TEACHING CULTURAL SAFETY THE CULTURALLY SAFE WAY

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Abstract

The concept of cultural safety emerged in New Zealand in the late 1980s as a response to the differential health experience and negative health outcomes of Maori, the first nation people of New Zealand. It was introduced and developed by Irihapeti Ramsden who recognised the effect culture has on health and who understood safety as a common nursing concept. Cultural safety is taught by both Maori and non-Maori educators as part of all nursing and midwifery curricula in New Zealand. This paper presents a strategy to assist nurse educators teach cultural safety in a culturally safe way. It was developed from my own experience and acknowledges the work of (Wood & Schwass, 1993).

Key Words: Cultural safety, nursing education, transformative education.

Introduction

Cultural safety has been a compulsory component of New Zealand nursing education for ten years. By requiring that within the nurse's practice there are processes whereby the nurse's service is evaluated by the client, it is a genuine attempt to transform the historic power relationship between nurses, nursing and those they serve. This process identifies the power of the nurse as a culturally constructed person, as well as a nursing practitioner. It also shows the unsafe nature of health institutions for those with little or no culturally constructed power.

Cultural safety education is directed towards assisting students to understand their own culture and the theory of power relations, in a safe, non-judgmental way. With limited social and collegial mandate the nurse educator faces a difficult task. The aim is also to develop culturally safe nursing practice as defined by the recipients of the nurse's care, an outcome which may require significant attitudinal change on the part of the student.

The process of teaching cultural safety

Wood and Schwass (1993) constructed a framework to promote the development of culturally safe nurse practitioners. This highlighted the requirement for a significant movement in the student's attitude from cultural sensitivity to cultural awareness to cultural safety. The Nursing Council of New Zealand, Guidelines for Cultural Safety in

Nursing and Midwifery Education (1997) also acknowledge the requirement for exploration of attitudes and values as important to the development of cultural safety. There is now recognition that this process is difficult, with the possibility of students experiencing some discomfort depending on their life experience, readiness to address the issues and the learning environment. Wood and Schwass (1993) also discuss the difficulty of changing attitudes especially when these are deeply held and involve a complex set of beliefs such as those surrounding concepts which underpin cultural safety. "Attitudes entangled in the concept of cultural safety are indeed complex, intense, and deeply held" (p.7).

There are many challenges to the teaching of cultural safety. As a cultural safety educator for over ten years I have been fascinated by the general, collegial and professional criticism of cultural safety and its teachers. I am aware that many cultural safety educators are very experienced and competent and in most cases highly regarded by their students. The premise of this paper is that the major difficulty of teaching cultural safety relates not to the expertise of the educators but to the lack of social and collegial mandate referred to above. Wood and Schwass (1993) acknowledge the struggle students and the public have with cultural safety but suggest that this is to be expected when people are exposed to immense or rapid change. This paper extends that explanation to include a discussion of the social and cultural context within which the change has occurred.

Nurses, the most numerous health care providers, hold positions of power which enable them to impose their realities on the people they serve. Often they are unaware of this power and express feelings of powerlessness especially in the face of managerial and medical dominance. Though nurses individually may be members of the dominant culture, collectively, according to Freshwater (2000), they can be members of an oppressed group. Freshwater and others, suggest that nursing has minority cultural status because it lacks autonomy, accountability and control over its own profession (Freshwater, 2000; Harden, 1996; Roberts, 1985).

Cultural safety nursing education is primarily directed toward improving nursing practice while acknowledging the social and cultural construction of nursing power. It requires that nurses and nursing empower clients by opening up to them the liberating experience of being assessors of the nurse's practice. Theoretically this liberation should benefit the nurse as well as the client, but achieving it involves the nurse in personal and professional risks. Such risks are easier to take in an environment where nurses' education and practice are valued and where the nurse has personal and professional confidence and control. In reality nurses and nursing are constrained by a long-standing hierarchical tradition and by institutional organisational factors and demands (Perry & Moss, 1989). It is not surprising that many nurses resist cultural safety seeing it as requiring them to relinquish power. As Ramsden, (1994, p.22) notes: "It should be acknowledged that it is not

normal for any group in control to relinquish power and resources to the less powerful simply on the grounds of good will or a sense of moral obligation".

Another reason for the lack of general and collegial support is the difficulty members of dominant cultures have in recognising their own racialisation. The term racialisation derives from many studies in the United States of America on 'white' identity and 'whiteness' as a racial identifier. Racialisation is the process of recognising that each individual is racially as well as ethnically constructed. For those belonging to the dominant race recognition of their racialisation is particularly difficult (Page, 2000; Echols, Gabel, Landerman & Reyes, 1988; Morrison, 1993). When nurses are part of the race and culture regarded as 'normal' they are almost always unaware that they may be perceived by others as being different, and do not appreciate this being pointed out to them. To a nurse from the dominant culture the client's experience of being culturally unsafe, relates to the client's 'otherness' not the nurse's 'otherness'. This use of the term 'other' comes from the work of Wilkinson and Kitzinger, (1996, p.9) "... Other is a construction or set of discourses through which the dominant group defines itself, (and) the Other is silenced or delegitimized. Others' representation (of themselves or of 'us') are threatening to the dominant groups."

One of the tasks of cultural safety education is to assist students to recognise themselves as different rather than always seeing the client as different, and also to recognise their power to define 'others' and question the appropriateness of their practice of 'othering'. Cultural safety education points out the importance of the nurse engaging in critical self-reflection because for clients to whom the nurse is different or 'other' it is the nurse not the client who is likely to be the source of the problem. It is not easy to see yourself as others see you and not very comfortable seeing yourself as the possible problem.

In New Zealand cultural safety became part of the race relations debate, and as such drew unwelcome negative publicity to educational institutions. Cultural safety as a critique of the nation's health inequalities is situated in the broader social context of biculturalism, which has become a visible construct to the dominant culture in New Zealand over the last twenty years. Biculturalism in New Zealand is based in the Treaty of Waitangi, a treaty signed in 1840 by Maori people and the British Crown. This treaty differentiates two groups: "People who came to New Zealand as the result of the Treaty settlement and Maori, the multiple iwi, tangata whenua who agreed to immigrant settlement subject to the series of conditions embodied in the Treaty of Waitangi." (Ramsden, 1996, p.21).

The Treaty has recently been given national legal stature by Parliament as New Zealand's 'founding document' and is recognised as being instrumental in improving Maori people's health (Shipley, 1997). National recognition of the Treaty has

happened at the same time as New Zealand is experiencing the effects on its culture and social structure of an emerging Maori elite who articulate their long held resistance to the dominant ways of thinking and acting. As this resistance has become more visible, members of the dominant culture, including some nurses, have become vocal in their disapproval of changes to the status quo. Both students and educators may live with family and friends who are themselves not comfortable with the changes in race relations in this country, consequently transformative education that is supportive of social change is often seen as threatening. Comments from students and colleagues suggest that they do not discuss their cultural safety education at home or with friends because it often results in conflict.

The New Zealand parliament has, over the last fifteen or more years, embraced a market model of reality, and educational institutions throughout the country have been encouraged to adopt a more market lead philosophy (Crozier, 2000). In the same book Crozier notes that application of this philosophy in education places the student as consumer and the educator as provider and thereby erodes the educator's academic freedom. One particular problem the educator faces is the emphasis on student satisfaction as a criteria for educational acceptability. This requirement makes it difficult for educators to encourage students to critique the status quo and advocate for social change when the students themselves benefit from retaining the status quo. In my experience students are generally altruistic enough to engage in the task, but are not supported in this undertaking either by society at large or educational and health institutions.

The situation described above has a number of implications for educators, with respect to culturally safe nursing education. Their first option or strategy, is often to multiculturalize the course, which means that, "...rather than viewing the situation in terms of power, the tendency is to use the lens of culture - in a partial way and from the dominant perspective" (Jiwani, 2000, p.3)

An example in the New Zealand context is the substitution of a course on Maori health for a course on cultural safety, rather than seeing them both as essential parts of a New Zealand nursing curriculum. I suggest that in the case cited the substitution does both topics a disservice. Cultural safety prepares students to understand the complexities of Maori health, and in practice cultural safety and Maori health reinforce each other. Cultural safety requires recognition of cultural uniqueness but also focuses on the historical and sociopolitical aspects and influences which inform the reality of all people the nurse serves (Jiwani, 2000).

A second option or strategy is to remove the relevance of ethnicity altogether and focus on the categories of differences (highlighted to prevent the development of stereotypes and to recognise the reality of cultural diversity) as competing cultures. This

is a form of multi-culturalizing and by placing one form of oppression or deprivation in competition with others is inclined to maintain the status quo by the process of 'divide and rule'. In itself it does not deal with the multiple issues of power relations and provides the student with very confused messages. Students are likely to end up reducing themselves and their clients into cultural parts and care of the latter into cultural compartments.

Another way of making cultural safety more acceptable is to de-personalise the process by focussing on nursing culture rather than the nurse as a culture bearer. This means that the nurse does not examine her/himself culturally in practice but only nursing as a culture in practice. This results in the personal culture and personal power of the nurses becoming invisible behind their professional culture and power. This situation is characterised by students whose comments suggest they are two separate people - the person and the nurse. This process of rendering the person, and their power invisible or covert does not allow for culturally safe practice by design, only by accident.

The fourth option is that the cultural safety nurse educator, in a market-led education system, focuses on achieving student satisfaction as an end in itself. In this process students are cheated of challenges that, while they may be uncomfortable at the time, allow for a feeling of being stretched and the achievement of something of value. Students thereby lose the chance of quality education and are denied the preparation for real nursing practice with difficult people in challenging situations.

I would like to offer a fifth strategy which originated in my own experience, research into emancipatory educational methods, and collegial advice and support. This option is a development from the work of Pamela Wood and Margaret Schwass (1993) and is informed by the writings of (hooks, 1994; Freire, 1972; Ramsden, 1994, 1996; Giroux, 1988).

Wood and Schwass (1993) discuss the process and teaching of attitudinal change recognising that the latter is a necessary part of cultural safety education. They identify the role of the teacher as one of support and challenge and offer a model of curriculum stair-casing for the learning of cultural safety. However the model presented, although helpful in the development of appropriate teaching methods, does not address the lack of social mandate for the teaching of cultural safety. The work of bell hooks (1994) as outlined in Teaching to Transgress was very useful in addressing this issue. Rather than the objectives model used in many nursing schools, one which focuses on control and social domination, (Perry & Moss, 1989) she presents the notion of flexible agendas and student-centred teaching co-existing with serious intellectual and academic engagement. Irihapeti Ramsden (1994) and bell hooks (1994) envisage liberating education of the sort that underpins cultural safety and emphasises and promotes well-being. "Education should be emancipatory and liberating. People

should be able to use it as a revealing and guiding tool for their lives." (Ramsden, 1994, p.20)

Freire (1972), hooks (1994), Giroux (1988) and Ramsden (1994) all argue that no education is politically neutral. In any educational course the information included, or excluded, is politically dictated. Ramsden (1994, p.20) states specifically that "... the system of information delivery called education, its priorities and direction, have all been selected to fulfil the agendas of their times."

The first step in teaching cultural safety in a culturally safe way is the acceptance of the political nature of education. Cultural safety nurse educators are engaged in a political act. The second step involves the recognition of the professional mandate nurse educators have from the Nursing Council of New Zealand plus the moral mandate based on the differential health statistics between the privileged and deprived (Bell et al. 1996; Crampton, Salmond, Kirkpatrick, Scarborough & Skelly, 2000; Legge 1996; Marmot et al. 1991; Pearce 1991; Pomare et al. 1995; Whitehead & Dahlgren, 1991).

The third step addresses the issue of a culturally safe classroom. This is only possible if both the educators and students take responsibility for safety. Compliance is not required by students engaged in cultural safety education, but neither is the freedom to harm others considered acceptable. At the beginning of each course the educator is encouraged to develop a learning contract with each class. Included in the contract are the requirements that no member of the class in their communication within the class diminishes, demeans or disempowers any culture. It is likely that students who experience life from a dominant reality have difficulty initially with the concept of checking what they are going to say before they say it. They equate this practice as a loss of free speech. Only after a period of time and reflection do they learn that their assumed right to free speech may result in another person's fearful silence. A culturally safe learning environment recognises that in the education environment people from all cultures need to be able to maintain their safety. As well, they need to be enabled to engage in honest critique and reflection on their experience and on the concepts offered. As described in Riley-Doucet & Wilson (1997, p.965) "A safe environment is one in which students are free to examine and reflect on their work with patients thoughtfully and honestly without fear of judgment or reprisal."

The fourth step in the development of teaching cultural safety in a culturally safe way is for the educator to surrender the need to be liked.

> *"Moving away from the need for immediate affirmation was crucial to my growth as a teacher. I learned to respect that shifting paradigms or sharing knowledge in new ways challenges; it takes time for students to experience that challenge as positive." (hooks 1994, p.42)*

A helpful part of this process is to set

up at least one other person to help de-brief after particularly challenging sessions, or have someone sit with you in class to provide constructive critique and suggestions.

The fifth step involves recognising that giving up familiar ways of thinking involves pain. A comment from hooks (1994, p.43) is helpful in this respect: "...there can be, and usually is, some degree of pain involved in giving up old ways of thinking and knowing and learning new approaches. I respect that pain. And I include recognition of it now when I teach..."

Students can respond to pain in a variety of ways including withdrawing, being angry, blaming the educator or absenting themselves from the class. A more positive response requires that they take responsibility for their own learning including time to process new material. The educator also has a responsibility to provide a safe, stable, interesting and democratic classroom to encourage learning. Figure 1 below is the present author's representation of concepts involved in the learning of cultural safety. The three zones - fear, challenge and reflective are those through which both students and educators must move in taking responsibility for learning. At any given time in relation to each of the concepts, each student will be operating primarily in one of these three zones.

Learning, particularly in the area of attitudinal change, will be faster when the student has frequent but relatively short times in the challenge zone with these followed by time in the consolidation or reflective zone.

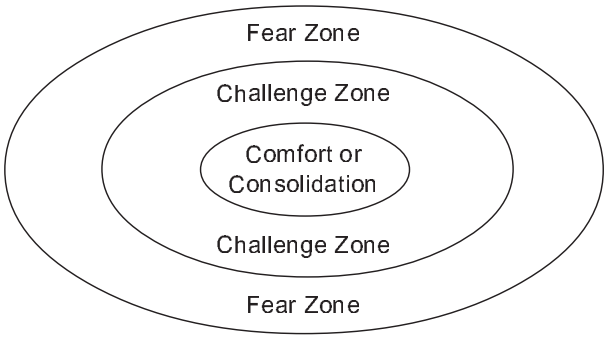

Figure 1:
Teaching Zones for Emancipatory Education

Prolonged exposure to challenge may move the student into the fear zone where little or no new learning occurs, and previous positive learning may be undone. Too much time in consolidation or comfort may result in boredom and/or loss of interest. The student's experience of the topic under discussion defines their level of challenge, comfort or fear. Their reality is dependent on many factors, perhaps the most relevant being their own life experience and previous learning in relation to the topic. Individual herstory/history generally defines the size of the respective zone.

As educators we generally have little or no control over the student's previous life experiences, neither what they were nor how the person dealt with them at the time. Yet these experiences greatly affect their capacity to learn. This is particularly so for controversial material (Wood & Schwass, 1993). If the material has an acceptable social mandate students will often be encouraged to develop skills to manage it and their associated feelings. If there is no social mandate then the onus is on the educator to assist the student to

develop the skills to manage. This can be done by developing a learning contract and explaining the zone diagram so the students are clear about their responsibility and role in the process of learning cultural safety, and at the same time are reassured that they will not face challenges beyond their capacity to cope.

Conclusion

In summary, emancipatory education requires change to the status quo and as such provides challenges to both the educators and students. The strategy identified above has been used successfully and is offered for comment and critique. The process includes setting up a learning contract and explaining the meaning and complementary nature of the three zones of experience - fear, challenge and reflection/ consolidation/comfort. The role and responsibility of the educator is identified, as are those of the student. According to the Nursing Council of New Zealand, (1996) cultural safety requires the nurse to practice regardful of uniqueness. Cultural safety education practised in a culturally safe way carries the same requirement.

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Acknowledgments

The author would like to sincerely thank Irihapeti Ramsden, Trudy Mackay and Helen Gibson for their guidance and support. Also the Christchurch Polytechnic Institute of Technology Cultural safety team including Irihapeti, Helen Gibson, Michelle Edwards, Mary Foster, Dr Ausaga Faasalele, Dr Ann Winstanley and Margaret Hughes.