working with people from other cultures, as a public health nurse, Jane talks of "*doing my utmost for the family [explaining further that] there are times that I go further than the job involves*" (Jane, 1:54). Jo says: "*There are a lot more things that I don't take for granted. There is a lot more learning ... watching their body language, what they do, trying to pick up on how they are feeling*" (Jo, 1:55), and Anne, referring to cross-cultural communication difficulties, explains that: "*It takes more energy and time*" (Anne, 1:36).

The point being made cumulatively in these statements is that trying to nurse, in the face of difference and its related uncertainties, requires greater effort than does nursing a person from one's own culture. Thus although 'trying' is the word most frequently used by the nurses, its repetition builds to a meaning that demands a stronger descriptor. The term 'striving' was selected because it encompassed and extended the notion of trying.

Nurses strive, for the most part, because they are called to respond towards others (Lashley, Neal, Slunt, Berman, & Hultgren, 1994). This present striving originates from the past, both in personal memories of how hard it is to try and in those nurses who have striven historically and influenced the profession's philosophies. Striving describes the nurses' 'trying to be', their 'ways of doing' and their experiences adapting and compromising in uniquely dynamic situations. Striving can mean making great and tenacious effort, and being stubborn, persistent and forceful in the pursuit of goals. However, it is also revealed through indifference and apparent non-striving. Striving anticipates 'getting it right', an ideal that guides and inspires nursing effort but that does not guarantee success.

This chapter examines the nature of striving. The meaning of nursing a person from another culture as striving is revealed through the interrelated themes: 'striving as a hermeneutic response', 'striving as conscious and deliberate action', 'the being and doing of striving', and 'struggling against hindrances'.

### **Striving as a hermeneutic response**

Nurses, by the very nature of their relationship with society are, in Heidegger's terms, "thrown" into close contact with other human beings. "We are "delivered over" ... with ... "responsibility toward that into which we are delivered" - to an actuality, to a "there", to a complete, enveloping presentness" (Steiner, 1989, p.88). The meaning of *Dasein* is "to be there ... and 'there' is the world" (ibid. p.83). Thus, "the world of Dasein is a with-world" (Heidegger, 1927/1962, p.155). Although relationships begin with the self and happen to the self, they are unavoidably about being with others (Smythe, 1998).

Expanding this notion, Levinas (1984) contends that an ethical perspective coexists with Heidegger's ontological perspective.

I would maintain, against Heidegger, that philosophy can be ethical as well as ontological ... that man's ethical relationship to the other is ultimately prior to his ontological relation to himself (egology) or to the totality of things which we call the world (cosmology) (Levinas, 1984, p.57).

In the inter-human relationship Levinas argues that the face of the other makes an appeal, or ethical demand. Ethical responsibility is described as "*insomnia* or *wakefulness* ... because it is a perpetual duty of vigilance and effort which can never



slumber” (ibid. p.66). Thus the nurse is charged with an ethical responsibility towards the other and continually strives because of the primordial nature of this call. The ethical pain that prompts engagement comes prior to thought and action. “I can never escape the fact that the other has demanded a response from me *before* I affirm my freedom not to respond to his demand” (ibid. p.63). The call of caring responsibility to other is therefore a pre-reflective experience.

Van Manen (1999), exploring the experience of caring in nursing, speaks of caring-as-worrying. Referring also to Levinas’s notion of Other, he suggests that in being face to face with other, one is ‘taken hostage’ in a manner that is initially beyond one’s control. Using the example of a Save the Children Fund television commercial, van Manen draws attention to the ‘uncanny sensation’ experienced when a poverty-stricken child, held by its mother, is turned to directly to face the viewer. Whether or not one agrees with such advertising strategies, their power is unmistakable. The child’s face and eyes evoke a hermeneutic response and the audience is challenged to reconsider the meaning of care and how this influences thought and action (Hultgren, 1994).

In a similar way, the person from another culture, by being present, asks something of the nurse. The person not only asks for care but also that his or her heritage and condition be respected (Shabatay, 1991) as is exemplified in the following story.

*There was a lovely, lovely Niuean lady, right back when I first started. She had come in electively for gall bladder surgery I think, and by the time I saw her she was in quite a state. She told me she didn’t know whether to have the operation and started talking about how the doctor had made her feel really awful about her size. Like many Niuean women she had a lovely rounded body and he’d obviously, in her mind, made a big deal of this. She was frightened. Obviously he’d over emphasised her obesity, and I know you have to tell about the risks of more adipose tissue, but I just think she needed to be related to in a more appropriate way. She was feeling really self-conscious. It was devastating. She was in pain and she did need the surgery. It was awful. Fortunately we weren’t too busy. I talked to her for a long time and gave her some shoulder massage. She really liked that. And we had quite a good house surgeon at the time, so I said I would arrange that they could talk and see how she felt then. When I came in on the following afternoon the lady was feeling a lot better and she had decided to have the surgery. I just think she needed a bit more information given in a different way (Lara, 1:5).*

Lara strives because she is concerned for this woman, the play on her emotions evident in the phrases: ‘*It was devastating*’ and ‘*It was awful*’. In exploring the meaning of “being called to care” Berman (1994, p.7), suggests that when seeing the face of the

other, nurses accept their most basic mode of responsibility. The vulnerability of the face compels a response and nurses, for the most part, find it difficult to disregard such an appeal. But what of the response?

Although 'being called' happens in a variety of ways, it ordinarily also means hearing and responding to one's history and intentions (Berman, *ibid.*). In this story, Lara believes that the doctor's bias is partially unjustified. Furthermore, she believes that the manner in which issues are discussed is as important as the issues themselves. She wants to relieve the woman's feelings of distress and fear in order to assist her decision-making regarding surgery. Lara's ability to accurately appraise the situation, her understanding of differing cultural beliefs in relation to the body and her interpersonal skills, enable her to sustain the call to care (Lashley et al., 1994). Lara strives because nursing in the words of Bishop & Scudder (1990) is a caring practice with an inherent moral sense. Ethical and ontological perspectives coalesce because the face of the other makes a claim that questions the response to care.

### **Striving as conscious and deliberate action**

Gandhi, whose voice begins this chapter, interprets the meaning of striving to be conscious and deliberate action. In addition to 'being called', nurses strive because there are personal and professional standards of practice to be maintained. In Chapter Four, I discussed Gadamer's (1996) claim that horizons and prejudices affect interpretation. The notion of 'strong evaluations' (Taylor, 1985a) was also used in reference to the distinctions of higher importance or worth that become embodied in action because they matter. What, then, are the 'things that matter' when nursing a person from another culture? What informs striving as a hermeneutic response?

Anne speaks of patient wellbeing as her major nursing goal: "*I would put wellbeing above anything*" (Anne, 1:33). Theresa believes "*practising holistically is the essence of nursing*" (Theresa, 2:106) and, for Lara, seeing the person as an individual is paramount: "*The way I behave has to do with a basic respect for people and that they are different. I would leave nursing if I had to clump everybody together*" (Lara, 1:85). Without exception each of the participants also refers to the central place of the nurse-patient relationship in the practice of nursing.

### **Striving because relationships matter**

Establishing interpersonal relationships is crucial to the purpose of nursing and being accepted personally by patients assists the development of a good working relationship. The increasingly socio-political interpretation of culture in nursing (recall Chapter Three) has heightened nurses' awareness of difference and the previously described 'experiencing tension as questions' provides a catalyst for additional effort.

*Am I doing the right thing? When I go to the door: 'Are they wearing their shoes? Yes they are, then it's probably OK if I wear mine'.... I don't take anything for granted. I just go with the flow and sort of wait for them to make the cues and then I follow them.... If they ask me to sit down, I sit down (Anne, 1:2).*

Anne expects that the norms of entering a house may differ and checks her behaviour in relation to those with whom she is interacting. She has a sense of the 'how' of responding but is unsure of the particulars of the 'what'. She raises questions, watches for difference and tries to follow the lead set by the person who is other. She strives because something taken for granted in her cultural group is no longer straightforward in another. Although the to and fro nature of her questions and answers conveys a sense of uncertainty, it also reveals highly developed skills in observation. Anne strives because it matters, both personally and professionally, that these people accept her. Furthermore, in being alert, she will be more able and ready to respond variably according to the changing demands of the situation.

### **Striving because all people matter**

Bobby emphasises the need to nurse in a manner non-critical of the patient:

*Regardless of who they are or what's wrong with them ... not putting your own values and judgements on to them or the situation (1:82).*

Pam's concerns are humanitarian,

*I'm always aware that I'm dealing with another person. I guess I treat people the way I would like them to treat me, with respect, allowing dignity and choice (1:94)*

And for Tara the issue is one of equality and obligation.

*My job is to care and treat patients regardless of their race, gender, status or whatever.... I don't think 'Well I'm Polynesian, How am I going to approach these patients?' (1:262).*

Bobby, Tara and Pam strive to actively uphold their beliefs about the rights of all patients to nursing care that is equally respectful. Their statements are consistent with a long tradition of idealism in nursing and demonstrate commitment to a principle of

justice that is underpinned by humanitarian and egalitarian philosophies. These nurses strive because people matter equally in nursing. But what does it mean to matter equally? Do these stories exemplify an interpretation of justice that remains essentially assimilationist?

The liberal humanist view, which promotes treating everyone according to the same principles, rules and standards, reinforces assimilationist ideology (Young, 1990). Efforts towards equal treatment, the elimination of group differences and the promotion of individual choice may achieve respect for diversity within private and social spheres, but blindness to group differences prevents the attainment of a radically democratic social justice. The cultural value of individualism is embedded firmly in nursing yet the related values of autonomy and respect for self-determination highlight the tension or play between the forces of individualism and the value of care (Katims, 1995). If giving care in accordance with a person's values is important, then the recognition of divergent needs and interests is mandatory. Thus Katims argues that the public articulation of caring practices in nursing significantly tempers the tendency towards non-interference within western notions of individualism.

The nurses' use of the term "*regardless*" implies denial of difference and Tara's assertion that being Polynesian does not alter her approach to people from other cultures also suggests that such differences do not matter. Yet there is more in these stories. Bobby recognises that some of the values she holds may differ from those of her patients and that judgements based on these values may be inappropriate and unjustified. Thus she strives because she believes it is important to minimise this risk. Pam, in using herself as a yardstick, could be judged unfavourably for seeming to believe that one should nurse others on the basis of one's own preferences. However, her use of the word "*choice*" in conjunction with the words "*respect*" and "*dignity*" suggest a belief that entitlement to a standard of care does not exclude the acceptance and accommodation of difference. However the references to "*person*" and "*people*" [as collective individuals] suggests that such striving occurs predominantly in nursing at the interpersonal level.

### **Striving because of concern for the future**

The nurses' stories also provide evidence of their hopes for a better future for New Zealand and its people. Amanda speaks of being:

*... more acutely aware for Maori people (1:91). I'm trying to make an effort.... Yes. I really want to be part of this country so I believe I have to put in effort.... I feel accountable because if we have a Treaty and are saying this, then I feel I have to uphold my end of it (Amanda, 2:103).*

Born in New Zealand, Amanda describes herself as a Pakeha New Zealander. Underpinning her nursing efforts is an awareness of bicultural issues and hopes for the positive accommodation of cross-cultural differences. In Gandhi's words, Amanda strives consciously and deliberately towards this end.

Jane also shares this ideal and believes it is congruent with nursing values.

*In terms of honouring the Treaty, the CHE<sup>52</sup> has made some great advances towards making changes in its structure, more positions available for Maori nurses, that and orientation requirements to go to a workshop. I think those are positive things. Going into any situation, I treat them all as bicultural. It doesn't matter whether they're Maori or not. I try to use the ideas of the Treaty with every culture. It really goes back to, like being a nurse, that basic principle of partnership (Jane, 1:86).*

The cultural and historical horizons of 'being a nurse' and 'being in New Zealand' are clearly evident. The notion of partnership, previously interpreted in nursing as the nurse-patient relationship (Christensen, 1990), now has additional meaning deriving from the Treaty of Waitangi. During the 1980s, as discussed in Chapters Four and Five, the Treaty's relationship with health was reinterpreted to emphasise the three principles of protection, participation and partnership (Durie, 1988). The subsequent implementation of Ramsden's model of Negotiated and Equal Partnership in nursing education, together with other efforts towards a bicultural society, have influenced these nurses' orientations. Thus there are occasions when striving extends beyond the nurse-patient interface to encompass the broader notion of community.

Elisabeth speaks of actively striving to reverse practices that deny Maori participation and exclude partnership with Maori.

*You have to steel yourself to have a go. And it's not easy (Elisabeth, 1:22).... More than just changing things in myself, I try to change others around me.... I try to give my knowledge to community health workers so they can change things as well. And I try to get nurses to study further and to gain what I did personally so their practice is enhanced (Elisabeth, 2:5).*

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<sup>52</sup> Crown Health Enterprise: employing institution

In addition to the efforts she makes to uphold Treaty principles in her own practice, Elisabeth strives to assist others to do likewise. Knowing that change needs to be broadly based, attempts are made to influence those with whom she works. Within both student nurses and community workers she sees a potential for improvements in health service delivery.

There are occasions when effort is also expended at the interface between nurses and their communities. In the following story, Pamela describes her attempts to manage a situation of potential conflict between patients from differing cultures.

*A Pakeha family asked, 'How long are those people going to be next door? It stinks.' So I talked about it with them saying, 'Well that's what they want to do and you're doing what you want to do'. And they were quite surprised and said: 'We're not doing anything to offend them.' And I said, 'How do you know that?' and they said, 'Why should we be?' so I explained.*

*'You might like to know that they're staying in their room because they're too embarrassed to come into the lounge.'*

*'Why would they be embarrassed?'*

*'Because they see that you are there.'*

*So in the end they said, 'Well we don't want that', and I went to their room and said, 'The people next door would be happy if you want to come into the lounge but she's feeling a bit sick because of the smell of your Kentucky Fried Chicken.'*

*So they said, 'Oh, OK we'll eat it up and then come through.'*

*And everyone sat there quite happily. Afterwards the Pakeha husband said to me, 'They were really quite nice weren't they?'*

The issues raised in this scenario are complex and interrelated. Misunderstandings and assumptions abound and are related to the groups' different cultural horizons. The lack of physical space is also constraining yet potential conflict is skilfully avoided by a nurse who sees and accepts that there are differing perspectives. Pamela's persistent and tactful management facilitates a resolution that is acceptable for all parties. Committed to broadly healthy outcomes, she willingly extends her educative role into the area of ethnic relations. Does Pamela strive, in this situation, towards the concept of a healthy community? She seems to understand, as Buber (1947) suggests, that community must begin in small groups and that dialogue between individuals assists the confirmation of 'other' even when conflict occurs (Gudykunst & Kim, 1992, p.260).

Thus striving means responding consciously and unconsciously on multiple levels. It means striving towards other because one is called upon to do so. It also means striving to implement and maintain professional ideals and seeking, where possible, to

extend these to the wider community. But in addition to effort expended in relation to personal, professional and societal values, nurses strive (although they seldom use this term) in very practical and down-to-earth ways with and towards people from other cultures.

### **The being and doing of striving**

Striving encompasses the nurse's 'trying to be' and 'ways of doing' when nursing a person from another culture. The being is not separate from the doing. Each is related inextricably to the other and both are oriented towards 'getting it right'. 'Right' in this context refers to a standard of care that meets the patient's and the nurse's expectations as well as those of the providing institution.

Although the ways and means of 'getting it right' constantly change as circumstances alter, there seem to be some 'musts' or 'universals' that have to do with attitude and with the nurse's manner of being: a letting be at the same time that there is striving. Striving to get it right requires learning 'how' to be, in addition to learning to 'do for' and 'do with' the person from another culture. The being of striving underpins the doing aspects of striving. It comprises essential, often taken-for-granted attitudes such as willingness, respect, compassion, awareness of self and openness towards others. The being of doing describes the difficult to measure attitudes that enable the nurse to work flexibly with the person who is culturally other.

Recognising this essential but often elusive aspect of nursing, the participants talk about 'a way' of being a nurse:

*It's an approach. It's a way of being a nurse (Jane, 1:63). A lot of it is the way I go about things. The way I am as a person (Jane, 1:71). You might not be able to put into words exactly what it is, but it's about the way you talk or act (Anne, 3:43).*

### **The less visible strategies**

Striving can show itself through creative use of the imagination. There are times when the nurse uses strategies of visualisation to assist understanding of the patient's situation. Beverley imagines that the patient is someone of special importance:

*The way I nurse people is to look at them as if they are a relative of mine and to think, 'How would I like my mother to be treated?' ... I try to*

*keep that attitude, so that I have compassion and feeling for what I am doing (Bev, 2:67).*

Lara uses herself as the yardstick:

*I have sometimes thought, 'Imagine myself in that situation. Whatever that person is feeling is real for them'. And if I were lying there, I wouldn't want to be told 'this, that and the other thing' (Lara: 1:94).*

Tara draws specifically on a past experience:

*I felt sorry for her not being able to understand English.... I have been in that situation. I can understand how difficult it is to learn. So, even though I was frustrated, I thought 'What if it were me? It would be the same' (Tara, 1:317).*

In each of these situations, the nurses seem to be searching for an aspect of familiarity among the differences. They are striving within their imagination, both retrospectively and prospectively, for something within their personal experience that will help begin their relationship with the person from another culture.

The nurses seem to be both sympathising and empathising with their patients. Yet, Gudykunst and Kim (1992) argue that, while empathy increases the likelihood of effective communication with strangers, sympathy invariably leads to misunderstanding because the referent for sympathy is one's own experience and not that of the stranger. In this argument, sympathy is defined as "the imaginative placing of ourselves in another's position" (Bennett, 1979, p.411), whereas empathy is "the imaginative intellectual and emotional participation in another person's experience" (ibid. p.418). However, the participants' accounts suggest that both may occur simultaneously.

How can the nurses not use themselves as referents? Is it ever possible to stand outside one's own experiences? Perhaps the belief that some human experiences are universal enables the nurses to work successfully in this way? Perhaps being part of a family and being able to draw on one's own experiences are inherently human characteristics? Anne, for example, talks about the bonds of motherhood and many of the participants vividly recalled experiencing frustration and vulnerability when unable to communicate their needs in foreign countries. The nurses' efforts to empathise seem to provide a valuable beginning point in the nurse-patient relationship. However, there is also recognition of the limitations of such imagining. Alongside the search for something similar, as a point of contact, the nurse is aware that understanding of difference can never be complete. Anne explains this inherent tension:



*You go into their homes and there's this amazing sort of 'people thing' going on - all these people - rich relationships - lots of interactions and a lot of closeness that compensates for other things that aren't there. But it can be quite difficult. I mean ideally you want to become one of them to be really able to, I mean 'How do you put yourself in their shoes?' That's difficult if you're not Samoan (1:20), and then elaborating further: I suppose I'm saying 'How can I know how they feel if I'm not one of them. It's impossible. But I'm doing my best (Anne 2:65.)*

Anne, like Gadamer (1996), recognises the impossibility of putting oneself in the shoes of another person or group. Yet this does not stop her from trying. Lampert (1997) suggests that the person, whom we are trying to understand extends our horizon.

The person to my left can see further to the left horizon than I can, but I can see further to the right. At no point do I step into her shoes and see what she sees ... yet my interpretations of what she says are a way of extending my own horizon, and of constructing an understanding of a larger world that we share (Lampert, *ibid.* p.353).

Perhaps difference, like language, is a "point of contact" (Gadamer, 1996, p.442) that potentially extends understanding?

### **Becoming more like the patient**

Changing things in oneself is another other aspect of striving towards right. Changing involves adapting and compromising in an effort to meet multiple needs and expectations. Sometimes it means becoming more like the patient. Anne feels herself 'change' when she visits Maori homes.

*I think I sort of try to become a bit more Maori when I go to a Maori home. It's like part of me takes on, not consciously, but being a bit more like them, I suppose.... She then reflects that this happens similarly in her own culture.  
When I go to an employer meeting, I'm different again (Anne, 3:45).*

Thus, it would seem that, even though nurses value uniqueness and difference, there are times when they make themselves more like others in an effort to foster the building of relationships. A recent exploration of nurse-patient interaction by Aranda and Street (1999) refers to nurses' references to the term 'chameleon'. Used by Australian nurses to describe the way in which they alter their approaches to people and practice "in order to become the sort of nurse the person required" (p.75), the notions of 'empathy' and 'being a chameleon' support the behaviours described above. Also congruent with this study's substantive findings is the inherent tension between the nurses' desire to be genuine and their need to be congruent with patients' wishes

without subjugating their professional responsibilities. Perhaps this phenomenon is, in some ways, universal?

### **The ‘small practices’**

Jane similarly wonders if there aren't some “*basic things*” that underpin all meaningful human interaction. She talks of “*things, not specifically cultural things ... [like] listening, seeking permission and using a person's name correctly*” (Jane, 1:5). Bobby refers to “*picking up little things ... like whoever takes over. Perhaps the man does the talking (1:21), general things like removing shoes at the door and accepting that they may want things done differently (1:49) ... perhaps working out a way you can use Maori medicine and modern medicine together*” (1:53). Anne remembers wondering what she had done for a Samoan woman who wrote her a card saying “*Thank you, you made a difference*”. Anne didn't believe she had done anything other than visit and listen. “*Basically I listened. On a practical level I didn't do much but I gave her my time and that seemed to make a difference*” (Anne, 2:105). Jane mentions “*being there for the family*” (1:67) and “*leaving my phone number*” (1:19) and Anne talks of “*being a sounding board*” (2:38).

These are thoughtful, seemingly simple yet complex, nursing behaviours. In a sense they describe ways of working with any person who is new and therefore unknown to the nurse. Yet when Lara explains that nursing a person from another culture means “*just being around a bit more. Sometimes it's tone of voice, sitting down with the person, thinking about how you will use space ... yes ... maybe using touch but being aware enough not to do that if it isn't appropriate*”, her use of the word “*just*” contradicts the quite explicit ways she comports herself with people from other cultures. Pamela explains that, for her, such nursing “*means identifying what's important for the people ... not following a set of guidelines that someone else has written up*”. It is relatively straightforward to follow guidelines, perhaps a standard care plan or a text outlining a specific cultural group's health beliefs, but Pamela chooses not to do this, and thus makes the effort to come to know the person's needs individually. Tara, in an emergency setting, worries that “*For them I'm asking too many questions*”. She goes on to explain: “*I have to say: 'Sorry I'm asking so many questions, but I need to know exactly what happened in order for me to document it'. When I explain myself, and they understand, then they are happy to give more information*”. Tara appreciates that the questions can seem invasive and overwhelming when English is the second language. Thus she takes the extra time and effort to explain.

Striving also involves seeking permission and tactfully using one's knowledge of cultural practices. Knowing that, for some Maori, the head is tapu<sup>53</sup>, Amanda checks the person's preference in a way that does not impose or demean. "*I'll say [to a Maori patient], 'I need to lift your head. Is that alright?'*" (Amanda, 1:45). She anticipates the person's need as a member of a group yet seeks also to accommodate the possibility that individuals may vary from others in the same group. Her nursing action recognises that degrees of acculturation coexist with ethnic identity (Lipson & Meleis, 1985) and her capacity to discuss the issue with the patient provides evidence of effort and a willingness to change familiar patterns of practice.

In striving towards a positive outcome the nurses in this study are also quite specifically aware of how **not** to be and of what **not** to do. Beverley talks of "*not calling the shots*" (Bev, 3:36), and Lara "*of not bustling ... trying not to barge in, ... and doing things more quietly and gently*" (Lara, 1:83). Bobby recognises the importance of "*not just bowling in [to do a dressing] and bowling out again*", because she knows that the task only constitutes part of her job. Anne talks of knowing you don't "*trample over people*" and that, although a nurse may have things she needs to do, it is the person who is receiving the treatment who should be in charge.

Thus striving, when nursing people from other cultures, is visible in numerous "small practices" (Diekleman, 1997). These are the 'little' and 'basic' 'things' that are cumulatively important because they demonstrate a respect for and acceptance of difference. Such striving includes actions like taking one's shoes off, not sitting on tables or not sitting at a level that precludes a Polynesian person from showing respect by being lower than the nurse. Yet 'getting it right' is not just a matter knowing a list of 'correct' things to do. Although knowledge of people's customs is important, striving is most significantly a way of being open and honest with other human beings. It is also possible that, from the patient's perspective, the nurses' effort is more important than 'getting it right'.

Striving includes supporting patients' decisions to use their own forms of medicine and allowing religious rituals to be observed before intervening with other forms of treatment. It often involves advocating for the patient in relation to other health care personnel. There are also times when it means apologising, times when the nurse stands back, seeming to not strive and, times when efforts are made to ensure that

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<sup>53</sup> Sacred; not to be touched

feelings of frustration are not shown. Yet showing humility and standing back are not 'usual' or 'basic' ways of being in modern western cultures. Humility implies an awareness of one's personal limitations and acceptance of the need for continuous learning irrespective of the extent of one's previous learning (Carper, 1979). Critically examining one's personal value systems and maintaining ongoing learning require considerable effort. Hence the so-called "small practices" allude to the paradoxical nature of striving. Perhaps their importance lies in their illumination of effort where there seems to be none? Yet, it is also significant that such striving does not ensure a positive outcome. One may strive but not necessarily 'get it right'.

### **Not always getting it right**

Striving means being prepared to learn from one's mistakes and not being paralysed by them. Believing in the importance of pronouncing names correctly, Amanda (1:185) says: *"I ask. I try it out a couple of times ... and I slip. I get it wrong sometimes"*. Amanda does not give up. She keeps on trying.

Theresa accepts that mistakes happen and emphasises their contribution to learning:

*As long as you can look back on them and say "Well that didn't go quite as I had planned but what have I learned for next time?" (Theresa, 3:54).*

The efforts do not stop.

Amanda recognises that trying to respect specific health beliefs may not be straightforward. Nursing an Indian man, who had previously had a tracheostomy, she ruefully remembers getting it wrong:

*You know I trap myself all the time, assuming about beliefs.... The first thing I thought he would want to eat was a curry, but he wanted Kentucky Fried Chicken.... That was good for me (Amanda, 2:41).*

Thus there is difficulty even when the nurse has knowledge of specific cultural practices. Allowance for individual variation must be made if feelings of embarrassment are to be avoided and sometimes admitting one's lack of knowledge can be appropriate as Pamela explains:

*I'll say, "I'm a bit ignorant here. Is there anything I need to know so that I don't give offence?" (Pamela, 1:102)*

In striving towards right, it therefore helps to be humble and to question one's assumptions. The nurse learns to watch, listen and check, to be continually aware of self, the patient and others significant in the situational context. But it also 'true' that it is difficult to sustain such effort. Nurses do not always strive.

### **Deficient modes of striving**

Nurses, like all human beings, have a capacity for choice and are confronted with the burden of choosing and deciding (Travelbee, 1971). Just as there is disproportionately more medical staff in wealthy suburban environments, some nurses choose to practise in places where their contact with people from other cultures is minimal. Heidegger (1962) reminds that "deficient and neglectful modes" of concern (*Besorgen*) "characterise everyday, average Being-with-one-another" (p.158). Thus striving coexists with indifference or 'not striving'. Discussing the role of Kai Atawhai in a hospital setting, Amanda knows that this service is misused.

*We just abuse them.... On the admission form ... you tick and date that you have contacted them. We're quite good at passing the buck.... We assume that once we've introduced them and we've got the whanau room for them to stay in, then everything will be all right (Amanda, 1:101).*

Amanda is referring to the occasions when nurses minimise their involvement in meeting patients' cultural needs by referring them to a specialist service. She is describing the everyday world in which other matters claim nursing attention.

Pam and Elisabeth are similarly aware of the difficulty maintaining an adequate level of commitment towards meeting such requirements. Reflecting on her efforts to provide culturally appropriate care, Pam says: "*There are days when you flag it away.... You usually hate yourself afterwards*" (Pam, 1:80) and Elisabeth, talking about the effect of age on her energy levels, states:

*Old age - Sometimes it's easier to do things **not** appropriately. Socioeconomic issues come into it. It requires more effort, extra visits. Sometimes I'm just too tired.... It worries you. You should spend more time at Kohanga<sup>54</sup> for example, not just quickly checking and going.... Sometimes when you work that way, afterwards you think "Oh my God".... It makes you sick working like that (Elisabeth, 1:24).*

On initial reading the behaviours, "*passing the buck*", "*flagging it way*" and "*quickly checking and going*", exemplify instances of non-striving. As both a clinician and a

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<sup>54</sup> Pre-schools in which only Maori language is spoken

teacher of nurses, accepting that these, and similar, behaviours occurred in nursing was difficult. They engendered 'cool spots' (recall the reference to Peshkin, 1988 in Chapter Five), the understanding of which required that I re-examine personally held expectations in relation to standards of practice. In judging without fully exploring these actions, I risked over-looking other possible interpretations. Elisabeth "worries" and feels "sick". Pam 'hates herself' and Amanda's statement shows insight into the abuse of a service supporting patients from other cultures. Thus, there is coexisting evidence that these nurses are striving to come to terms with the fact that they have failings. Sometimes the demands of nursing a person from another culture seem too difficult to meet. Yet the nurses' striving continues intra-personally as they struggle with feelings of guilt and remorse. Furthermore, in focusing on their personal shortcomings, these nurses do not lose sight of the broader picture. Anne describes going into a street, parking the car and then suddenly realising the enormity of the task she faces.

*I'm in an area that is totally Polynesian, and I'm alone. I feel quite afraid. I think it's my fear of being attacked. There is a rawness that is quite eerie. It's not the cultural differences that get to me. It's the poverty. It's the fact that these people don't have anything and their lives are so hard because of this. They are poor. Sometimes it's just too hard to bridge the gap between our cultures. And if I'm tired and haven't the energy, then I can't do it so well.*

Anne strives within herself as she wrestles with fears for her personal safety. Despite feeling tired she continues to try, albeit with less energy. Her reflections on society's injustices reveal an awareness of the situated nature of her striving. Like Elisabeth, she recognises the effect of socioeconomic constraints on her practice yet it seems that the non-striving or lesser striving is a transient phenomenon. Perhaps the feelings of tiredness disappear as these nurses get to work? Perhaps there is also a sense of hopelessness? How can such poverty be overcome? Are there other hindrances to striving in the cross-cultural context?

### **Struggling against hindrances**

Although the nurses' shared experiences convey an overall sense of their striving, this descriptor sometimes seems too definite and uncomplicated. Feelings of anxiety and vulnerability often accompany nursing action and the environments in which nurses work do not always support their efforts. When striving under difficult circumstances then, the term 'struggling' more appropriately conveys the ongoing sense of toil and the

interplay between effort and resistance. The nurses are not only hindered by the embodied nature of their own assumptions but also by the strength and prevalence of colleagues' attitudes and behaviours and the prejudices institutionalised within the health care system.

### **Struggling with negative prejudices**

Anne's statement that: *"It's really difficult at times ... that whole thing about not being judgmental, not putting your thing on them because their way of life is valid"* raises the issue of cultural relativism (Herskovits, 1973). Does Anne's striving relate in part to concern that where nursing values conflict with those of the patient, they are neither 'right' nor 'wrong', but rather a point of difference from which to begin negotiation? These difficulties are also recognised by Bobby who struggles to separate personal and professional aspects of her being.

*We all have our values and opinions and there are times when you have to keep those to yourself. You may go back to the office and say "This is what happened and it pisses me off", but you've got to go with it (Bobby, 1:129).*

Yet, in asking: *"Are we forgetting where we're coming from? Are we too accommodating, by trying, too often, to be so non judgmental?"* Jane (3:81) is implying that, in being concerned to accept and accommodate people from other cultures, nurses may sometimes overlook other professional responsibilities. She seems to know that there are occasions when differing values and expectations need to be confronted. It is not that differences should not be respected but rather that several perspectives may need to be considered in order for the most appropriate decision to be reached. Jane is suggesting that nurses need to be clear about what is acceptable and what is not acceptable in professional terms and to be confident about 'drawing the line'. Said in the context of a group discussion, the nods and murmurs around the table are supportive but seem also to imply an understanding that this is no easy task.

Theresa remembers nursing a non-English speaking woman in a four-bedded room:

*It was first thing in the morning, around 7.30, and there was a man sitting with this lady because she had not long been admitted. Our charge nurse asked if he could leave the ward because there were other ladies beginning to have washes and doing quite personal things. I'm sure many people would feel uncomfortable about having a man in the room.*

*But he got very angry and said she was being insensitive and I was really frustrated. I thought, 'We've been sensitive enough to let you be with your mother because she doesn't speak English and we've*

*explained that we want you to leave while the ladies have a wash, but you're throwing it back in our faces' (Theresa, 2:52).*

In this story, an appeal is being made for support of the nurse's perspective because the issue is not only one of ethnic difference. Theresa believes, like the charge nurse, that gender differences should take priority. The man seems to disagree yet it possible that he has interpreted the nurses' request differently. The struggle to clarify and accommodate everyone's expectations under such circumstances is not easy.

Striving to establish relationships also means becoming aware of one's own prejudices. Beverley recognises the inappropriateness of imposing personal values and expectations on others and consciously reminds herself of this fact:

*I can't go in and say 'I'm putting you in the bath' ... and, just because I like my house to be 'spik and span', it doesn't mean everyone in NZ is like that.... They certainly aren't. I can't let my judgements come into it (Beverley, 1:38).*

Thus effort is expended in the form of 'self-talk' to develop and maintain attitudes that are open and accepting of difference because Beverley knows that negative prejudices will undermine the trust essential in a working relationship.

When working with refugees, Anne talks of trying to be "as unthreatening as possible ... because there's the feeling that perhaps where they come from they were in situations where people could have threatened them". Then, elaborating further on how she makes herself "unthreatening", Anne explains:

*I try, when I go to the door, to get myself in a frame of mind that is really open. And I try to be a friend I think. Yes, tone of voice, a feeling inside, smiling, allowing them to invite you in. Being very simple I suppose (Anne, 2:63).*

These are not usual ways of being. Through experience, Anne knows something of the traumas that many refugees have suffered. She works hard to minimise the risk of further harm. Watson (1988, p.63), describes a "transpersonal caring relationship" as being a special kind of human care relationship in which there is high regard for the whole person and their being-in-the-world. In Anne's story, an awareness of the other's need for care is evident. A self-reflective consciousness of the power differential between refugees and health care workers is also apparent. Thus the actions Anne takes towards establishing relationships are based both on this knowledge and on an underlying commitment to human care ideals.



Reminded through experience about the importance of remaining open to the possibility that patients' responses may differ individually, striving is showing itself as effort to resist listening to the stereotypical generalisations of colleagues. Pamela talks of the danger of taking *“a whole lot of baggage that might not necessarily be your own [and of] trying to leave that outside the door when going into the room of a Maori or Indian woman”* (Pamela, 1:90). She is striving to ensure that her nursing responses are not affected by the prejudices of others.

But are nurses necessarily aware of their prejudices or of their prevalence and strength? The irony here is that although some prejudices may be known, or become known through contact with others, many are not. The embodied nature of attitudes and beliefs, at both personal and professional levels, means that their familiarity can reduce their visibility and that, even when they are visible, making decisions about their relative worth is seldom straightforward.

Amanda, in the context of a group discussion, recounts the following incident:

*Just last week the bell rang for visitors, seeing if they could come in ... and the nurse who answered went to the bedside and said to the relatives already there, 'It's one of your fellow tribesmen outside.' I just crumbled. It shattered everything for every other nurse who had ever been involved with that patient and family. You talk about building bridges and I think of the bridges that I have built that have been destroyed by other people (Amanda, 3: 85).*

The non-verbal expression of empathy, in response to this statement, is palpable around the table. The seconds hang in the air, and then Theresa responds:

*I don't think we realise what we say and how we come across. I've been in situations where I've felt embarrassed to be there. I know that it may not have been meant in the way that it came across, but...*

More seconds pass and there are nods of assent. Once again, it is quiet. The group seems sobered by the realisation that nurses often hinder their own aspirations and progress towards 'getting it right'.

### **Struggling with the demands of the job**

Striving in nursing also inevitably means juggling multiple demands. Effort is required to prioritise needs and to communicate these to patients and their families. Alice recalls a situation in which the relatives of a Lebanese man seemed angry at what they perceived to be lack of nursing attention.

*She [the patient's wife] would just look at you stonily and you would think 'Oh crumbs I've upset her, but I've got to go now'. You know, 'I can't stop now' (Alice, 1:22).*

Alice feels the tension of not being able to respond to these people because of the demands of a busy workplace. Perhaps the difficulties increase, particularly in acute care environments, where language and differing expectations slow communication and nurses must prioritise their time? Yet it may also be that nursing's embodied 'busyness' is a contributing factor. In exploring cultural practices in nursing, Street (1992) notes that nurses have learned to keep active, to move around and look busy. While such activity is indeed essential to being a 'good' nurse, striving within nursing means trying to balance 'being there' and 'doing for' or 'doing with' the clients for whom the nurse is responsible. In this example, Alice has prioritised the 'doing' aspects of nursing. She does not stop and thus undermines her relationship with this family.

Benner's (1984) work on levels of clinical competency suggests that nurses, at the advanced beginner stage, experience difficulty setting priorities and that it is not until the level of proficient practitioner that the nurse can interpret and respond to the nuances in situations. The capacity to strive in terms of cross-cultural interaction seems to depend, in part, on the nurse's developing level of expertise. Lara, when reflecting on her own progress in nursing speaks of needing, in her first year post registration, to concentrate on "*monitoring the life-threatening, physical things. It's only been in the last few months that I have been able to think more broadly. It's getting easier to address those other things*" (Lara, 1:134). Lara explained that assessing and meeting patient's cultural needs had not featured significantly in her practice as a new graduate.

Prioritising physical safety is indeed important in all cultures. But in a world of finite resources, heavy emphasis on medical technology and cure rather than care, it is difficult to assert the value of 'being with' and 'being present' in the process of healing. Nurses seem therefore to begin by focusing on tasks. Their appreciation of the person and differing cultural needs, although inherent philosophically, is often regarded to be a lesser priority.

Most nurses strive in the interests of their patients, both individually and collectively. Many of these stories tell of the struggle against the social injustices perpetuated by

the health system. But sometimes the demands seem too many and there are hints of Englehardt's notion of being "caught".

*You get some people who don't like being in the same room as Island patients.... There is still that racist element.... Well you can't expect to change attitudes overnight, so the initial problem is finding a room that's more appropriate.... But a lot of it is time and resources. In an ideal world, you might sit down with them and work through why they feel that way ... and show them that 'OK, it's different, but we are all people', but meanwhile someone else wants a pan (Gail, 1:53).*

Gail feels unsupported in terms of having the time to make the effort. There are always other demands. Perhaps some of the pressure relates to living at a time in which racist attitudes are receiving greater attention? Gail seems to anticipate a more ideal world, perhaps seeing the possibility of other ways of being, under more supportive circumstances.

### **Struggling with the interpreter service**

Despite the considerable emphasis placed on building relationships and on being able to communicate, a degree of ambivalence exists in relation to the interpreter service. This service is located at a South Auckland hospital and serves the entire Auckland region. Language support from the service, although valued, involves effort and is perceived to vary qualitatively in terms of outcome. Theresa explains:

*It's something like \$50 or \$60 per hour, so if you're going to use it you have to get the doctors involved too ... and maybe the physio. You really have to make the most of them to make sure you get your hour's worth (Theresa, 1:25)*

Anne, speaking of her experiences in the community, comments similarly:

*It can take quite a long time to organise.... On paper it looks quite easy but you have to organise the time and the person to come. It's quite an undertaking (Anne, 1:10).*

Then, referring to a situation in which the service was used for a Taiwanese woman in labour, the following account highlights further difficulties.

*The woman's husband had some English but it seemed that his view of what childbirth was all about didn't sit with what we could see was happening. I would say something to him and have the feeling that what he then told her wasn't quite what I had said. It was so frustrating and the feeling of mistrust was difficult. My perception was that the woman had a horrible labour. He kept shouting at her not to push but without any explanation as to why. By the time we got someone in to interpret ... a man without any medical or nursing background ... from Telecom; the*

*only person they could find. And then I had two men goggle eyed over this woman labouring away. But he did speak good English and she agreed to have an epidural because she still had a long way to go. But it was so frustrating. It took two hours to achieve and it's days like that that I think the organisation pays lip service to cultural safety (Pam, 1:29).*

Although the nurses want to communicate effectively, there are numerous impediments. A large part of the nurses' striving in relation to their use of interpreters relates to 'feeling okay spending the money'. The sums being paid seem huge when compared with their own rates of pay. Moreover, the feelings of responsibility regarding the need for cost containment in the health service raise further questions about perceived value for money and the play between 'the ideal' and 'the real' becomes evident once again. However, although there are times when the results of their efforts seem disappointing, there are also occasions when the outcomes are more satisfactory. During our second conversation, Beverley recounts:

*I actually went back thinking 'Blow it. What am I worrying about cost for? It's ridiculous, absolutely ridiculous'. So, I just found out how to do it, filled in the forms and off I went. It was easy.... I mean once you know how. So, since then, I have used them twice for things I've felt to be important (Beverley, 2:11).*

Perhaps discussing these issues had helped Beverley to overcome a previous lack of knowledge about how to access the interpreter service? Perhaps the opportunity to reflect on her decision-making role in this area provided a new-found confidence and greater resolve?

The nurses' experience is one of struggling to access a service, coordinating with the patient and other health team members and trying to meet the needs of people from other cultures, always mindful of the constraints of time and cost. The nurses strive to get what they need from the service and to ensure that the outcomes benefit the patient but experiencing success is haphazard.

### **Struggling with others in the health team**

Nurses regularly interact with and are influenced by the attitudes and priorities of other health members. They struggle both to contribute their knowledge and skill and to accommodate the sometimes, contrasting views of others on behalf of the patient.

At the nurse-patient-family interface, the participants praised the support provided by community health workers. These health team members provide the nurses with valuable information about how to handle situations. They also assist in helping

patients to understand the goals and intentions of nursing. However, from the nurses' perspective, the experiences are paradoxical.

*We have problems with community health workers, particularly if they're known to the client through a network of extended family or if they're from the same tribe, because there is not understanding about things confidential. To them, they are part of the tribe and it's everyone's business ... but in some situations, of an extremely delicate nature, clients have refused a Maori person to come in (Jane, 1:28).*

The introduction of Maori health workers (who are not nurses) into the area of public health has not, in Jane's experience, been wholly successful. As a Public Health nurse she is bound by a Code of Ethics which emphasises the patient's rights to privacy and confidentiality. Absence of this safeguard, in relation to the health workers, not only presents a problem for Jane it is a problem potentially for the patients. Anne is similarly aware that "one of the best things is referring them to their own people if possible", but she knows too that "there are right and wrong people" (Anne, 1:48), that in most cultures there are social levels that create their own barriers. Getting the 'right' person is not always possible and there may also be difficulty determining who is 'right'.

In asking: "Isn't it more important to be open as a person than to go in with your only mantle being 'I'm from this ethnic group'?" Jane is challenging the notion that ethnicity is the only criterion for appropriateness. Bringing 'sameness' (in this case ethnicity) to a situation does not necessarily bring improvement and she wonders about the assumptions underlying such practices. It is not that she does not support this innovation but rather that she believes ethical and practical issues must also be considered.

Jo, referring to "the well-known trend" (1:90), or tendency for some medical staff to more heavily medicate "the big Islander", has learned she must keep an eye on certain psychiatrists. Thus despite feeling "there's only so much you can do as a nurse", she strives through remaining alert to discriminatory attitudes and actively enlists the support of others in the team, in this case, the cultural liaison service: Kai Atawhai.

*Some of the South African doctors are quite petrified of Kai Atawhai. When Kai Atawhai come in, they do as they say. So if you're talking to them [doctors] because you don't think somebody should be on such a whack and they're not listening to you, then I actually sneak out of the way and get Kai Atawhai.... Yes, quite a few of us do that ... and it gets worked out (Jo, 1:198).*

Englehardt (1985) describes the nursing role as one of working between “two rather powerful individuals” (p.75), the doctor and the patient. Thus he suggests that nurses are “caught” between those in authority, ie. doctors who prescribe treatment, and patients who give authority for health care interventions. Yet being caught has connotations of incapacity for action and the nurses in these stories seem far from inactive or incapable. Their striving is more characteristic of Bishop & Scudder’s (1991, p.18) “in-between stance in nursing”. They are continually involved in making moral decisions about “what is medically correct, what is institutionally permissible and what is desired by the patient” (ibid. p.19). They cooperate, challenge and coordinate all health care team contributions to patient care, and more than this, anticipating a better future, they seek to extend what is currently possible.

However, struggling to assert one’s viewpoint on behalf of the patient is not confined to convincing medical staff as the following conversation, on the subject of menus catering for Polynesian dietary preferences, testifies.

*Just look at how many Polynesians make up the population of a hospital. There’s a lot. It must be a third, I would say. And look at the menu. No catering at all. We approached this subject because we couldn’t see why there wasn’t Polynesian and Maori food. There are some similarities and some of it is cheap to make .... But they [the dietary staff] just said ‘It’s not an option financially’. They got on the back foot. We were just saying ‘Have you thought of it?’ Even something simple and basic. Even just one thing ... and they [seriously ill patients] lose so much weight and then we’re trying to keep their weight up (Alice, Angie and Meg, 1:231-236).*

In this instance, the nurses’ efforts had not been successful. Are the issues only financial? Also critical of the lack of dietary choice for people with mental illness, Jo notices that “*the patients ... don’t get a choice unless they’re vegetarian*” (Jo, 1:154). It seems that some people are less deserving of choice and quality than others. This is consistent with the conclusion by Heyman and Shaw (1984) that many of the problems inherent in inter-professional practice do not derive from defects in the nurse, but from conflicts and contradictions in the wider structure in which nursing occurs.

### **Striving: bringing the meanings together**

In an overall sense, 'striving' therefore consists, paradoxically, of 'being yourself, but not being a shape'. Striving means knowing one has values and intentions but trying to be flexible in terms of their implementation. In 'striving to get it right' nurses try to integrate personal values with those of the professional and bureaucratic systems of which they are a part (Kramer, 1974). But more than this, when nursing a person from another culture, most nurses strive additionally to accommodate health beliefs and expectations that are different from their own. Striving successfully requires knowing and valuing the patients' worlds and their different ways of being. Nurses do not, and know they will not ever, know all of these differences and thus cannot meet them exactly. Yet for the most part they persevere and, in doing so, develop ways of being towards people who are different.

The specific ways in which nurses strive comprise the multiple different practices used intra-personally, interpersonally and in relation to the wider community. There are the 'hows' of making contact, the 'ways' of showing respect, of trying to ensure that feelings of compassion are fostered and communicated and of how personal awareness is developed and maintained.

Meister Eckhart, a German philosopher and theologian, talks of "detachment" or proper attitude as being a necessary part of "fiery striving" (Smith, 1987, p.100). Eckhart suggests that sometimes striving 'looks like' sitting still. Benner's (1984, p.57) description of "presencing", as a possible way of being with a patient, similarly illuminates nursing ways of being rather than doing. Referred to also as the art of nursing, throughout the nursing literature, what is unnoticed and taken for granted in nursing is often the result of considerable knowledge and skill.

However nurses can, to some extent, choose their work settings. Familiar environments provide security. There is less challenge to personally held values and less is required in terms of practice adaptation when those with whom you work come from backgrounds similar to your own. Thus opportunity for contact is one factor, but nurses can also choose their ways of responding to people who are different. They can elect to remain distant or less engaged in interpersonal situations. Decisions are also made about whether, and to what extent, they are prepared, for example, to bend institutional rules or persist in advocating for the person from another culture. The participants in this study willingly nursed patients from cultures other than their own. Yet their experiences are paradoxical. Does striving begin with nurses' willingness to

work with such people? If hermeneutics is the foundational practice of Being itself (Hultgren, 1994), then there is something beyond the willing.

### **Conclusion**

The following poem, composed while I was out jogging, embodies the 'lived-throughness' (van Manen, 1997) of striving.

### **Striving**

I strive within me I strive towards you  
It's the 'how' that I am in the 'what' that I do

I question my thinking I try to reach out  
Imagining helps but there's always some doubt

Respect is important and the fact that I care  
Helps me to listen, to be more aware

Of the way that I am and the way that you are  
Of the way the world is, the ways that can bar

I try to be there, to inform and explain  
To watch, ask and check, to help with your pain

The little things count I know that is true  
It's about how I am and what I can do



## Chapter Nine: Working with Prejudice, Paradox and Possibility

The truth reveals itself most fully not in dogma but in the paradox, irony and contradictions that distinguish compelling narratives  
(Lopez, 1989)

The previous chapter focused on striving; its underlying meanings, the ways of being and doing when nursing a person from a culture other than one's own and the barriers or hindrances to getting this 'right'. But is it always possible to get it right? Are there situations that feel both right and wrong? What is it like to get it 'wrong'? How best can the experience of nursing a person from another culture be summarised?

A sense of continual uncertainty and tension lies beneath the surface of the nurses' experiences. Yet, in encountering difference, experiencing tension, and striving, the nurses are not really uncertain. Throughout their accounts this apparent uncertainty co-exists with purposeful nursing action. The nurses have a clear sense of what it is they wish to achieve and are active towards this end. Their feelings of uncertainty relate to knowing what might be required but struggling with the specific form their action should take. Moreover, such nursing seems to involve experiencing and working through tensions that are intra-personal, professional and societal in origin.

Representation of the nurses' experiences has, until this point, been achieved through the description of sub-themes. In examining the parts that constitute the experience of nursing a person, or people, from a culture other than one's own, I have sought to articulate the nature of this phenomenon. Yet, in describing the parts separately, a sense of the whole experience has been compromised. Common to and pervasive throughout the sub-themes are the notions prejudice, paradox and possibility. Thus the meta-theme "Working with prejudice, paradox and possibility" draws together the three themes described previously and enables exploration of the interplay of these constituent elements. The chapter also seeks to illuminate the coalescent and contradictory meanings within the experience as a whole. There has been a temporal logic inherent in the construction thus far. From the nurses' perspective, the story begins when people from other cultures are noticed to differ from the nurse. Encountering difference means experiencing oneself as a nurse in relation to patients who differ culturally, primarily in terms of ethnicity but also in relation to characteristics like age, gender and class. However, such differences co-exist with some

commonality. People from other cultures are known, for example, to be similar to all patients in that they need nursing. The existential approach taken by Paterson and Zderad (1988) recognises the relationship between “uniqueness” and “otherness” (p.4) as being a universally human capacity. While each person is unique, he or she is like others. Thus uniqueness is a common characteristic.

Nurses, by the nature of their occupation, come into close contact with individual differences. However, their lesser familiarity with the person from another culture engenders anxiety and uncertainty because less is known about the health beliefs and expectations of these people. Trying to nurse in the face of difference and its related uncertainties therefore requires greater effort than nursing a person from one’s own culture.

A moral and professional imperative to assist those in need prompts nurses to strive to provide care that meets multiple requirements. Nurses not only strive to reconcile personal and professional expectations, they also strive to meet those of their patients and their employers, and the outcomes of their efforts are variable. Initially, the outcomes of such striving appeared to me to be aligned along a continuum from ‘right’ to ‘wrong’. Yet with deeper exploration, a more comprehensive understanding was reached. Having previously quoted Ritchie’s definition of culture (see Chapter One, p.9) as congruent with the meanings revealed in this study, I now suggest that it, too, is synonymous with the participants’ experiences as whole.

[T]he real stuff of culture [*ie. striving*] in any of its meanings is messy, confusing, paradoxical, ironical, unclear, allowing some alternatives and interpretations on some occasions but not on others ... [*striving*] is warm, fuzzy, slippery and covered in adhesive and hooks ... we are continually negotiating [*the possibilities*] (Ritchie, 1992, p.99, *insertions mine*).

Increasingly aware of the practice dilemmas experienced by the participants, my early impressions of the phenomenon of nursing people from cultures other than one’s own was that of never really achieving one’s ideal, yet continuing in the hope of such a possibility. Outcomes, rewarding from the nurses’ perspective, seemed only to happen sometimes, in some situations, for some nurses, with some patients, and I wondered how the nurses continued to strive in the face of such adversity.

But why the negativity? Like the participants, I too had experienced rewarding cross-cultural encounters. Yet they were not uppermost in my mind. Were such experiences

really so few and far between? The following comment from a colleague extended my understanding at this point. Perhaps nurses tend to reflect more on situations that cause dis-ease? Perhaps dilemmas and ambiguities stay in our memories while straightforward happenings disappear more quickly?

A statement by Dilthey (1961, p.109) also furthered my understanding. His reference to “the connectedness of life itself which can never be wholly accessible to the understanding” helped me to comprehend the infinite nature of human understanding in relation to the infinity of truth (by which I mean ‘that which is knowable’). If tension is inherent in all aspects of daily living, perhaps it is possible through exploring the nature of such tension to more adequately understand the uncertainties experienced. Rowan and Reason’s (1981) discussion of the limitations of orthodox thinking was also helpful. Their description of dialectical thinking as the interdependence of opposites, the interpenetration of opposites and the unity of opposites, provided additional insight into the way that contradictions are interrelated and never fully resolvable. Following Gadamer’s suggestion that understanding requires submission to the dialectic of question and answer, that for every answer there are further questions, I came to recognise that in saying “Yes this is right”, I must also continue to ask “Is this right? And, when, how, and for whom is it right?”

The notion of paradox is therefore central in this chapter. Its position between prejudice and possibility is pivotal. Yet each of the elements is inextricably related to the others. Paradox refers to the co-existence of apparent opposites and, more specifically, it describes situations which, initially seeming to be incongruent, on closer examination are proved to have foundation. Paradox, in this thesis, describes the dynamic interplay of numerous tensions. Nurses, for example, feel bound to nurse all patients regardless of differences in ethnicity, class and gender etc. (See reference to nursing Codes of Ethics in Chapter One). Yet they must also accept and actively uphold differences between individuals and groups of individuals (Lipson & Meleis, 1985; Ramsden, 1995; Meleis, 1996). If equitable outcomes are to be achieved, egalitarian ideals need to be understood in relation to the numerous factors that reduce this possibility. In the context of cross-cultural nursing, the ethical command to respond to *all* persons equally is a powerful facilitator of nursing action. Yet, also necessary is understanding of the ways in which people’s specific nursing needs vary and a concomitant capacity to provide care differently in accordance with these. Paradox acknowledges the existence and interpenetration of opposites, not as dichotomies, but as variances, checks and juxtapositions that recognise the contribution and relevance of more than one

understanding. Thus prejudices, that are both enabling and limiting, 'feed in' to paradox and provide the potential or possibility for new or different understandings and outcomes.

In the hermeneutic context, prejudice refers to the unconscious judgements and prior understandings that influence interpretation. True prejudices facilitate further understanding while false prejudices hinder such development. Prejudices originate from past experiences and influence future possibility. They enable us to make sense of the situations in which we find ourselves, yet they also constrain understanding and limit the capacity to come to new or different ways of being. It is this contradiction that makes prejudice paradoxical.

Winnicott (1974, p.xiii) asks for "paradox to be accepted, tolerated and respected, for it is not to be resolved", but such acceptance does not imply passivity. It is through exploring such contradictions that understanding deepens. Efforts to reduce or suppress conflict risk failing to realise the necessity of conflict to growth (Miller, 1985). Lampert (1997) suggests further that in cross-cultural hermeneutics there is a need to read conflict as a form of communication. Accepting the notion of paradox is therefore a means of keeping such tensions alive and keeping possibilities open.

In this thesis, possibility acknowledges the infinite nature of understanding. The potential for new and different understandings derives from the human capacity to interpret and communicate. Gadamer (1996) refers to a 'true prejudice' as that which prompts questioning and thus keeps open the possibility of new understanding. Yet such questioning is paradoxical, for in posing a question both openness and limitation co-exist because the openness to a question is limited by its horizon. Thus, even questioning which is inclusive of what can be seen and not seen remains partial and is infinitely ongoing. Possibility therefore describes potentialities that are diverse and truth, which is infinite. It predicates a condition of openness that always operates within a limited horizon. In relation to nursing a person from another culture, possibility can therefore mean getting it right, getting it wrong and simultaneously getting it both right and wrong, as this chapter's stories will reveal.

Exploring prejudice enhances the possibility of recognising the positive and negative contributions to interpretation. Exploring paradox enables the possibility of seeing how opposites coexist, interpenetrate and fuse. Exploring possibility provides an opportunity to experience the future in a different way.

The nurses, in each of the following stories, live and work with prejudice, paradox and possibility. Although the specific form and relative emphasis of these three notions vary, each is always present and together they describe a wholeness that extends and enriches the sub-thematic descriptions.

### **Alice - wanting to be better prepared / not helping**

*I particularly remember looking after a Lebanese gentleman and his family. He had come in with an acute illness and a potentially fatal prognosis and neither he nor his wife spoke a lot of English, although they understood a limited amount. Their sons spoke and understood English well.*

*I noticed that any staff involved in looking after this man seemed to get pulled into a very intense caring relationship with the family - more intense than I've seen with other cultures and I didn't think it was just them as individuals. It seemed to me that people from that part of Europe or the Middle East were more passionate. Their facial expressions. They wanted so much. They were what I call 'emotional people', wearing their hearts on their sleeves, and I wondered if looking after Italian people might be similar.*

*What really struck me was that there were no resources. I didn't know who or where to turn to for information on how to care for these people in a cultural sense. They seemed easily offended. If you didn't accept food when they offered it to you, no matter how fast you were speeding down the ward, or how many drips or things you had in your hands, they got very offended. It was almost as if they wanted you to really like them because if you didn't, they thought they wouldn't get good care. And maybe where they come from, that is what happens.*

*Then, for a time, I couldn't look after this man. He had developed some nasty infections that placed my other patients at risk. But trying to explain this to the family - that it wasn't that I didn't want to look after him. They were very hurt and wouldn't talk to me. I'm sure there was a major cultural component. It was more than a family in grief. I knew they didn't understand and I tried to support them. But time, in work hours didn't allow searching for things and it wasn't the interpreter service that I needed. I felt I needed to be better prepared.*

In this story the interplay of the previously described sub-themes is highly visible. Encountering difference has meaning for Alice in terms of the greater demands perceived to be being made on the nursing staff, by this family. Alice experiences tension in the form of feelings of confusion, frustration and guilt. Aware that she does not understand the meaning of the family's expressions, she wants to be better

prepared and tries to find resources to assist. Like the family, she too strives to be understood and liked, yet she is unable to help and feels harshly judged because the family cannot understand her position.

The prejudices constraining cross-cultural understanding in this scenario outweigh those that enable. Alice seems to assume that because the sons are fluent in English, the family should be able to understand and accept the priorities and practices of the health care system with which they are engaging. Although there is evidence that Alice questions her interpretation of the family's more passionate expressions, she attributes cultural difference greater significance than the possibly universal emotional pain of a potentially fatal prognosis. Thus, in interpreting their behaviour in terms of difference, she paradoxically sees, but does not see, the family's pain. Furthermore, in seeking resources to improve her knowledge of cultural difference, Alice seems to have overlooked the potential for her relationship with the family to provide this information. Her busyness with "*drips and things*" and fears of 'infection risk' appear to have unwittingly precluded the development of trust with this family. Styles (1991) suggests that nurses, more than any other group of professionals, experience the paradoxes, dilemmas and challenges at the jagged interface between science and service. Perhaps, in prioritising medical science and technology, Alice is underplaying the importance of human care processes in nursing (Watson, 1988).

Yet the issues are not as simple as they might seem. Overlapping hermeneutic circles of understanding and misunderstanding coexist. There is, on the part of the nurse and the family, a 'reaching out' at the same time there is a 'calling or pulling back'. The family want support and need care. The nurse similarly wants support and needs to give care. There is lack of understanding by both parties. Confusion exists on the part of the family in relation to the nurse's behaviours. But the nurse is also struggling to understand the responses of the family.

Forrest (1989) notes that when situations become difficult, nurses often distance themselves from the patient by providing limited or routine physical care. In 'being busy' one can avoid the deeper and more challenging levels of involvement. However, it is only when we strive to understand others' perspectives that we can begin to discover concerns that are critically important to us as well (C. Taylor, 1994). The attempt made in the following story to understand the patient's perspective, illuminates matters of considerable importance to the nurse, yet the outcome again is less than ideal.

### **Sue - wanting to learn but being rejected**

*I was a staff nurse in a Maori psychiatric unit that had been newly set up and there was a lot I wanted to learn. As a newcomer to New Zealand, I was particularly interested in learning about Maori protocol and it was quite a steep learning curve for me. I knew that to function in New Zealand I had to come to grips with the Maori culture. I had to be culturally safe.*

*It was hard. The Maori people seemed to guard their culture quite jealously. When a client of Maori and Pakeha ancestry was 'put down' because he couldn't give an account of his genealogy I felt angry and confused. I asked about the reasons for this treatment but was told "You wouldn't understand" and that "maybe if you lived in New Zealand for another twenty years you might pick it up".*

*My background was multiethnic<sup>55</sup> and I had thought myself to be quite culturally sensitive, but this was a different ball game. I thought a bicultural unit would be different - that instead of concentrating so hard on Maori culture they should have taken into account that there were non-Maori in the setting ... the non-Maori staff and patients felt very alienated. ... and the way things were going, it felt like apartheid in reverse (Sue, 1:41).*

For both personal and professional reasons Sue is pro-active in wanting to extend her understanding of a new environment. As a nurse she knows that social and cultural factors contribute significantly to mental health. She has also experienced personal rejection on ethnic grounds in her homeland and is strongly committed to respecting people's cultural identity. But her hopes that such differences will be accommodated in an environment promoting biculturalism are not fulfilled and she is angry and disappointed.

From Sue's perspective, both she and the patient have been "*wronged for daring to try and learn, for trying to break into this exclusive club*" (Sue, 1:28). Then, when having expressing these concerns to the charge nurse, it is suggested that she ask for a transfer, Sue experiences further disappointment. "*There was no room for learning ... no 'We'll show you'. I got no support*" (Sue, 1:28).

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<sup>55</sup> Each of Sue's parents had different ethnic backgrounds. She had also married a person whose ethnicity differed from her own and had lived in several different ethnic communities.

In this scenario, the hindrances to Sue's 'getting it right' appear to exist within the staff running the unit of which she is a new member. This, specifically Maori, service is part of an effort by institutions to support and actively promote cultural difference within the health service. But the experience for Sue is confusing and distressing.

*The bicultural aspect was just lip service. I left the unit feeling very disgruntled. If I had stayed on, I would have become a saboteur (Sue, 1:30).*

Recognising that she does not fully understand Maori traditions and practices, Sue knows she risks 'getting it wrong' if she responds according to her own values and beliefs. Thus she seeks the assistance of colleagues in order to 'get it right'. These are enabling prejudices. In striving to become more knowledgeable about Maori culture, however, Sue opens herself to the possibility of new understandings. But her efforts are rebuffed and her willingness to try dissipates. She moves on in search of more rewarding work.

This story engendered a distinctly 'cool' (Peshkin, 1988) response on my part. Like Sue, I felt disappointed that her colleagues had failed to respond positively to her efforts towards understanding. I had expected her questions to be answered and, having previously been a charge nurse, I found it difficult to accept the lack of support provided in this situation. Struggling to come to terms with the disparities between ideal and real, it was through reflexively engaging both with hermeneutic literature and that pertaining to cultural pluralism that my understanding was extended.

The prejudices effective in this experience derive from several sources. When confronted with another person's suffering, Sue re-lives earlier experiences of similar anguish. These are issues that matter personally and professionally. But the apparently non-supportive response by her colleagues leaves her feeling exposed and unprotected and, paradoxically, the sensitivity that draws her towards the person who is "other" becomes self-defeating. Sue takes action to protect herself from further harm and, in doing so, forgoes the opportunity to contribute to future changes in the unit's practices.

Lashley (1994) suggests that the development of a professional identity is an ongoing, tension-filled and contradictory process. "Self-discovery and the possibilities one faces in redefining who one is and what one stands for create many tensions. One cannot remove the boundaries or change perspectives without becoming vulnerable" (ibid.



p.43). Sue experiences tension and contradictions that challenge her identity both personally and professionally. The fact that she moves on suggests that the level of vulnerability became intolerable. But more than this, the strength of the negative prejudices in this story precludes the development of further understanding. Sue's use of the term 'apartheid in reverse' indicates the highly charged feelings of resistance and hostility.

Perhaps cultural pluralism is an ideal that is espoused and written about by some but not yet lived (Shabatay, 1991). The unit in which Sue is working has been established to facilitate tino rangitiratanga or Maori control over Maori issues (in this case the management of mental health). Yet the response by the Maori staff towards Sue suggests that the strength of their group identity is a significant barrier to cross-cultural understanding. In the current New Zealand context many Maori claim to be bicultural because of their capacity to live in both Maori and Pakeha worlds. However, this scenario suggests otherwise. Antagonism on the grounds of ethnicity prevents respectful interaction. It would seem that Sue's cultural identity is perceived to be a limitation and that she cannot learn. Her skills as a psychiatric nurse are apparently discounted.

Coming to understand difference may indeed take time, perhaps not "twenty years" as Sue's colleagues suggest, although there is an element of truth in this. Coming to know the perspectives of Maori happens slowly. Information is made available as one is trusted and deemed worthy rather than through the 'ask and be told' philosophy common in Western cultures. It is possible, therefore, that Sue's requests are considered to be premature and therefore inappropriate.

Also alluded to by Sue's use of the phrase 'apartheid in reverse' are the tensions associated with cultural pluralism. Boxill (1992, p.174) explains:

*On the one hand, we must overcome segregation because it denies the idea of human brotherhood; on the other hand, to overcome segregation, we must self-segregate and therefore also deny the idea of human brotherhood.*

The terms, 'segregation' and 'apartheid', are similar in that each implies separatism but the latter term carries very negative connotations. Boxill's second reference to self-segregation implies that those segregating have chosen their path, whereas the term apartheid, because of its association with racial discrimination in South Africa, clearly implies a forced segregation or privileging one group and disadvantaging another. I

interpret the term 'brotherhood' in Boxill's statement to mean community with others. But I do not believe, as he appears to, that segregation and community are necessarily mutually exclusive. In Sue's situation, consciousness of the apartheid system has conjured fears of similar possibilities in New Zealand. What is not recognised, however, is the possibility that asserting cultural specificity and advocating separate development can be steps along the route to equal partnership with others.

Young (1990), with reference to Minow (1985), argues that it is more valuable to understand group differences in relational terms than it is to define them according to substantive categories and attributes. Although not substantiated by Sue's story, for reasons beyond her control, the nurses in this study generally anticipate that people from different cultural groups will always be similar in some respects and thus there is potential for sharing some experiences and goals. But crucial to such an outcome are relations that facilitate communication. Lampert (1997) suggests that mutual understanding becomes possible through the dialectical relationship between identity and difference. A hermeneutics of conflict is therefore important because it alerts us to the presence of different interpretations. In the next story a sharing of conflicting horizons is evident. Distance is recognised through contact and the interpretation exemplifies the co-existence of both conflict and agreement.

### **Lara - knowing, not knowing and coming to know**

As a nurse in a Women's Health Clinic, Lara is uncertain about whether or not a Chinese woman will be included on the afternoon operating list. The woman is seeing her counsellor again. Perhaps the decision to terminate the pregnancy is a difficult one? Then, when her place on the operating list is confirmed, Lara learns that the problem is not one of ambivalence on the woman's part. The husband, who strongly opposes the termination, had been berating his wife since their arrival four hours earlier. In her late forties, this woman has had two terminations and a child in China. Two more children have been born in New Zealand but of the three, only one is a boy. Through an interpreter, the woman has explained that her husband wants this pregnancy to continue because, irrespective of her age and feelings, having a larger family is acceptable in New Zealand and it might be another boy.

The story, from Lara's perspective, is as follows:

*The woman looked exhausted and worn when she came through to meet me pre-operatively. She was thin, and her skin was wrinkled and dry, accentuating her tiredness. As I spent time with the very helpful interpreter, discussing the expectations for self-care post operatively, the woman sat patiently but very sadly. Her frequent eye contact was unusual and now and then she spoke directly to me as if expressing from the heart what was happening to her. Through the interpreter, I learned that she thought the decision to terminate would probably destroy her marriage.*

*But there was another problem. Unfortunately I had to tell the woman that she had a Chlamydia infection. Giving such information is always difficult and it's worse when the person is in a stable relationship. There are huge implications for those who are certain of their own fidelity. The woman took it all in and then sadly turned to me saying she didn't expect her husband would listen or take the prescribed antibiotics.*

*This patient was in crisis. Feelings of injustice flooded through me. I found myself judging the husband for being selfish, non-supportive and abusive. Regardless of their cultural beliefs this woman was being punished unfairly. And all this in a different world.*

*Then, again through the interpreter, I learned of her feelings of guilt at having taken up so much of our time and of her shame that something so private had come to involve so many people (the charge nurse had previously been with the interpreter). I felt deeply for her. At this hugely distressing time, one that would have implications for the rest of her life, she was explaining that she had not received this sort of attention during the terminations in China. Although she seemed greatly to appreciate our support, she was embarrassed that the care had been so concentrated and lengthy.*

*The woman left immediately she recovered post operatively. I understood her need to go quickly. I respected that she had had enough and I admired her courage. Of the many people I have nursed, this woman and this experience have remained unique.*

The prejudices that enable Lara's actions are again both personal and professional in origin. The intensity of Lara's emotional response to the woman's situation reveals the importance of personally held values pertaining to justice and equality. Matters such as the child's gender, the age at which pregnancy may no longer be safe for women, and whether husbands have the right to be unfaithful yet authoritarian in relation to their wives, create tension in Lara. There is evidence of heightened awareness and concern on her part and she is alert to information that will help her to decide how best to respond in this situation.

Lara's nursing background provides skills in observation. She listens and watches, relying heavily on the contribution of non-verbal cues to assist her developing understanding. Lara notices characteristics in the woman that prompt her continued

engagement. Eye contact and the direct appeal by the woman to her, rather than to the interpreter, communicate an intensity and passion that are interpreted by Lara to mean crisis for the woman. Recognition of the woman's social and emotional needs means that attention is given to aspects of care beyond the physical nursing requirements associated with a termination of pregnancy.

In this scenario, the combination of personal and professional skill and concern is enabling. Yet these are prejudices that can just as easily obtrude and limit the capacity to respond appropriately. Inherent in the development of professional expertise is the possibility that the more technically expert the nurse becomes, the harder it is to 'switch off' this embodied expertness in order to be authentically present (Lashley et al., 1994) with the patient. The constant struggle to combine the being and doing aspects of nursing is evident in the sub-themes 'experiencing tension' and 'striving'. From a personal perspective, difference has meaning for Lara in terms of conflicting values, especially in relation to women's rights. She struggles to accept that these are her values; that they may not be shared and, in striving to remain open and present for the woman, she learns that there are times when people may be helped most by a carefully made decision not to intervene further.

The experience is tension-filled and paradoxical. The interplay between knowing and not knowing is constant. Lara knows she will have a role in the woman's care and has beliefs, based on her professional education and experience, about what is 'best' in relation to this. But she is uncertain about the woman's specific needs and thus does not know what the woman expects and requires of her. Lara knows, therefore, that she needs to know more and, in the process of coming to know, she develops new understandings.

Also present is the tension inherent in the call to meet patients' social and emotional needs for wellbeing. It could be argued in this situation that responsibility for the social and emotional needs of this woman lies with the counsellor rather than the nurse, and indeed having to retell her story clearly added to the woman's distress. Yet it is Lara's personal and professional prejudices that enable her continued engagement with this woman. Perhaps not recognised is the impossibility of ever fulfilling such expectations, but without contact with this woman's difference Lara would not have learned the inappropriateness of the support she offered. Paradoxically then, it is the coexistence of knowing, not knowing and being unknowing that makes possible a new and different knowing.

Munhall (1993, p.125) suggests that “the art of unknowing” is an essential pattern of “knowing” in nursing. Unknowing is described as a condition of openness that minimises the risk of premature closure to other possibilities. The nurse needs to be unknowing in order to hear the other person’s perspective. An “air of mystery” and an “attitude” that is “open to alternative interpretations” is adopted (ibid. p.127) and, in coming to ‘know’ the patient’s world, the nurse’s knowing is temporarily suspended. Yet the idea that one’s assumptions and beliefs can be held in abeyance is limited by the impossibility of standing outside one’s own horizon or frame of reference. Do we therefore become prisoners of ethnocentrism (Taylor, 1995)? Can understandings change and develop as argued by the proponents of Gadamerian philosophy?

Taylor (ibid.) suggests that the possibility of coming to know another’s perspective lies in being able to articulate and question our implicit understandings. It is through identifying and contrasting these “home understandings” (p.150) with those of another person that reveals them to be one possibility among others. The hope that ethnocentrism can be overcome therefore derives from the potential for these contrasts to challenge and go beyond previous understandings.

Speaking of the possibility that in challenging others’ understandings we may also challenge our own, Taylor contends further that understanding is inseparable from criticism which in turn is inseparable from self-criticism. Thus it is possible that Lara, in re-examining her own values, comes to see with renewed understanding, the tension between women’s rights to justice collectively and one woman’s rights as an individual to choose her course of action. When Lara hears of the woman’s shame and embarrassment at the lengthy and concentrated care being offered, it is also possible that nursing notions of holism are re-evaluated for their appropriateness. Lara seems to recognise that in showing concern for the woman’s social and emotional needs she, like the husband, is contributing to the woman’s suffering, albeit in a different way.

Lara’s compassion, her capacity to listen and hear, and to see personal and professional values in a new light, together with the respect and admiration developed for the woman in this story, are crucial in enabling Lara to let go, yet remain hopeful, in this situation. Moreover, it is through engaging with and reflecting upon co-existing differences and tensions that the paradoxes become evident. Lara’s level of understanding grows beyond that which it was. A sufficiently common understanding

develops that allows both horizons to be and, although not fully satisfying for Lara in terms of 'getting it right', this experience is epiphanic<sup>56</sup> for the learning it provides.

This story amply illustrates the potential for foreign cultures to be an important source of learning and, furthermore, that pre-understandings do not necessarily "lock us into ethnocentric prisons" (Taylor, 1995, p.149). Inherent in encountering others as different is the possibility of exposure to new understandings. If we respond to our feelings of uncertainty and dissonance by re-examining our implicit beliefs, changes in understanding become possible. If we work consciously to identify and articulate the contrast between these prejudices and those of the other person, "distortive understandings" can be re-evaluated. Broader and new possible understandings therefore arise through comparisons and contrasts which "let the other be" (ibid.). Moreover, as will be seen in the next story, the memorable nature of the event suggests that self-understanding is also enhanced through contact with others who are different.

### **Jane - a precious moment**

The following experience, which triggers the vivid recollection by Jane of "a precious moment", took place four years prior to its telling. For Jane, the moment was special because, although she and Sulu came from different worlds, they were united by a common goal in which ethnic boundaries lost their significance. We were "*just human beings together*" (Jane, written anecdote).

#### **Background to the story**

Sulu, Samu's mother, was born and educated in a Samoan village. She is married and has little money but is strongly supported by her religion and the Samoan community. For her, New Zealand, the hospital and the intensive care unit are new and difficult. Jane is older than Sulu. She is Pakeha, single and has a career that enables her to feel confident within an intensive care environment.

*I knew Samu from one month old until he died at 18 months, caring for him on almost every shift. I was there at every milestone. I watched him gain head control, learn to sit, say his first word and I was as proud as*

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<sup>56</sup> The term epiphany is used by Denzin (1989, p.15) to describe "interactional moments that leave marks on people's lives."

*his parents of the achievements he made. My love for him was like love for my brother.*

*As the trust between his mother, Sulu, and I deepened, she was able to confide in me some of the stressful times in her marriage. We grew, learning from one another. I grew as a person and she developed confidence in the technical aspects of Samu's care, becoming able to accept and understand machines bleeping, tubes and central lines in different places, ileostomy bags etc.*

*I was at home the night he died suddenly. A nurse rang to tell me the news and that Sulu wanted me to come in. I went completely numb. Then I felt hot all over. I couldn't hear my partner's question, only stammering "I need to get to the hospital." We drove in silence.*

*I went to the whanau room where Samu's family and church members were gathering. Other nurses who were on duty were there. I remember slipping off my shoes. There were lots of shoes and the people, lining the four walls, were looking at me.*

*I saw Sulu holding Samu. He had his best Sunday wear on - a little tuxedo and tiny black patent shoes. Sulu beckoned and I haltingly took steps to get there. Everything around me dulled. As I knelt before her, all I could see was the two of them together. Then Sulu leaned forward asking if I wanted to hold Samu and, stunned by this gesture, I cried. I couldn't see a thing but felt his warmth as she placed him in my arms. All the machines and tubes were gone. Samu was free at last. I didn't speak and can't remember how long I held him.*

*Life is so precious and he had enriched my life. His mother was giving me the opportunity to grieve and say goodbye. I have never forgotten that closeness and acceptance of death. It was a precious moment.*

Stories like this offer a glimpse of the meaning of a shared humanity that encompasses difference. Levinas (1987) speaks of something passing from one to another as human beings are seen as being in need. Beverley Taylor (1994) suggests that nurses and patients relate to one another as different people with unique backgrounds yet they are often able to find commonality in their human-ness. In describing this commonality as "ordinariness in nursing" (p.33), a paradox emerges in that cumulatively the ordinary can also be seen to be extraordinary. Travelbee (1971) argues that the emotions of "love, tenderness and compassion are readily comprehended by individuals from all cultures and backgrounds" (p.19) and Paterson and Zderad (1988) describe the human capacity of "becoming more" (p.15). Drawing on Buber's (1958) notion of *I and Thou*, "man [sic] becomes more through his relations with others" (Paterson & Zderad, 1988, p.44).

Within this story, these authors' ideas each have meaning in terms of possibility, yet the experience may be regarded as atypical for several reasons. Jane's use of the term 'caring for' rather than nursing, the analogy 'like love for my brother' and the request that she come from home immediately after Samu's death suggests that this is not an everyday nursing encounter. Numerous factors have combined to contribute to the epiphanic nature of the experience. Samu's illness, the availability of a whanau room and time, in terms of the prolonged period of contact between the family and staff, supported the development of trust and reciprocal learning. Jane's knowledge of child development, her technical expertise and willingness to teach are enabling prejudices that derive from her nursing background. The notion 'brotherly love' implies a genuinely rewarding relationship and, as discussed in Chapter Two, 'caring' has been reclaimed as centrally significant in nursing. These philosophies are enhanced and coalesce with Jane's personal capacity for compassion and concern. But, in addition to this, Jane feels enriched. Her understanding of the meaning of life and death deepens at Sulu's feet.

In Peshkin's (1988) language, this was a 'warm' story. It was one that I responded positively to and one that I would have liked to have heard more often because of its positive outcomes. Exploring its meanings was therefore more enjoyable, and yet it too engendered feelings of regret. In my experience, the opportunity for sustained engagement with patients was rare in acute care settings.

Jane's and Sulu's backgrounds were very different and, had it not been for Samu's illness, their paths would have been unlikely to have crossed. Jane values the experience for its learning. She also believes, and is pleased, that the learning has been reciprocal. Yet pleasure and sadness are intertwined. Perhaps she and Sulu had lived through similar tensions? Each had experienced shock, hope, friendship and loss, although they had done so from different vantage points.

Slunt (1994), with reference to Paterson and Zderad (*ibid.*), contends that "beautiful moments give meaning to nursing" (p.57). Gadamer (1986) speaks, too, of 'the relevance of the beautiful' and the potential for unexpected encounters with beauty to illuminate truth.

Plato describes the beautiful as that which shines forth most clearly and draws us to itself, as the very visibility of the ideal. In the beautiful presented in nature and art, we experience this convincing illumination



of truth and harmony, which compels the admission: "This is true" (ibid. p.15).

... the work of art transforms our fleeting experience into a stable and lasting form of an independent and internally coherent creation. It does so in such a way that we go beyond ourselves by penetrating deeper into the work (ibid. p.53)

Jane's 'precious moment' simply and powerfully expresses something profoundly universal. It offers an assurance that truth and beauty can be encountered in the pain and disorder of reality. It also reminds that, as human beings, we are continually faced with the challenge of learning from each other. The words in this story seem both to express us and speak to us. There is a unity that values difference; that stimulates and nourishes thought and human community. Gadamer (ibid.) suggests that encounters with art do not leave us feeling the same about life as we had done previously. "The ontological function of the beautiful is to bridge the chasm between the ideal and the real" (Gadamer, 1986, p.15). In this story, there is a 'genuineness' and shared understanding that makes the world seem brighter and less burdensome and, later in our conversation, Jane talks about nursing transcending cultural difference.

*For me, nursing transcends all different cultures because we go in caring and I think that's the one thing all people look for (Jane, 1:63).*

Is this the 'possibility' towards which nurses strive? Are these the beautiful moments that encourage and inspire both learning and the continued commitment towards others in nursing?

### **Bringing the stories together**

These stories have highlighted some of the intra-personal conflicts experienced as nurses try to integrate personal and professional aspects of their being when nursing people from other cultures. They also exemplify attempts to reconcile interpersonal aspects of nursing within a highly political, socio-cultural context and illuminate some of the prejudices influencing nursing practice. Prejudice, paradox and possibility coexist and interpenetrate the sub-themes: encountering difference, experiencing tension and striving.

In each of the stories, there is a conscious awareness of difference. There is also hope and continued effort towards the development of mutually rewarding relationships with patients from other cultures. Difference is encountered as difference from the nurse in terms of cultural values and expectations. Difference creates anxiety and tensions that

remain a barrier, to a greater or lesser extent, depending on the success or otherwise of the establishment of interpersonal trust. The prejudices that facilitate 'getting it right' when nursing a person from another culture include attitudes of respect, concern, openness and commitment. But equally important are self-esteem and clinical competence. Confidence in one's identity is enabling. The nurse who possesses a strong sense of self-worth and integrity experiences less tension and is more able to continue striving. A lack of knowledge about culture-specific health beliefs and practices can be a limiting prejudice. Yet, in most cases, the tension associated with this deficiency prompts or enables action that reduces the limitation. Using highly developed skills of observation and interpersonal communication, effort is expended towards coming to know each person's particular needs for nursing.

Sue and Lara are aware that they draw upon personal experiences and values. Sue expects her mixed ethnicity to assist her contribution and Lara, as a person with strong views about women's rights, expects to be able to advocate on the woman's behalf. All three nurses are concerned for the vulnerability of their patients and each works hard to reduce this. Questions are asked of themselves and of others. Efforts are made to communicate both with the patients and with other people significant in the situation. But in each encounter the constraints and opportunities differ. Time, the opportunity for contact and the participants' capacity for communication vary in each situation. Uncertainty and dilemma are ever-present, yet the tensions continue to create possibility. Perhaps striving renders negative tension more manageable?

The outcomes and rewards of striving are variable. People and their prejudices can be unpredictable, as can their situational contexts. Although the nurse generally feels confident in terms of her technical skills she is less confident about her ability to adequately meet the relatively unknown needs of people whose values and beliefs differ from those of the mainstream. She also feels uncertain about whether and how she will be accepted by the patient. She knows that her embodied ways of being may not be appropriate and that her environment may not easily facilitate practice that accords with other cultural values.

However, despite the sometimes overwhelming feelings of uncertainty experienced in cross-cultural situations, nurses continue to strive both to achieve personal satisfaction and the satisfaction of their patients as individuals. When Jane describes the need to be "*so flexible you're not even a shape*" (1:71), she is referring to the need to be open and ready to listen and respond. Gadamer (1996) suggests that the person who listens

is fundamentally open. Such readiness opens the possibility for entering the 'play', a questioning and inquiring which is directed towards escaping the thrall of our prejudices. Possibility, in this thesis, recognises that there will undoubtedly be tensions, misunderstandings and distortions. But this does not mean that pursuing different understandings is impossible. Nor does the infinite nature of this process mean that such engagement is without value because movement between opposites is an inevitable part of the human condition (Rowan & Reason, 1981).

Getting it right involves accepting the invitation to reflect, to reconsider one's responses to another and, through reflecting on experiences with others, to obtain new insights about self which in turn enable seeing others with fresh understanding (Taylor, 1995). When nursing a person from another culture, possibility therefore means being alive to the way understanding shapes disrupts and facilitates practice. It means being willing to wonder, being open to positive and negative judgements and moving with ever-changing horizons (Gadamer, 1996). It also means being open to the possibility of seeing good in another person's ways, even when these conflict with our own. The recognition of "two goods" becomes possible where previously "we could only see one and its negation" (Taylor, 1995, p.163). The possibility of coming to understand others and of continuing one's self-development arises through engaging with people who are culturally other.

### **Concluding comments**

The following statements by Jane: *"I don't think I'll ever be comfortable saying, 'Yes I know how this culture works'"* (1:34), and Pam: *"I'm convinced you've never got it sussed"* (1:45) encapsulate the paradoxical nature of nursing someone from another culture. Being oneself in a way that enables others also to be themselves, under circumstances that are intrinsically never fully knowable, is never likely to be free of tension. The nurse therefore seems, perhaps more so than others, to be faced with learning to live within the play of uncertainty and paradox.

Mulling over the tensions and paradoxes inherent in such nursing, I wrote the following, once again, while jogging. The ongoing effort, the purpose and the need to negotiate obstacles seemed congruent with the nurses' experiences.

## Towards Right

*I know 'it' and yet I don't. I'm learning all the time  
'It' is nursing that you need. But your view, Is it the same as mine?  
I know some of what I think you need but does that fit with you?  
Is there more you wish to tell or have I made a blue<sup>57</sup>?*

*I want to help. I have these skills. I need your guidance please  
I don't want to get it wrong. I want to meet your needs  
Will 'they' help? Do 'they' care? Is there time to ask?  
Is there information on how best to do this task?*

*If we work together I think that we just might  
Come to know our differences and be on the way to 'right'.*

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<sup>57</sup> This term is used colloquially to mean 'mistake'

## Chapter Ten: The state of the 'play'

I do not wish to conclude and sum up, rounding off the argument so as to dump it in a nutshell on the reader. A lot more could be said about any of the topics I have touched upon.... I have meant to ask questions, to break the frame.... The point is not a set of answers, but making possible a different practice.  
(Kaepler, 1986, p.212)

The aim of this thesis has been to describe, clearly and intelligibly, the phenomenon of nursing a person, or people, from cultures other than one's own. I have sought to contribute understanding of the cross-cultural experiences (notable for their absence in the literature) of nurses in practice. Stories of what it is like to nurse a person from another culture have been interpreted within their cultural and historical context for the purpose of illuminating the understandings implicit in nursing practice.

Parallels between the method of hermeneutics and the phenomenon itself are evident throughout the work. The nurses' interpretations of their experiences as lived are characterised by the same reflexive structures inherent both in the interpretation of data and in human processes of understanding generally. There is a continual to and fro movement between familiar understanding and new understanding. These dialogues, within and between people and between person and text, seek new understandings yet they require an already existing understanding from which to begin. Moreover, the relationship between interpreter and event and interpreter and text is infinitely ongoing because of the ever-present interplay between the potential for understanding and the limitations of our humanness. Our understanding is always "only 'under way'; it never comes entirely to an end" (Gadamer, 1976, p.211). Thus in terms of research, "there will always be a dynamic tension between what we can do - methodological critique - and the 'ontological' limit imposed by our human finitude" (Cameron, 1996, p.166).

This final chapter begins by returning to the notion of play (Gadamer, 1996) interpreting its meanings in relation to the understandings that have emerged from this study. The relevance of Lampert's (1997) discussion of cross-cultural hermeneutics is then explored with reference to the notions of contact, conflict and critique. The study findings are also examined in relation to salient nursing literature and recommendations for education practice and further research within nursing are made.

### **'Play' as a clue to the phenomenon**

How can 'play' bring meaning to the findings of this study? In using the analogy of 'play' to illustrate the structure of human understanding, Gadamer (1976) draws attention to play as an event of movement that has its own dynamic. Play connotes being in flux. The naturalness of the movement, the immanently dialectical relationships and the process of playing out possibilities are emphasised. Play absorbs its players and is thus, to some extent, a de-centering process. When encountering difference, for example, contact with other "breaks into my ego-centredness and gives me something to understand" (Gadamer, 1986, p.46). Play also renews itself constantly extending and playing further those who participate. Moreover, its to and fro movement essentially precludes players from playing alone because, even in the absence of another player, there has to be something with which the player plays or to which the player responds (Gadamer, 1996).

In focusing on nursing experience, this study placed nurses at the centre of the play. Exploration of the phenomenon of nursing a person, or people, from cultures other than one's own revealed the coexistence and interplay of prejudices, paradoxes and possibilities at intra-personal and interpersonal levels as well as in relation to professional and other social discourses.

### **Being in the play**

The study has shown that nurses, irrespective of their level of awareness, are always already within the play of the prejudices and contradictions inherent in their social world. Nurses are not independent. They exist historically and culturally in relation to other people. They are continually in the play of the past with the present and towards a future as they seek to make sense of their situation. Decisions about action are made amidst the voices of others with different priorities. There are rules and conditions, yet there are also glimpses of freedom. 'Being in the play' means having a certain directedness. However tasks proceed according to plans in which there are elements of variability and choice (Gadamer, 1986). The chapter on striving, for example, revealed the numerous ways in which nurses try things out, selecting, rejecting, succeeding and failing. The need to be flexible became apparent as did appreciation of the play between 'the how' and 'the what' of practice. The nurses' ways of being, although inextricably related to their doing, are critical in terms of outcome. Attitudes of

openness and a willingness to be in the play of differences increases the likelihood of 'getting it right'.

Play also has meaning as a communicative activity. There is "a spirit of buoyancy" (Gadamer, 1976, p.66), a sense of being carried by dialogue with another. When genuinely in dialogue with a person from another culture, nurses try to understand how what the other person is saying could be right (Gadamer, 1996). Thus being in the play makes possible the movement towards ways of knowing beyond the existing understanding.

Lara's story of the Chinese woman who came for a termination of pregnancy (see Chapter Nine, p.170) illustrates the nurse's struggle to remain open to the possibility of different needs. The personal and professional prejudices at play in this story both enabled and constrained Lara's actions. Amidst a play of feminist discourses and nursing philosophies of individualism and holism, Lara engaged with and successfully outplayed prejudices present in the encounter that may have restricted the negotiation of a successful outcome. Thus being in the play has meaning in terms of 'being played by' (or effected) and 'playing out' (affecting) embodied values and beliefs. It was being involved in the play between her own and the woman's prejudices that facilitated a movement towards greater understanding.

### **Playing and being played**

Gadamer (1996, p.104) acknowledges "the primacy of play over the consciousness of the player" and suggests therefore that "all playing is a being-played" (ibid. p.106). There is evidence that the nurses in this study are called to respond yet, at the same time, they need to avoid interactions that put them at risk. They have, as discussed in Chapter Eight, an ethical responsibility to the other that prompts their engagement prior to thought and action (Levinas, 1984). However, the to and fro movement is both a form of restraint and freedom at the same time. When encountering the difference of the person perceived to be Rastafarian (Chapter Six, p.97), Sue was played simultaneously by emotions of fear and feelings of professional responsibility and accountability. In a difficult and anxiety-provoking situation, she also played with cultural difference, watching, imagining, questioning and checking. Sue risked 'playing' and remained engaged. Then, as she was able to move through what could have become blocks, her feelings of hesitation, reluctance and fear were gradually replaced by feelings of strength, greater insight and self-understanding. New and unforeseen ways of being became possible. Thus there is evidence of play between the conception

of self as an autonomous agent and a more relational view of the person as a being who responds because things matter in a more original sense (Taylor, 1985a). Sue reasoned and responded in an instrumental way at the same time that she maintained sensitivity to certain matters of significance. Personal feelings of vulnerability were reconciled in the interests of the patient, which, from Sue's perspective was the aim of the play.

### **The spirit of play**

Gadamer (1996, p.106) refers to every game as having "its own proper spirit". In a dialectical examination of the art of nursing, Johnson (1994) contends that "the artful nurse" must not only be competent, but be able to demonstrate competence, "no matter how arduous the circumstances" (p.11). The view that nursing's "proper spirit" has a moral dimension has been reiterated in various ways throughout this study. It is also a view propounded by the literature (Gadow, 1985; Van Hooft, 1987; Bishop & Scudder, 1990; Watson, 1990). Yet, within this notion, there is further evidence of a tension or play between the duty to care as a professional obligation, and an ethic of care, freely and authentically given, and focused on the person receiving the service (Condon, 1992; Blair, 1995). In a similar vein, Bishop (1996, p.196), suggests that nursing's "moral commitment focuses on the charge to care ... naturally, if we can and if we cannot, then ... because we want to be good nurses". Thus caring, as a way of being towards patients, is juxtaposed with caring motivated by strong moral principles, and acting in a fully moral way coexists with 'playing a role'.

### **Playing a role**

Playing a role involves the ideas of "mimicry", "show" and "appearance" (Gadamer, 1986, p.128). Seeing the nurse as an imitative representation, or idealised image, facilitates the consideration of role expectations and how a player's conduct may be tied to the goals and rules of the game. In the scenario in which Amanda was invited by a Maori couple to use the titles 'Uncle' and 'Aunty' (Chapter Seven, p.118), the strength of socialising influences is revealed. Amanda's fear of appearing disrespectful of patients' identity combines with her fear that colleagues will also disapprove and thus she is unable to break from the forms of address traditionally expected in Western nursing. However, although the formal titles appear respectful, the "appearance" is not common to both parties and thus is not a 'true' showing of the anticipated relationship. In fact, in this situation, the playing of roles precludes seeing and understanding the play of cultural differences.



### **Seeing the play**

Gadamer (1986) speaks also of seeing the play as “a mirror that, through the centuries constantly arises anew, and in which we catch sight of ourselves in a way that is often unexpected or unfamiliar: what we are, what we might be and what we might be about” (p.130).

In this thesis, my ‘seeing the play’ began with the nurses’ efforts to articulate their experiences in cross-cultural situations. The seeing continued as I sought to background these experiences through explication of the participants’ cultural and historical horizons and then through attention to the way in which my understandings affected interpretation of the phenomenon. How we act is not just a matter of how we are but also who we are (C. Taylor, 1994) and what we hope to be. Nursing is underpinned by humanitarian philosophies, yet there is evidence of ethnocentrism. New Zealand, too, has been founded on the visions and myths of egalitarianism. The play between powerful steering mechanisms within our society, the market and bureaucracy and commitment to ideals of fairness, freedom and rights (Taylor, *ibid.*) permeates all aspects of human experience. The fusion of these horizons within nursing has culminated, in this study, in a presentation that reveals the phenomenon of nursing a person, or people, from a culture other than one’s own as complex and contradictory. Nurses are constantly in the throes of encountering difference, experiencing tensions and striving. It is being in the midst and seeing the play of differences that helps in finding the way forward. Enabling and constraining prejudices coexist in dynamic relation. Thus the possibility of new understanding always exists.

It is part of the reality of play that it leaves an infinite space around its real theme ... It would be a false reality if the action could all be calculated out as an equation. Rather, it becomes a play of reality when it does not tell ... everything ... The more that remains open, the more freely does the process of understanding succeed (Gadamer, 1996, p.498).

### **Staying in the play**

In terms of recommendations then, the task is to remain open, risking involvement so that the meanings in play can unfold and be seen. Neither the sameness nor the difference between those from different cultures is pre-established. Rather, understanding of difference develops dialectically through contact, conflict and critique (Lampert, 1997). Establishing contact requires accepting “some things that are against me, even though no one else forces me to do so [because] without such openness to one another there is no genuine human bond” (Gadamer, 1996, p.361). ‘Staying in the

play' also requires a capacity for questioning and recognising when multiple interpretations are genuinely in dialogue. According to Lampert (1997), the plurality of discourses within each culture creates spaces for different forms of engagement. The cross-cultural interpreter must therefore be a respectful listener and one who is willing to play with possible interpretations rather than merely passing judgement upon them (Lampert, *ibid.*). Moreover, often the most open and authentic dialogue occurs in moments of crisis just when the contact between interpretations risks falling apart. Relevant examples, in this study, include the incidents that initially sparked my exploration of the phenomenon, Maori nurses' experiences in monocultural learning environments and the political controversy which prompted the revision of Kawa Whakaruruhau in nursing education. In each of these situations, sustained contact and critique of the conflict has engendered a deeper understanding. Success in the context of cross-cultural nursing therefore requires the embodiment of attitudes and behaviours that keep open the play and support the continued playing out of differing possibilities. If there are "common elements which unite us in being responsible for our future" (Gadamer, 1992, p.192), there needs to be a willingness to create spaces for the critical examination of difference. For, as argued by Lampert (1997), "It is only when the deepest conflicts are set in motion that multicultural interpretations come into contact and a common world of possibilities is opened up" (p.364).

## **The phenomenon and the substantive literature**

Having offered the notions of prejudice, paradox and possibility as descriptive of the phenomenon of nursing a person from another culture in an overall sense, I need now to examine these findings in relation to salient nursing literature. In Chapters Two, Three and Five, I discussed the awareness of prejudice in its negative sense with reference to several articles in the literature on transcultural nursing and cultural safety. I have, through appropriation of Gadamer's interpretation of the term, demonstrated the value of extending this understanding to include the notion that true or enabling prejudices are those that assist to enlarge our understandings. Where there is a willingness to be open to possible alternative meanings, prejudice, as the precondition of interpretive understanding, therefore facilitates the development of further understanding. Yet the search for one 'true' understanding remains illusive as multiple views oppose, coexist and interpenetrate with one another.

In her early writing Leininger (1994, chapter reprinted from 1968) referred to the notion of paradox in relation to culture. Drawing on the work of Herskovits (1955) she noted that although the concept of culture is universally experienced by mankind, [sic] no two cultures are alike. A culture's stability also coexists with its capacity for change and furthermore, although culture determines the course of our lives, it rarely intrudes on our conscious thoughts.

The capacity for change is congruent with the use of 'possibility' in this study. The way in which culture pervades our lives has parallels with the notion of prejudice and the apparently contradictory coexistence of similarity and difference is one of many examples of paradox. The findings of this study also support Leininger's suggestion that, even when cultural knowledge is forthcoming, nurses may over-identify with the patient. When nurses decide to follow patients' cultural preferences without openly discussing the possibility of adverse repercussions (pressures sores for example, in Theresa's situation, Chapter Seven, p.120), they risk compromising the patients' health outcomes. They also risk being sanctioned negatively by others in nursing and medicine, their experiences therefore congruent (as discussed in the same chapter) with Englehart's notion of being 'caught in between'. Furthermore, as acknowledged by Leininger, they can also experience difficulty reconciling (in a democracy) the emphasis on one culture when it is expected that equal care and attention is given to all patients. The stories told by Alice about the Lebanese family who 'seemed to expect

so much' (Chapter Nine, p.165) and Theresa's account of the frustrations experienced when 'troops and troops of visitors' need to be accommodated in the acute hospital setting (Chapter, Seven, p.122) exemplify this dilemma.

Leininger (1994, chapter reprinted from 1974) speaks further of the 20th century paradox that an increasing knowledge of many things coexists with a paucity of studies seeking to illuminate the qualities that make man [sic] human and sustain humanistic striving. Her theory of "Culture Care: diversity and universality" (1991) emphasises the coexistence of commonality and difference among, within and between cultural groups. Her plea that nurses should neither over-employ diversity nor assume similarity (Leininger, 1995) alludes to the inherent tensions between and within groups. But Leininger does not focus on transcultural experiences as lived by the nurse. Moreover, the theoretical concepts are described objectively rather than inter-subjectively, with an "I-It" rather than an "I-Thou" (Buber, 1958) emphasis. In making such an observation, I do not mean to down-play the significant contribution of Leininger's work. Both I-It and I-Thou relationships are essential in nursing. The I-It kind of relating enables nurses to acquire, interpret and categorise knowledge about others, whereas the I-Thou contributes understanding of being and belonging with others. "Thou is not an object but is in relation with us" (Gadamer, 1996, p.358).

The humanistic nursing theories developed by Paterson & Zderad (1988) and Parse (1981; 1992) are focused, more than Leininger's work, at the personal and interpersonal levels of practice. Both Paterson and Zderad and Parse specifically discuss the notion of paradox and, in Peplau's (1952) model, the terms tension and striving are used. Underpinning Peplau's focus on interpersonal relations is the assertion that because all people "live in an unstable equilibrium ... and life is the process of striving in the direction of stable equilibrium" (p.82), patients have needs which produce tension. While such a claim has definite possibilities in biophysical terms, its relevance in cross-cultural situations is not considered. Tension in a biophysical context implies a need to restore balance and the Peplau model appears to focus on restoring the patient's health rather than resolving either the nurses' intra-personal tensions or those experienced interpersonally between the nurse and the patient. The suggestion, however, that the nurse-patient relationship provides the means to resolve such tension is congruent with the efforts of the nurses in this study to establish trust and achieve compromise when encountering differing expectations in relation to health care.

Exploring nurse-client patterns of relating, again in general rather than cross-cultural nursing contexts, a focus of the works by Paterson and Zderad (1988) and Parse (1981) is the actualisation of nursing potential. These writers approach nursing as an existential experience emphasising opportunities for intra-personal development. The purpose of nursing is to promote higher level consciousness in both the patient and the nurse. Yet, although there is occasional mention of personal and professional self-fulfilment in my study, the goal of actualisation seems neither a priority for the nurses nor an expected outcome on behalf of their patients. The participants' overwhelming concern is 'getting nursing done' in a way that is acceptable both to themselves and to their patients. Perhaps the issue is one of reconciling pragmatism with idealism? Nurses in New Zealand have appeared reluctant to embrace theories that they perceive to insufficiently reflect their practice reality. Yet, this does not mean they are not motivated by philosophies shared with their international colleagues. The impact of the philosophies of humanism, holism and caring have, for example, repeatedly surfaced in the participants' stories.

There is much in the work of Paterson & Zderad (1988) that resonates with my interpretation. The appropriateness of their "call and response" (p.29) notion has previously been discussed. The simultaneously reciprocal nature of nurse-patient interaction exemplifies the inherent tension or 'play' (Gadamer, 1996) between the nurse and the person who is other. The nurse may or may not be available for the patient. The patient hopes to be cared for according to his or her expectations and values. The nurse responds for the purpose of providing care and, in doing so, partly shapes the patient's response. The tension and reciprocity is ongoing. Thus Paterson and Zderad's focus on the "between" as being "an essential inter-human dimension ... beyond and yet within the technical, procedural or interactional elements of the event" (p.13), is congruent with the findings of this study. There is also compatibility with the existential paradoxes: "uniqueness-otherness", "authenticity-experiencing", "moreness-choice", "value-non value", and "all-at-once" (ibid.). The terms struggling, striving, feeling morally responsible and seeking genuineness describe the experiences of the participants in my study. The fleeting moments of 'no tension', joy and fulfilment also describe, at least from the nurses' perspective, occasions of sharing that can transcend cultural difference. In fact, the following statement seems to be appropriate in both a general and cross-cultural sense: "A nurse is a being, becoming through inter-subjectively calling and responding in her suffering, joyous, struggling, chaotic humanness, always trying beyond the possible while never completely free from ignoble personal human wants" (Paterson & Zderad, 1988, p.56).

Yet, the phenomenon I am describing also has meaning beyond that of a call and response between individuals. When nursing a person from another culture, prejudices, paradoxes and possibilities not only exist between the nurse and the patient. They are evident within the nurse, between the nurse and nursing and between the nurse and the wider community.

The chapter focusing on encountering difference reveals not only what counts as difference but also the significance of these differences in nursing. The contemporary discourse, which equates cultural difference with ethnicity, predominates. Yet it coexists and interplays with discourses in nursing that centre on the uniqueness of patients as individuals. What matters from a nursing perspective is that difference can mean difficulty. Although some difficulty is experienced in relation to insufficient knowledge, the impossibility of maintaining up-to-date information about large numbers of ethnic groups is recognised. Most significantly, difficulties are perceived to relate to patients from other cultures, because of their greater vulnerability in a health system based upon values that may not be shared. Of particular concern to the nurses are communication difficulties which compromise the quality of care received by the patient. Thus difference as difficulty has meaning in terms of the greater time and effort needed to advocate for the patient in this regard.

Nurses therefore experience tension intra-personally as the uncertainties associated with cultural difference interplay with their professional goals and expectations. These tensions are revealed in the contradictory emotions that derive from the tensions and dilemmas existing in the wider community. New Zealanders may, for example, believe in equality, yet they have difficulty with the notion that respecting others' differences requires treating people differently. They may also support Maori rights in relation to the Treaty of Waitangi yet sharing land and resources is problematic and, although there have been some changes towards biculturalism in health care delivery, New Zealand's health system remains dominated by Pakeha values.

These tensions, paradoxically, both constrain and enable nursing action. The tension of reaching out and responding in a culturally appropriate way to the person from another culture coexists with the need to protect one's own identity and beliefs. Thus tension as uneasiness or the anticipation of difficulty interpenetrates with the tension inherent in the call to care. Moreover, because tension prompts effort towards its reduction, it is an important contributor to nurses' striving.

The dialectical 'tug and pull' continues in the chapter on striving. What is it that each nurse strives towards? Something unique to the person, something contextually dependent, something partially known but not fully knowable. Then, within the practice of nursing there are tensions between aspects of being and aspects of doing, and, in relation to the wider arena of health care, a dialectical relationship exists between the efforts made by nurses and those made by others involved in the delivery of health services.

Priority is also given by Parse (1992) to dialectical relationships. The argument that 'meanings come into being' through "languaging, imaging and valuing" and the notion that the paradoxes, "enabling/limiting, connecting/separating and revealing/concealing" are lived "all-at-once" (ibid. p.38) is consistent both with Paterson and Zderad's work and with the findings of this study. Parse's "powering" seems akin to the notion of "striving" in my work and the "pushing-resisting rhythm" resembles the way in which contact and conflict make new understanding possible. "Tension is the struggling between pushing and resisting while contending with others, issues, ideas, desires, and hopes all at once in the process of striving to reach new possibles" (Parse, 1987, p.58). However, there is less emphasis on connections with the past, and the differences across traditions likewise receive little attention. In the cross-cultural arena, understanding and acceptance of diversity relates more to the coming together of differences as individuals come into contact with one another. It is possible, however, that the difference between my interpretations and those of Parse relate to their focus and means of generation. I have focused on showing an insider's perspective of what it is like to nurse in a specific cross-cultural context. Parse's work tells generally what nursing is or can be.

Much of the literature pertaining to 'culture' in nursing has generated information about the differing health beliefs and practices of specific ethnic groups. Murphy and Macleod Clark (1993) published the only study that I could locate that focused upon nurses' experiences in the cross-cultural context. Although the underlying meanings and consequences for the English nurses participating were not fully articulated in the article, the similarities between the findings of both studies are striking. Especially synonymous are the experiences deriving from communication difficulties and concerns about standards of care. Also common is the recognition that the working environment does not always support nursing philosophy and that frustration and stress are experienced because of the inability to provide holistic care. Not only are

service inadequacies perceived to exist in relation to dietary and interpreter services for example, they are also recognised to derive from insufficient knowledge of other groups' health beliefs and practices. The recommendations made by Murphy and Macleod Clark (*ibid.*) provide further evidence of similarity between the English and New Zealand experiences. Their suggestion that cultural awareness could be enhanced through mini-ethnographic studies aimed to increase knowledge levels is synonymous with Alice and Angie's expressed need for resources to provide a basis for understanding. The establishment of support networks and sessions to help raise nurses' awareness of their attitudes and the effect of these on their patients also has parallels with this study's recommendations. However, the findings of the present study are different in terms of their emphasis on the tensions and contradictions experienced by nurses personally, professionally and in relation to their particular society. It is my contention that understanding and critiquing the cultural and historical horizons at play in cross-cultural nursing encounters is an essential prerequisite, not only for service improvement, but also for the rewards which fuel ongoing nursing effort.

Moving now to the New Zealand context, the present work exists alongside the literature pertaining to *Kawa Whakaruruhau* or cultural safety in nursing education. Like Ramsden, the author of *Kawa Whakaruruhau*, I write from an embodied cultural and historical position. Although we are both nurses, I write knowing that I belong to New Zealand's dominant ethnic group. Ramsden's experiences derive both from membership within a colonised indigenous group and the insights gained through studying anthropology. Ramsden's contribution to curriculum changes within nursing arose from consciousness of the difficulties facing Maori nursing students in a monocultural education system whereas my work was prompted by consciousness of the difficulties associated with implementing cultural safety in nursing practice. Thus I write, as it were, in Ramsden's shadow.

My contribution is a research project based in nursing practice. Its purpose has been to illuminate some of the understandings embedded in New Zealand nursing. Use of a hermeneutic framework does not enable me to generalise the experiences to all nurses. Yet it is likely that there are commonalities. Ramsden's is a political exposition that has radically changed nursing education. Overtly political in orientation and purpose, it has effected change and ongoing revision within nursing. It has also been a catalyst for several research projects (eg. Seaton, 1994) and numerous publications (Wood & Schwass, 1993; Cooney, 1994; Sturch, 1994; Coup, 1996; Leininger, 1996; Leininger, 1997; Polaschek, 1998). Although my work differs vastly from that of



Ramsden, each recognises the interplay between person and society and recommends strategies that promote critical reflection. Each seeks to enhance nursing's contribution to a more equitable health system through critique of the historical and cultural influences on health service provision.

### **Implications for education and practice**

I believe that nurses have much to offer patients from other cultures. Yet, they are only partially aware of the complex and contradictory nature of this undertaking. Their reflective thinking is action-oriented and primarily focused at the micro-level. Effort is directed towards making sense of the situation at hand rather than recognising the historical and cultural influences on practice (Teekman, 1997). I believe there is a need to foster environments that facilitate the surfacing of prejudices, the recognition and acceptance of paradox and the exploration of possibilities for change in health care. Strategies and structures need implementing, pre and post nursing registration, in both education and practice settings. In terms of ongoing research, studies are also needed which generate information in ways that acknowledge not only the dynamic and interactive nature of cultural understandings, but also their complexity and inherent contradictions.

Nursing has theoretically, and to some extent in practice, embraced a movement towards transformative education (Habermas, 1971; Smyth, 1986; Dieckmann, 1988; Perry & Moss, 1989; Cox, Hickson, & Taylor, 1992; Spence, 1994). Congruent with the recommendations from this study are teaching practices which support openness and dialogue. Schon's (1983) notions of reflection-in-practice and reflection-on-practice have underpinned strategies such as journaling and exemplar writing which encourage nurses to explore the meanings they attach to their experiences. Yet such practices achieve little in the way of change when the emphasis is on reflection rather than critique and when the focus is limited to the self and does not include the social structures which prescribe the frames of reference (Tennant, 1994).

The risk that reflection, for the purpose of understanding, does not extend to the point that change occurs in practice suggests that a more rigorous and sustained Socratic style of questioning, by nurses individually and collectively, may be beneficial. However there is always the possibility that such a strategy could become one-sided and thus

preclude the 'give and take' of genuine dialogue. Socrates often begins his questioning knowing where the critique will end. According to Davidson (1997) "Philebus" is the Platonic dialogue which best exemplifies active and open engagement through questioning because Socrates does not predetermine the answers. Congruent with Gadamer's conception of dialogue and play, this form of conversational exchange (Wicks, 1999 in press) could therefore assist in reducing ethnocentricity and fostering an engagement with difference (Taylor, 1991b).

Mesirow's (1994) theory of perspective transformation and the notion of "critical self-reflection of assumptions" (Mesirow, 1998, p.193) also offers guidance. Based on the premise that the way in which learners interpret and reinterpret their experiences is central to learning, Mesirow advocates a critique of assumptions in order to determine whether beliefs, often acquired through cultural assimilation as a child, remain functional in adulthood.

Critical *self*-reflection on assumptions (CSRA) emphasises critical analysis of the psychological or cultural assumptions that are the specific reasons for one's conceptual and psychological limitations, the constitutive processes or conditions of formation of one's experience and beliefs (Mesirow, 1998, p.193).

However, once again there are potential limitations. Mesirow's model tends to emphasise rationality, logical thought and planned action (E. Taylor, 1994). Emotions, rather than being understood as signalling matters of significance prior to conscious thought (Taylor, 1985a), are dealt with simply as interpreted feelings and thus the possible contribution of non-reflective learning and embodied values is denied. Such criticism would also be upheld by Linge (1976, p.xxvii) who, in support of Gadamer's work, reminds us that "critical self-reflection does not remove our historicity".

Seeking to delineate the process of becoming "interculturally competent", a study by Edward Taylor (1994) revealed affect, or emotion, to play a prominent role in the transformative learning process. Taylor's assertion that "the emotive nature of a disorientating dilemma" (E. Taylor, 1994, p.170) derives from an array of personal goals and previous experiences which effect learning readiness is congruent with the appropriation of prejudice in this work. In Taylor's study, the participants experienced periods of dissonance as they tried to integrate themselves into the host culture. This stress pushed them to learn new ways in order to restore balance to their lives. The relationship between the emotional nature of this driving force and what Taylor calls "cultural disequilibrium" (ibid. p.161) is also congruent with the experiences of tension

and striving described in my interpretation. Despite being in situations in which their cultural mores predominated, the tensions experienced when encountering difference similarly prompted the nurses in this study towards new forms of practice.

### **Recommendations**

What seems important then, in terms of recommendations, is continuation of the twofold emphasis implicit in the Kawa Whakaruruhau documents. Cultural safety in nursing and midwifery education is predicated upon understanding the power differentials inherent in health service delivery and redressing these inequalities through processes of education that are free from threat or guilt. Understanding and critically examining the impact of the differing cultural and historical horizons is an ongoing requirement. Attention is focused not only upon personal but also institutionalised values and assumptions. Moreover, in a practice-oriented profession such as nursing, the understandings gained must inform action. Just as the nurses' ways of being and doing cannot be separated, neither are education and practice separate entities in nursing. The journey towards 'getting it right' when nursing a person from another culture, may begin in and return to educational settings but it is predominantly learned and evaluated in the clinical environment.

Environments that foster egalitarian and pluralistic conversations (Diekleman, 1991) must therefore be created in education and practice settings at both undergraduate and postgraduate levels. Nursing mentors in practice and education need to develop strategies that not only encourage reflective thinking but also assist the sharing and critique of experiential knowledge. The aim is to provide environments that enable individual practitioners to develop understanding of the prejudices, paradoxes and possibilities inherent in the situations they encounter.

The Sense-Making method articulated by Teekman (1997) offers a potentially useful framework. Building on "the 'natural' tendencies of human meaning making" (p.192), this model encourages individuals to engage consciously in problem posing through self-questioning. It also advocates the sharing of "concerns, discoveries and victories [and] 'breaking up' complex situations into manageable micromoments" (p.191) while maintaining the integrity of the situation as a whole. Examining the questions and contradictions inherent in cross-cultural nursing experiences and exploring what helps

and what hinders the acquisition of deeper insight and understanding could enable nurses to move from micro to macro-levels of reflection (Teekman, *ibid.*), and thus to potentially change their practice.

Teekman's work, like the present study, acknowledges that assumptions and values are inherent in all interpretation. One's personal prejudgements or prejudices exist alongside, opposing and interpenetrating the other interpretations inherent in cross-cultural encounters. Contact with difference and a willingness to engage with, rather than shy from, potential conflict is therefore essential. I believe that recognising and valuing the positive possibilities of prejudice (Gadamer, 1996) can make it easier to examine the negative prejudices and that exploring the meanings and implications of difference can often illuminate the unintended consequences of nursing action. Questions that seek to uncover the layers and diversity of meanings need to be asked in ways that do not alienate those participating in the dialogue and an emphasis on processes rather than solutions is also more likely to engender understanding. Like Teekman, however, I am also aware of the constraints on such practices. Staffing levels, workloads and an emphasis on technical rather than interpersonal aspects of care often militate against the implementation of such strategies. So, too, do decisions regarding the funding of health service provision. Yet opportunities exist for nurses to share and critique their practice understandings. Nurses need to more fully exploit the use of critical incident debriefing practices (Fish & Twinn, 1997) at the unit level, for example. Greater participation by nurses at case presentations, 'Grand Rounds', seminars and conferences will facilitate the interdisciplinary dialogue and critique necessary to advance practice. Then, at the institutional level of responsibility, there is a need to lobby for the implementation of management practices that support collaboration, power sharing and ongoing critique.

From a philosophical hermeneutic perspective the following questions are offered as a framework to assist deeper understanding of practice situations (be they clinical, education, research or administrative).

1. What is valuable about this practice? What are its limitations? How does the language currently used define the practice and implicitly determine the outcomes?
2. What are the origins and purpose of this practice? Do the prejudices that prevailed when the practice originated still prevail? What are the reasons for preserving the practice and what are the reasons for changing it?

3. How are things done differently elsewhere? How might things be said or done differently?
4. With whom should I engage in dialogue in order to discuss the practice and what are the prejudices of those persons with whom I need to speak?

As reiterated by Gadamer (1996), the art is in seeing what is questionable and to this I add that there is art in knowing when to question and in questioning in a manner that makes new understanding possible.

In addition to critically reflecting on assumptions, be they personal, professional or institutional, there is much to be gained through the sharing of stories. Dieklemann (1991) suggests that in telling their stories nurses can learn from each other and come to know practice in new ways. Structuring opportunities that regularly enable storytelling in the clinical and teaching environments will, I believe, enhance nurses' understanding of cross-cultural experiences. Placing emphasis on the surfacing of feelings and the exploration of motivations will be particularly valuable in illuminating prejudices, both positive and negative. Sharing ways of being, rather than focusing on identifying right and wrong actions, will similarly help in the surfacing of taken-for-granted knowledge and new understanding. Furthermore, of particular importance is the encouragement of what might be referred to as 'warts and all' stories so that the voices of those who have been silent or silenced can be heard and engaged with. Confronting these 'less than ideal' stories is not easy. However, as seen in this study, doing so provides great opportunities for learning.

Assimilative learning needs also to be recognised for its capacity to transform frames of reference (E. Taylor, 1994). Rowan and Reason (1981, p.129) suggest that "we can only grasp what it means to be in relation with another if we first grasp that we are different from them". At present there is little opportunity in the undergraduate curriculum for New Zealand nurses to immerse themselves in a culture other than their own. In addition to advocating the use of 'culturally safe' role models and mentors to maximise learning, I therefore encourage the structuring of clinical experiences that facilitate self-learning through sustained and supported encounters with people from other cultures. Seeing and experiencing other ways of living and practising has the potential to substantially increase the understanding and appreciation of cultural differences and thus to develop ways of practising that more fully satisfy the needs of both nurses and patients.

### **Study limitations and the need for further research**

This study has provided insight into the experience of nursing people from cultures other than one's own. The use of a hermeneutic approach has enabled exploration of a complex, situated and, in this case, controversial area of practice. Yet, as with all research, the study has its limitations. The findings of this study relate specifically to the experiences of seventeen women from the Auckland region and thus they may differ from the experiences of other nurses in Auckland as well as those in other regions. Also significant by their absence are male nurses and nurses whose lack of fluency in English precluded them from participating in the interviews.

In Chapter Five, I discussed the rationale for not using observation as method of collecting data and thus the potential for a mismatch between rhetoric and reality is acknowledged. Further limitations derive from the fact that the nurses' interpretations have been intersected by, and fused with, my horizons as a middle-class, female and Pakeha teacher of nurses. An action research approach using more collaborative forms of analysis, for example, is likely to have engendered a different interpretation and yet, I believe that given the same purpose and question, the findings of other studies would be similar. I do not expect, however, that this interpretation is conclusive, or in any way, a final commentary. It has merely made a beginning (Smythe, 1998).

There is a need to hear the voices of nurses whose cultural backgrounds are different from the mainstream, especially those from ethnic minority groups. Although five of the participants in this study did not belong to the dominant Pakeha group, it is important that the voices of such nurses be heard in greater numbers and for data to be collected and interpreted by non-Pakeha researchers. In the interests of furthering bicultural understanding a study seeking to illuminate the experiences of Maori nurses would be particularly valuable.

Another absolutely critical component in this jigsaw puzzle of understanding is the voice of the patients being nursed. Despite the complex challenges associated with collecting such data, the potential for contributing to nursing knowledge in this way is huge. Moreover, if New Zealanders are committed to a harmonious and equitable future, and the health system is serious about 'consumer satisfaction', then the funding of such work is mandatory.

In order that nurses continue to work to improve their present contribution via Kawa Whakaruruhau, research is also needed to illuminate further the factors contributing to successful cross-cultural health outcomes. There is a need to understand what enables nurses to sustain the call to care for people from other cultures. The tension between increasingly technocratic demands and the more humanistic priority of 'coming to know' the patient (Tanner et al., 1993), for example, signals a need for studies which take more explicitly critical, post-modern and/or discourse analytic approaches.

The evaluation of current educational innovations is another very significant area needing research. Nursing, as a whole, needs to identify those strategies and programmes deemed successful in the implementation of cultural safety. The perspectives of students, teachers and recipients of care need to be canvassed in order that they become the catalysts for further innovation. New Zealand's potential to contribute to the international arena makes evaluation of the Kawa Whakaruruhau developments essential.

## **Conclusion**

In selecting a philosophical hermeneutic approach I have sought to produce a text that vividly portrays and contextualises the experience of nursing people from cultures other than one's own. I have attempted to reveal the depth and complexity inherent in this aspect of nursing and sought to show the possibilities as well as the difficulties.

As a teacher, I now spend more time helping students to identify, explore, and seek possible answers to, the paradoxes encountered in practice. Where in the past I sought to illuminate the influence of negative prejudices on nursing action, I now focus also on the philosophical assumptions that contribute positively to cross-cultural understanding. My use of questioning has developed in a way that acknowledges understanding to be at best partial and always ongoing. Moreover, as mentioned in relation to data collection, I have re-learned the importance of listening and believe there is value in seeking to maintain a level of humility.

Involvement in this study has enabled insight into the paradoxes and tensions within nursing. The experience of nursing people from other cultures is similar to that

described by Paterson and Zderad (1988), who suggest that nursing comprises “ever striving with certainty while constantly wrestling with the discomfort of uncertainty” (p.38). Thus there is much in the nature of cross-cultural nursing that is congruent with nursing in an overall sense. Such findings therefore concur with the part-whole relationships central to hermeneutic philosophy. They provide evidence of universality within the particular.

For many nurses, an ethic of responsibility towards others prompts their efforts to ‘get it right’. Being willing to listen and learn, trying to be flexible and gently, but rigorously, questioning personal and institutional assumptions helps achieve positive outcomes. Yet there are numerous forces that constrain such achievement. Insufficient time and a non-supportive environment are major limiting factors. However, nurses do not always recognise the ways in which they fail to challenge and therefore perpetuate some of these values and structures. Moreover, at times, the tensions arising from such conditions have not only facilitated useful debate they have stimulated positive change. The controversy over the introduction of cultural safety in nursing education certainly exposed previously unarticulated tensions, prompting the critique and revision of a significant educational innovation. Perhaps the earlier reference to the Treaty of Waitangi, as a Gordian knot (see p.33), can also be seen positively from this perspective. If understanding is a continual state of happening, how can it be otherwise?

Nurses have, through their opportunities for cross-cultural contact, learned and are continually learning how to be with people who are different. It is my view that the ‘basic’ or ‘small practices’ that constitute striving in relation to people from other cultures are not so small and basic when one compares nursing practice with the practices of many in the wider community. Nurses in New Zealand have experienced considerable public criticism for their efforts towards a fairer and more equitable health service. Both collectively and at individual levels of practice they have endured, and are negotiating, the conflicts essential for ongoing development. There is much that nurses must learn in order to ‘get it right’. Yet there is also much that they know and do. Striving for understanding is an ongoing project. Nurses will always encounter and experience difference in their relationships with patients. Striving, when nursing a person from a culture other than one’s own, lives in the tensions and the prejudices of nursing practice. Its fulfilment comes when possibilities are recognised and the nurse and the person from another culture come to understand each other in new ways. The challenge of this thesis is one of working through the tensions of difference by striving



to understand and move beyond the false prejudices, as well as accepting the paradoxes and exploring the possibilities.

In the words of the poet R. M. Rilke:

Be patient towards all that is unsolved in your heart and try to love the questions themselves like locked rooms or books that are written in a foreign tongue. The point is to live everything. Live the questions now. Perhaps you will then, gradually without noticing it, live your way into the answers (cited in Welwood, 1990, p.1).

## **Appendix A**

This is the information sheet and consent form used when the study began in 1994 as a Masters Thesis.

The experience of nursing clients from other cultures

### **Information sheet for potential participants**

As a graduate student of the Department of Nursing and Midwifery at Massey University, I am enrolled in a Masters thesis programme. I am a Registered General and Obstetric nurse and Midwife, who has spent fifteen years in acute care settings before becoming involved in nursing education. I am interested in cultural issues in nursing, particularly the experiences of nurses educated in New Zealand who regularly care for clients from other cultures. I would like to listen to and discuss issues that you believe affect the provision of culturally safe nursing care.

If you have nursed and are likely to be nursing such clients during the next six months, and have registered since 1985, you will be interviewed two or three times should you agree to participate. The first and second interviews will take approximately one hour and the final interview around thirty to forty-five minutes. With your consent the interviews will be audio-taped.

Between interviews one and two you will be invited to record, in a personal journal, the details of clinical experiences that you perceive to have cultural relevance. These and any other thoughts that you have had will be discussed at the second interview.

Opportunity to review the taped interviews and final presentation of data will be made available to you. The information you provide will be published in the form of a thesis available in nursing libraries. This will also be accompanied by journal article publication.

Your participation in the study will not be divulged, by me, to anyone. Your name will not be used, nor will your clients or place of work be identified. You may ask for tape recording of interview discussion to be stopped and will be free to withdraw from the study at any time.

I can be contacted at home: (address and telephone number supplied), or at work (address and telephone number supplied).

Dr Judith Christensen, the supervisor of the research can be contacted at (work address and telephone number supplied).

If you are willing to participate in this study, you will be asked to a consent form before interviewing begins.

This information sheet is yours. Share it with friends if you wish. Thank you for taking the time to read it.

Deb Spence

## Appendix A continued

The experience of nursing clients from other cultures

### Consent Form

Deborah Spence is a nurse and Masters student studying nurses' experiences of caring for clients from cultures other than their own. I have read the information sheet regarding her study and have had additional details explained to my satisfaction. I understand that I may ask further questions at any time.

I also understand that I am free to withdraw from the study at any time and may decline to answer particular questions or change information that I have given. I agree to provide information on the understanding that it is completely confidential.

I agree to participate in this study under the conditions outlined in the information sheet. I have a copy of this sheet.

Participant's signature:

Name:

Date:

Researcher's signature:



## **Appendix B**

Additional consent was gained from participants in May 1995 when the proposal was resubmitted to the Departmental Ethics Committee and the study became a doctoral thesis.

### **Additional Consent**

Relating to The experience of nursing clients from other  
cultures

I am aware that Deborah Spence's application to transfer from Masters research to a PhD study has been accepted and that the information I have provided will now be used for this purpose.

I am also happy that Deborah contact me should she require to clarify further the data collected, and that the previously agreed conditions relating to anonymity, confidentiality and opportunity to validate data will continue. I also understand I am free to withdraw from the study at any time.

Date:

Participant's signature:

## Appendix C

This is the information sheet and consent form in their revised form, following transfer to a doctoral study.

### INFORMATION pertaining to research exploring THE EXPERIENCES OF NURSING PEOPLE FROM OTHER CULTURES

Dear Staff Nurse,

I am seeking voluntary participation in a doctoral research study through Massey University. The purpose of the research is to investigate what it is like to nurse people from cultures other than your own.

As a study participant you will be involved in a group interview of three to five staff nurses with whom you feel comfortable discussing these experiences. Should you wish to be interviewed alone, this can also be accommodated.

The interview will be audio-taped and last approximately one hour. It will be transcribed by the researcher and, to maintain anonymity, a pseudonym or false name will be used. Your place of work will not be identified.

The only people who will have access to the data are the research supervisors and myself. All taped interviews will be kept secure in my home during the study. They will be erased when the study is completed.

The final research report will be published in the form of a thesis for placement in nursing libraries. Short articles may be published in nursing journals and presented at relevant conferences and seminars. Your identity will not be revealed in any of these contexts.

I appreciate the time taken to read this information. If you are interested in participating, I would be grateful if you would ring me (number supplied). I will be happy to answer any further questions at this time.

Thank you,

Deb Spence



## Appendix C continued

Nursing a person, or people from cultures other than  
one's own

### Consent Form

I have read the information sheet relating to this study and have had the opportunity to clarify any questions. I understand that I may ask further questions at any time.

I also understand that I am free to withdraw from the study and to decline to answer particular questions. I agree to provide information on the understanding that this is completely confidential.

I agree to participate in the study under the conditions outlined in the information sheet. I have a copy of this sheet.

Participant's signature:

Name:

Date:

Researcher's signature:

## Appendix D

The following definitions were shown to the participants at the end of their first interview.

### **Definition of Cultural Safety from the Nursing Council of New Zealand Standards for Registration of Comprehensive Nurses from Polytechnic courses (1992).**

The effective nursing of a person/family from another culture, by a nurse who has undertaken a process of reflection on her [sic] own cultural identity and recognises the impact of the nurses' culture on her own nursing practice.

\*Unsafe cultural practice is any action that diminishes, demeans or disempowers the cultural identity and well-being of an individual (Nursing Council of New Zealand, 1995)

### **Definition of Cultural Safety derived from Kawa Whakaruruhau (1990).**

Because cultural safety is based in the less measurable dimensions of attitude, it cannot be defined against physical or legal safety. Like ethical safety, cultural safety must be interpreted according to each event. The degree of cultural risk or danger must be assessed by those who are able to perceive it.

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