Cultural Safety:

Implementing the Concept

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In July 1993 there was a minor media explosion as the notion of cultural safety in nursing education hit the national newspaper headlines, the television news and the radio talkback circuits. Cartoonists in their succinct way also had a romp. Interestingly, the debate was located mostly in Wellington and Christchurch, sustained by the local daily newspapers.

Today any activity associated with cultural safety in nursing education or practice is still capable of attracting front page coverage. From time to time there is an eructation from some area of the media which is usually followed by the administration of some indigestion remedy by the Nursing Council of New Zealand. Despite the best efforts of the nursing and midwifery professions, the national digestion has not settled.

What is Causing the Discomfort?

Like all issues in which Maori are involved, there is a large race relations component in cultural safety. Race relations issues are usually controversial and therefore newsworthy. This increases the potential sales of newspapers and attracts advertisers to prime time television and talkback radio and sustains the news business.

The combination of Maori and nurses was particularly interesting to the New Zealand public since most people have some contact with nurses or midwives during their lives and everybody has an opinion about nurses and certainly about race relations.

Nursing and midwifery as female-dominant professions are regarded as somehow less professionally credible and more open to public comment than their legal or medical counterparts. Medicine and the law continue to be seen as male institutions despite the many women who belong to them. The nurturing nature of nursing also makes it particularly vulnerable to countering aggressive debate.

The stereotype of nurses as helpmates to medical doctors and wiping the fevered brow is still fondly held by much of the New Zealand public. More recently, and highlighted by the cultural safety debate, nurses are being seen as technically skilled, but the stereotype of nursing is still firmly located in secondary care. The role of nurses as promoters of community health or their location outside of hospitals is a concept which still does not sit easily in the public perception as evidenced by the cartoons depicting nurses dressed in symbols from cultures regarded as 'primitive' and being incapable of technical skills but good at greetings in Maori, which emerged during the debate.

When it appeared via the news media that Maori people were having input into the education and preparation of nurses to practise, very deep chords in some aspects of the New Zealand psyche were struck.

This is a neocolonial country. It was very rapidly and vigorously colonised, formally beginning only 154 years ago.The response of the indigenous people was passionate but their numbers were severely reduced by new diseases, civil war and the colonial wars. Now the numbers of Maori are increasing. Urbanisation and formal education have helped to create a critical mass of informed and analytical people who identify as Maori and require change in all service delivery and independence from the colonial systems with regard to the Maori future. People are wanting choices and to that end are becoming active in a range of ways.

In a climate of increasing new frontiers of debate and challenging political interaction between Maori and the state, the Crown, the government and the next door neighbour, the idea that the comfortable and trusted nurse image was being influenced by Maori who were demanding unreasonable and unrelated input into nursing education, was all too much for some people.

Nursing is inevitably involved in the cultural safety process because the role of nurses in all areas of society often involves frontline work with people suffering from the outcomes of poverty, as many Maori are. It is not coincidental that nursing has responded as solidly as it has to the ideas of cultural safety. The realities of barriers to service are norms for nurses, particularly those who work in communities outside secondary care and are able to equate the feelings of cultural risk which many people express, with missed opportunities in service delivery.

The underlying issue, and the cause of much anxiety, was the apparent power of Maori to create meaningful change in an established Pakeha system. In some views, a Maori takeover. If this type of liberal educational change had not been seen to have a heavy Maori involvement there may have been little public disturbance.

There are clear resemblances in the public aspects of the cultural safety debate to the media created moral panic associated with the Maori gangs of the late 1970s and the overstayer issues. Much smoke and a limited amount of fire.

The public response held some important lessons for nurses. On one level it illustrated how unprepared most nursing people concerned with the debate were to work with the people from the news media. Although the nursing teachers, students and Nursing Council personnel coped extremely well in an area which nurses traditionally did not occupy, the requirement for instant responses to media pressure highlighted the need for nursing to develop a much more realistic public persona. A public relations programme which puts the people in touch with the realities of the public-funded nursing and midwifery educational processes and with the activities of the Nursing Council would be very useful in helping to create informed debate.

On another and very serious level, the professional judgment of nurses and midwives to decide the parameters and content of educating future professionals was held up to public scrutiny by the media and found to be wanting by a largely uninformed public. This was trial by ignorance.

The issue of professional judgment and the confidence of nurses and midwives to set standards and to maintain, refine or defend those standards while remaining answerable to the public, helps to define professionalism. It seemed that the New Zealand public were not prepared to permit nursing to make these decisions.

Some areas of nursing did not feel well informed about cultural safety and therefore were not confident enough to defend them. The relationship between education and practice is an issue here.

There is a further issue of communication between education, practice and the older generations of nurses (many now retired but vocal in defence of the nursing philosophy of their times) who respond to their memories of service with little analysis of the power relationships and their implications. In those days a 'one size' service was intended to fit all. The condition was nursed rather than the person.

Traditionally nurses were educated to work with people without recognition of their difference. The now obsolete Florence Nightingale oath sworn by generations of nurse graduates stated that people should be nursed regardless of colour or creed. Power was located solidly with nurses trained in the military culture inherited from the British tradition. Cultural safety requires that all human beings be nursed regardful of all those things which make them unique.

Each person to whom nurses offer service should be understood to be part of a social, economic and historical framework. The idea of expanding the view that nurses have of patients to include their families and other relationships must expand even further if it is to be truly holistic and nursing is to be called comprehensive. Peoples' individual and group histories have a direct bearing on their attitudes towards communication and their interpretation of barriers and access to service.

Attitudes which block access to service are held by both nurses and patients. It is the responsibility of the service provider to identify such barriers and work towards eliminating them in the interests of improving service. It is not the responsibility of people made powerless by illness, poverty, age, youth, sexual orientation, ethnicity or any disadvantage. Barriers may be as subtle as the body language of the provider or as complex as understanding the poverty cycle and designing effective nursing interventions.

Nurse leaders in education were quick to realise that the fault lay with the service design and delivery rather than the people who had little choice but to use it. Cultural safety was designed to focus on the nurse as the bearer of personal and corporate culture, attitudes, preconceptions and power. Such attitudes are often seen by the powerless as arrogant and controlling, all of which obstruct access to free communication and service which the patient could define as safe.

During the 1993 cultural safety debate there were difficult moments defending the issues because there were few standards which had been nationally agreed upon. There were very good reasons for that. The rapid evolution of cultural safety was keeping pace with the demand for change in a very immediate way. There was a great deal of broad brushwork and little time for academic debate.

Nursing was in agreement that cross-cultural issues in service delivery were critical and that change was required. Significant data demonstrated that, and from the early 1980s challenges from Maori were consistent and strong. Government directives and the Department of Health required that the status of Maori health be brought to the same level as the rest of the New Zealand population. Education was an obvious place to begin.

The co-ordinating role played by the Department of Education in nursing education, particularly in relation to cultural safety, was lost in 1989 when the economic reforms of the Labour government restructured the department.

Along with the advisory and support functions of the tertiary education unit, the role of the Education Officer to Nursing specialising in Maori Health disappeared. This happened as the theory and application of cultural safety in nursing education and practice were being developed. Along with many other initiatives, cultural safety in nursing was no longer able to be funded or nationally co-ordinated. The report, Kawa Whakaruruhau, Cultural Safety in Nursing Education in Aotearoa, published in 1990, strongly recommended that teachers of cultural safety were able to meet regularly to peer review teaching practice, compare experience, build on successful teaching styles and outcomes and discard those which were not useful. Because this was not funded or supported to become a regular, national process, opportunities to set national teaching standards could not be developed.

Although responses were based on goodwill and concern, they were also often naïve and uncritical of the quality of service, focusing instead on the idea that becoming aware of traditional and rather romantic information about Maori could somehow translate into nursing practice.

Taking student nurses to 'marae' in order to sensitise them to Maori ritual and custom has little relation to practice. The equivalent in Te Ao Pakeha would be to take student nurses to Government House and hope that the experience would enable them to work with the diverse range of human beings who make up Pakeha society.

It was essential that students were enabled to understand the legitimacy of difference, and the Maori Studies approach was an early attempt to do this in the light of the little available information and the current educational climate. This process occurred regularly throughout the 1980s, most prominently in government departments, across the spectrum of education and in the private sector.

The colonial history of this country is referred to in a skewed and often very romanticised way in the general education system. When nursing and midwifery students begin to realise that the facts are very different and that they have a direct relationship to health in New Zealand for specific groups, they react in a range of ways. There is little in their educational experience or their daily lives for them to compare the new information with, and yet it becomes very clear that there are deep and complex issues to which they have not been introduced. Often students are angry at the shallowness and lack of critical analysis in their former educational exposure.

The evocation of sentiment or guilt has not been useful in nursing education which should be about creating allies. It is extremely difficult to avoid those reactions in some individuals and there have been disgruntled people who have had difficulty with new information. There are disgruntled people in all areas of education and in the wider society, and in combination with race relations quick ignition of emotional reactions can always be guaranteed.

Although the polytechnic nursing departments had responded so rapidly to the need for change, the loss of a central source of ideas and funding was critical to national development. Cultural safety became regionalised and dependent on variable local input.There was also a requirement that each polytechnic develop courses in response to local communities. Nursing teachers worked constantly to fulfil that.

This inevitably resulted in a wide reinterpretation of what cultural safety might be in education. Some course content drew public censure because it appeared to relate much more to Maori Studies rather than to nursing practice. It was often impossible to illustrate a relationship

between the study of traditional Maori activities and ritual, and contemporary practice. Students were quick to identify this and were clear in their objections. Relating information to practice rapidly evolved as a critical issue.

It was necessary to develop a body of knowledge which could demonstrate the social, economic, political, historical and often emotional reasons for the high incidence of, for example, rheumatic heart disease, the rates of asthma deaths, cot deaths, mental hospital readmission rates, uptake of tobacco smoking among young women, the rapid rise in high-risk behaviours and suicide, in which one sector of the New Zealand population far exceeds the rest. The people in this sector are Maori.

All these conditions are directly associated with poverty and can be found wherever poverty prevents access to help. In New Zealand there are clear reasons for these disease outcomes. Cultural safety does not justify the antisocial behaviours which happen in the context of poverty, unemployment and social stress, but it does help to explain them. This background assists nurses to make informed decisions and prevents the formation of attitudes which often blame victims.

This is an example of the educational theory of Brazilian educator Paolo Friere who believes that teachers must respond to student needs and tailor pedagogy to the realities of daily life. Nursing has learned quickly and, on the whole, well.

The Nursing Council of New Zealand provided a national shape for the terms of the development of policy and guidelines for polytechnics in curriculum development and the assessment of curricula when cultural safety became testable in the state examination for registration of nurses and midwives in 1992. Despite the media hype, the work of Nursing Council established guidelines and 'cultural safety' became part of the normal nursing and midwifery lexicon assuming parity with the philosophy of safety in all aspects of service.

Teachers were free to develop their course content and teaching styles locally as they did in all other courses. The Nursing Council does not have the right nor the will to restrict academic freedom of expression.

The term 'cultural safety' is consistent with normal nursing language. It has been firmly retained because the word safety is subjective. It gives the power to the user of the service to say whether or not they feel safe. The nursing skill involved here is to enable the person to express degrees of felt risk or safety so that they can expect and monitor changes in the behaviours of health professionals as a result.

Part of the public response to the idea of cultural safety was that somehow clinical teaching and technical skills would be sacrificed to undefined Maori 'things'. Cultural safety makes up 5–10 per cent of most degree programmes in nursing, that is, 90–95 per cent of programmes are not cultural safety.

The concept of cultural safety began to formalise at the Hui Waimanawa in Christchurch in 1988. Much of the basic theoretical work evolved at Christchurch Polytechnic Department of Nursing and Health Studies as well as at the Otago Polytechnic Department of Nursing and Midwifery. Both departments have important relationships with Ngai Tahu, Otago extending to co-ownership of the cultural safety component of the curriculum. Further developmental work from Maori nurses and from many other Maori, as well as people from other cultural and social groups, enabled work to progress.

There seemed to be a theme or continuity in the origin of cultural safety in Christchurch, the arising of the debate there and the support that tangata whenua were able to give the nursing department and the Polytechnic when it was besieged by the media in 1993. Several years before, a quiet gathering of senior Ngai Tahu had promised nursing their support in the development of cultural safety in return for a commitment to help improve the health status of Maori people through nursing education. Although most of those people have since died, the support has continued from their mokopuna.

Cultural safety has also evolved differently in North Island regions. For example, the Tihei Mauriora elective programme for Maori students at Waikato Polytechnic will be an important source of Maori nurse leaders who will be able to specialise in issues of Maori health. The Waikato programme has been developed in conjunction with the Tainui people in response to the Polytechnic charter to honour the Treaty of Waitangi and work in partnership with local communities.

The art of nursing in itself is a subjective experience between two primary people and others. All nurses and midwives understand the grey areas of care where professional distance is minimised and intangible skills are employed which become critical turning points in care. These skills improve the quality of human emotional and spiritual interaction and break down barriers to service as people feel safer. Without the art nurses become biomedical technicians. It is assumed that by graduation the level of beginning clinical skills have been tested and assessed in the basic course and that such skills are the tools of the art of nursing.

This work is about communication and access to service, quality assurance and patients' rights. However competent any nurse or midwife may be technically, such skills and experience will not be of use if people do not feel emotionally safe to approach the service, or if they use it too late.

If the term safety is changed to awareness, it immediately shifts the power away from the patient to define their subjective response and gives it to the service provider. Only the patient is able to say whether the nurse is safe regardless of how many awareness courses the nurse has attended.

Cultural safety differs profoundly from the Western traditional anthropological view in that it assumes that the nurse is exotic in the view of the patient, that the nurse is not the norm.

This view does not permit nurses to set up simple multicultural cultural check lists which deny the real and diverse lives of people who use their service. It insists that nurses and midwives become experts in understanding their own diversity within their own cultural outlines as well as their potential for powerful impact on any person who differs in any way at all from themselves.

This internationally original nursing innovation developed from the reality of nursing in New Zealand. There will be recognisable elements in other neocolonial societies. It has come out of the interaction of the indigenous people with a nursing service designed from the values and social shapes of another ethnospecific group. This makes it unique to the New Zealand experience and its interaction and evolution will eventually speak of a nursing service which has come from real neocolonial interaction and has created something new and positive.

Instead of standing by and allowing the misconceptions which the media have set up about cultural safety, nursing should rapidly and clearly respond to basically unsubstantiated accusations by adopting a marketing approach to clarifying the realities. Confidence in practice and positive change in service delivery need to be demonstrated.

There are six major categories of difference in the practice of cultural safety; between nurses practising in New Zealand and people who differ from them:

1. Tangata whenua and the Treaty relationship, and people of Maori descent in their neocolonial diversity.
2. The intercultural difference between aged and young people.
3. The intercultural difference between genders.
4. The intercultural differences in sexual orientation.
5. Socioeconomic and class difference – the cultures of rich and poor.
6. The cross-cultural difference between ethnospecific New Zealand nurses and midwives, and people from ethnospecific migrant groups.

These categories acknowledge that health is a dynamic combination of social factors which are contained in, but not restricted by, a package which can be called culture. Religious difference and difference by disability have been recently suggested for inclusion.

They involve understanding the universal theories of homophobia, of racism, sexism and ageism and issues of social class. They can all be applied to life in New Zealand. The skills of cultural safety should work as well for homosexual people being nursed by heterosexual

nurses as for people who differ by the apparently simpler context of their ethnicity.

The objectives of cultural safety in Nursing and Midwifery education are:

- To educate student nurses and midwives to examine their own realities and the attitudes they bring to each new person they encounter in their practice.
- To educate student nurses and midwives to be open minded and flexible in their attitudes towards people who are different from themselves, to whom they offer or deliver service.
- To educate student nurses and midwives, not to blame the victims of historical and social processes for their current plight.
- To produce a workforce of well educated, self-aware registered nurses and midwives who are culturally safe to practise, as defined by the people they serve.

These objectives do not include Maori Studies. Rather they are designed to help create self-knowledge and lead to practice wisdom.

The angry public and student response to some of the teaching anomalies must been seen as constructive and creative since it accelerated the awareness of teachers of the need to develop a framework of ideas in which to embed the concept of cultural safety. The outcomes of a culturally safe health professional graduate should be agreed upon. They should be achievable and assessable.

For example:

* all – to be able to recognise that change is needed
* all – to develop the skills of critical analysis
* $^2/_3$ to be able to recognise the opportunities to create change and see where to intervene
* $^1/_3$ contribute to change
* outstanding graduates – initiate change.

It also became very clear that suitably qualified nurses needed to teach cultural safety and to design and co-ordinate curricula and external input to the courses.

Cultural safety must continue to develop in a well thought out and co-ordinated way. A body of academic knowledge and tested paradigms will continue to be developed. Standards for teaching and for the education of teachers will require further co-ordination.

It is much simpler to teach bioscience, surgical, medical or other areas of nursing because there is a documented background of assessable knowledge and experience as reference. Working in the area of new liberal material, some of which is still being researched (as all knowledge always is), translating that into a teaching style which challenges without distressing students as well as relating to health and disease outcomes is a daunting task. To the credit of teachers, it is generally being achieved very credibly and although there have been difficulties along the way, approximately 4,000 students have graduated from the courses since their formal inception in 1992. If even a tenth of those people had expressed dissatisfaction there would be real reasons for anxiety. Three years have seen a rapid development in this area of education.

As well as traditional social science, anthropology and history skills, cultural safety teachers have to be well trained in issues of attitude development and change. They need to be able to teach so that students feel safe to be able to examine their own attitudes and realities. For this to happen teachers also need to be safe to teach.

A process to establish and define such safety will be developed. Teachers require a sound knowledge of New Zealand history to be able to place the health and illness issues in this society in their neocolonial framework and establish the cause and effect relationship for students.This is inordinately skilled work and cannot be achieved overnight.

Teachers in this area do not need to be Maori except where issues of Maori intellectual property are concerned.

Cultural safety has happened very rapidly as an educational process and is still being refined. There will be continuing controversy because it is an easy scapegoat, a useful diversion in toughening economic times and a climate of right wing economic reform.

If Maori had not acted upon the need for change in nursing education such a course may not have attracted the level of public attention that it has. The level of ignorance, misinformation and irresponsible media hype has been very painful for nursing and midwifery. Pain is intended to identify problems and problems call for change. Change is happening and happening very positively in many places. There is a deep groundswell of understanding and better educated nurses will translate that into practice.

People should have mechanisms to comment powerfully on all aspects of quality in nursing service. This can be achieved in several ways. Informal patient surveys seeking quality assurance which include access issues, such as illiteracy, are important. Formal qualitative research should seek to record a broad range of service indicators including subjective responses, or the intangibles. Quantitative research also provides insight into the use of service. There should be no fear of breaking down the groups of people into their ethnospecific or intercultural backgrounds if that is their primary identification. Only by allowing them to self-identify will any real approach to specific service needs be developed.

Although it was identified and initially shaped by the indigenous people of this country, Kawa Whakaruruhau, a process for protection, cultural safety, is the gift that Maori offer nursing, midwifery and all those who are different.

In the end cultural safety is about quality assurance and patients' rights, whoever those people may be. The nursing skill does not lie in knowing the interesting and exotic customs of ethnospecific cultures, that is completely unrealistic. It lies in enabling people to say how service can be adapted and to negotiate compromise.

It came out of the Maori pain experience, the unnecessary loss of beloved people, reduced life expectancies and the impaired quality of life still experienced by many Maori, but is offered out of that experience to all others.

The development of cultural safety belongs to life in New Zealand and to the story of this country. Nursing is to be congratulated on the journey it has made and the courage and determination it has shown to work with the issues. There will be an ongoing process of self-examination towards the expansion of practice in the search for excellence in the service offered and given to those fellow human beings who differ, fully regardful of their difference and of the realities of those people who are nurses or midwives. ■