

## INVITED ARTICLE

# CULTURAL SAFETY / KAWA WHAKARURUHAU TEN YEARS ON : A PERSONAL OVERVIEW.

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The Praxis editorial team has asked me to write about cultural safety over the last ten years. Having accepted the opportunity I have tried to thoughtfully review the growth of an indigenous New Zealand nursing and midwifery educational experience which has rapidly and often raggedly emerged from the New Zealand socio-political environment.

This is a personal reflection based on the original vision for change in nursing education and service which I and many others have worked to achieve. I have not intended this to be an academic paper but a gathering and presentation of ideas and personal conclusions.

This essay is informed by relationships with Maori and non-Maori people who use nursing service, students, teachers and their institutions, and practitioners of nursing and midwifery. Of critical importance has been the opportunity to work in the Department of Education from 1988 to 1992 and with the Nursing Council of New Zealand over the last ten years.

During this decade my grandparents and many senior women and men of our hapu have died. They supported the work of cultural safety until their

deaths. Our grandfather Te Uri o Te Pani Manawatu Te Ra gave the term Kawa Whakaruruhau to the concept of cultural safety and Hohua Tutengaehe of Ngai Te Rangi accompanied the kaupapa until he too died.

The ignition and then the glowing fuel to continue my part of the cultural safety initiatives were the unnecessarily early deaths of my mother, and countless other Maori who did not have access to a health service which could be of use to them. Nursing has been part of that story. The profession is now owning that history and working to change the future.

Cultural safety should be the experience of all the recipients of nursing care. It is about protecting people from nurses, from our culture as health professionals, our attitudes, our power and how we manage these things whether unintentionally or otherwise.

It is our responsibility as appropriately educated nurses and midwives to acquire insight and analysis into ourselves as members of human groups who develop powerful behaviours and practices. The culmination of this educational

process should enable the most vulnerable of our society to say that nurses are safe to be around. The definition of safety should rest with the people who use our service.

The movement toward the examination of the nurse as the bearer of power and attitude, unconscious and conscious, has entered nursing and midwifery education and has been maintained. It has been informed by emancipatory educational theory and critical thinking with feminist theory providing much of the theoretical glue. My initial ideas for cultural safety theory came from these sources and were clarified by the works of Paolo Friere, Edward Said, Frantz Fanon, bell hooks, J. Blaut, Ward Churchill and other neo-colonial theorists as well as transformative theorists concerned with the analysis of power such as Henry Giroux and Michal Foucault.

This genre of neo-colonial writing has emerged from the experience of colonised and marginalised people and is consistently developing internationally. People interested in the progression of the cultural safety arguments should refer to any of these writers.

Reception of the ideas for cultural safety was initially impelled by the revelation of the poor health status of Maori people in the mid-1980s and the clear demand by Maori for improvement in health service. In nursing their acceptance was sustained by the political energy of people determined to help make a positive difference. The intent was clear, the path was not.

The Treaty of Waitangi is the key to the application of cultural safety in the New Zealand context. Since the mid-1980s the Treaty has steadily become the principal negotiating basis for the relationship between Maori and the Crown. It defines the relationship between the Crown as provider of education resources for nurses and midwives and the employment of most nurses. The Nursing Council of New Zealand as a statutory body has recognised this and in a national climate which has often not favoured the Treaty, has conservatively attempted to respond to the case made by Maori for change.

Although gains have been made there is still a great deal of work to be done. A major step forward would be the establishment of dedicated positions to provide for Maori nurse and midwifery representation on the Nursing Council of New Zealand. In 1988 Nursing Council, in a move that was progressive for its time, required all schools of nursing to address their commitment to the Treaty relationship and to explain its expression in their school. In this way focus on the Treaty was required to be translated into action enabling local responses within schools of nursing.

Since then the Treaty as a health document and negotiating tool for resource allocation has experienced the same variable fate in nursing as it has in the wider New Zealand community. Treaty consciousness has often been kept in nursing education only by the sheer persistence of individual teachers and in some schools, reinforced by the Nursing Council requirements that the Treaty

form the basis of cultural safety education and that all students be given the opportunity to participate in Treaty of Waitangi education courses.

Traditionally nursing education has not been associated with history and political analysis. The public controversy aroused by nursing education's attempts to explore and explain the relationship of poor Maori health status to the colonial occupation of New Zealand demonstrated exactly what student nurses needed to understand. A reconstructed and sanitised history did not prepare health professionals for practice in a neo-colonial and extremely diverse social economic and political environment.

Nurses as a whole often found themselves unable to explain cultural safety as it rapidly evolved in education. The dramatic media activities of 1993 and 1996 and the public and political response to the teaching of colonial history in nursing highlighted this discomfort (Ramsden, 1995).

In 1995 the involvement of nursing with a potential Parliamentary Select Committee investigation into the teaching of cultural safety in nursing education caused anxiety at a range of levels. While the inquiry did not eventuate, nurses appeared before the Select Committee on Education and Science on three occasions. The first was heavily attended by television and radio media, Maori and pakeha.

The idea that there had been a take-over of such a trusted body as nurses and that their education was being manipulated by Maori, tapped

something very deep, a malignant anger, in the colonial psyche of many New Zealanders. Talkback radio had been running hot nationally for several weeks before the Committee met. A general theme discussed by callers was that teaching such matters as the Treaty of Waitangi and the health and disease outcomes of colonisation were irrelevant to nursing and anyway, if nurses were learning such material they would not be able to do practical nursing because their heads were being filled with extraneous information. The stereotype of nurses as female, passive and motherly simple souls was pervasive in these arguments.

Some politicians saw the furore as an opportunity to exploit their profiles. The original Chair of the Select Committee on Education and Science adopted a patronising and pompous attitude toward the nurses he was working with. Other members were overtly aggressive in their questioning and appeared to be relating their questions more to the media people than to considering the answers from the nurses. It was clear that some members of the Committee were intent on taking advantage of public racism and showed clearly that they had little knowledge of nursing education. The Hon. Margaret Austin brought her experience as a teacher and a scientist and focused on the real issues. It was she who recognised the pedagogy and its application and also saw the meaning and intent of the term, cultural safety and defended them from her later position as Chair.

Advice from the Chief Nursing Adviser to the Government was also crucial in explaining the realities of nursing

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education, practice and cultural safety to politicians.

There followed several investigations and reviews into the teaching of cultural safety in nursing education. The Nursing Council of New Zealand conducted a review. NZNO ran a major survey of its members opinions on cultural safety. The Student Unit of NZNO strongly supported cultural safety. The Polytechnics Association and the Ministry of Health also ran investigations and sought submissions. The findings were generally that cultural safety was important in nursing education, should be retained and that the term cultural safety should be continued. It was clear that the process of teaching was an issue and should be supported by training in conflict resolution and that clarification between Maori Studies and cultural safety was necessary. Media interest dropped off as support from nursing and midwifery leadership and the public became obvious. By the last appearance of the Nursing Council Chair before the Select Committee on Education and Science there was one media representative who departed before the hearing concluded.

The name remained a source of confusion to many. The popular understanding of culture as ethnicity only led to simplistic notions of cultural checklists avoiding the complex power relationships which the safety factor was intended to address. Many submissions wished to supplant the word safety with awareness or sensitivity which would have denied the obligation of the professional to practice safely. The

word safety was specifically selected to conform to the language of nursing and midwifery and to remain consistent with practice. That the term has survived ten years and shall continue to do so is a tribute to the determination of the people who have worked with the concept.

In a national climate of political conservatism and lack of political will to accept the Treaty as meaningful, Maori and pakeha teachers, and some students, have faced hard times within their institutions and communities. In some teaching institutions the response to the cultural safety debate was conservative retrenchment and reinforcement of the need for security and predictability in course content. This sometimes took the form of eliminating the term cultural safety altogether, or 'integrating' it into the curriculum until it appeared as an aside sufficient only to meet the standards for curriculum assessment by Nursing Council.

The redefinition of cultural safety into an idealised mixture of transcultural nursing and naïve often romantic reconstructions based in versions of Maori studies has persisted in some schools of nursing. At worst this has led to the creation of a stereotype of Maori which invites students and graduates to nurse stereotypically.

The evolution of the Maori stereotype is not necessarily the fault of teachers, although maintaining it can be. Nursing teachers are not usually educated in the complexities of political and social science, colonial history, economics and nursing or the

highly complex task of relating theory to nursing practice and explaining it in the context of the Treaty of Waitangi. The stereotypes are deeply embedded in the wider society of which nursing is a part. They are hard to recognise and avoid. Cultural safety is concerned with identification and explanation of such constructs in terms of their power to position people in society.

Teaching such material to undergraduate students who have not yet had sufficient practice to make their own comparisons requires a convincing skill as well as a deep understanding of the issues. Due to the short, sharp history of cultural safety, teacher and students often approach each other from an initial position of mutual discomfort. That it is possible to achieve a positive outcome is due largely to cultural safety being practice based which students respond to quickly.

Simplistic and romantic cultural reconstructions or checklists are always an easier political option, but they trivialise the realities which nurses need to understand in order to inform their practice. For example racism is part of the framework of every society. In recently colonised societies where resources are daily being contested racism takes particular forms. It exists in nursing as it does in the rest of society. Our skill as teachers is to help students understand it as part of the real world, identify it, relate it to practice and help create outcomes for patient care which are fully cognisant of the processes and implications of racism.

The people who bear much of this brunt are Maori teachers. Often recruited to teach because they have Maori descent it is somehow expected that they will have the experience and the analysis to teach issues of Maori health and the Treaty of Waitangi in all its many manifestations. Because they are usually concerned to maintain their mana Maori these teachers generally assume responsibility for the support and mentorship of Maori students and Maori community liaison. They also fulfil their teaching and assessment loads and clinical responsibilities as well as strive to maintain a pleasant and credible persona in staff and student relations. This can be very stressful and has come at a high cost for many Maori teachers.

The requirement in the Nursing Council Guidelines (1996) that all teachers of cultural safety have nursing qualifications and significant postgraduate practice experience as well as an undergraduate degree with strong social science content was designed to overcome the earlier practice of employing Maori by ethnicity with resulting disastrous effects for teachers, students and patients.

The expectation that students of Maori descent will automatically wish to work in areas of Maori health is also unrealistic. Like all other students Maori should be free to choose their area of practice without needing to fulfil the expectations of others. Increasing the numbers of students of Maori descent into nursing intakes will not necessarily increase the Maori health workforce. Identifying and

supporting motivated students would be of more help. Many Maori qualified to enter nursing now select careers which are likely to yield more opportunity to create political change or give them a higher income.

It would be more advantageous for Maori health service to create a credible postgraduate programme designed to enable interested Maori nurses and other Maori graduates to develop skills in leadership, management, contracting and other areas of professional development. Included should be those tikanga and Maori language opportunities which would further fit them as team leaders. Demographically Maori simply cannot provide a critical mass in the health workforce, but those who are interested should be supported as valuable resources. It is clear from continued Maori comment that the expectation of Maori service providers is based in professional excellence as well as an assumption of trust and shared meaning

The role of the 'unqualified' or second level Maori health worker, as support to the non-Maori health professional, does not lead to tino rangatiratanga and repeats the doctor, nurse, handmaiden relationship so abhorrent to nurses. While the Maori health workforce is largely unable to make decisions based on excellent professional education and practice, empowerment cannot happen, and health outcomes are not necessarily improved.

My belief after the last ten years of involvement with cultural safety is that the time has come to create a

different curriculum design. In the *Guidelines for Cultural Safety in Nursing and Midwifery Education* (Nursing Council of New Zealand, 1996) several social areas were identified which appeared to broaden and therefore lessen the impact of cultural safety in relation to Maori health issues. In fact the Treaty statement and intent as the defining priority remained very clear but within education there were views that there was an abandoning of the Treaty in favour of a less provocative political stance. There were concerns that cultural safety could be subsumed into sociology and that the focus on the New Zealand setting and the self examination of the nurse as a power bearer could be lost. To some extent this has happened as schools have reacted to the cultural safety controversy.

There is now a place for a stand alone generic core paper in Maori health. This paper should be available in all undergraduate programs and to all those graduate and migrant nurses and midwives wishing to practice in New Zealand. It should be accessible as on site and distance learning. The content should encompass all those areas of history, the Treaty of Waitangi, colonisation and its impact on health and service delivery which have traditionally not been available to New Zealanders subjected to the current colonial education system. Information should be examined from a critical distance while simultaneously enabling the practitioner to make informed decisions as a member of New Zealand society. The content should be academically sound and relate to

practice. This paper should be protected by a process of negotiated content and intellectual property, with learning outcomes and assessment developed with Maori health and education professionals, and supported as part of the Treaty agreement to Maori. It could be co-taught by pakeha and Maori or taught by those who understand the content and who have the skill and experience to deliver controversial material in enlightening and supportive ways.

Cultural safety in its broader context would then become the responsibility of all other teachers and be applied to the areas identified in the Nursing Council Guidelines throughout the rest of the curriculum. Integration of cultural safety could then occur without challenge to the integrity of Maori health and the Treaty.

Treaty of Waitangi courses for students and staff should continue as long as the education system in our country does not prepare New Zealanders to understand the Treaty and its implications, but the time has come for research into the effect of such education in practice to be undertaken.

The concept of transcultural nursing in current colonial New Zealand society should be constantly examined and debated. The traditional western anthropological stance of observation of *other* and the exploration of difference as a point of access to the lives of others assumes that people want their lives to be observed, predicted and responded to at the level of the exotic. My own academic training, experience as a member of

several marginalised groups in New Zealand, interaction with the health service as a consumer, as well as in practice and teaching tells me this is not so. People who have difference to protect from the powerful search first for the potential to trust. The *trust moment* may be fleeting and unspoken but the information load is high and influences all future interactions. Nurses are expert at creating and interpreting the trust moment but not at describing it as part of excellent practice. Establishing that moment is something we all do, or attempt to do. If trust does not happen very early in nursing interactions, people will continue to protect their difference from nurses and however transculturally informed we may think ourselves to be, we will not be seen as safe to practice by others.

Transcultural nursing could be seen by people who use the service of nurses as well meaning and naïve at best and stereotypically controlling at worst. In colonial societies there is an inherent history of distrust between the powerless and powerholders which must be understood in order to change practice.

To most people, nurses are *other*. Cultural safety therefore lies in the establishment of the trust moment and in shared meaning about vulnerability and power followed by the careful revelation and negotiation of the legitimacy of difference. It is our responsibility to translate the tired classroom clichés about respecting values and beliefs and the resulting behaviours into active and participatory practice.

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Experienced nurses and teachers and those who use nursing service could be creating or taking part in ongoing qualitative research which could help identify the intangible trust factors in nursing Maori people (and others) in all the neo-colonial diversity of the 21<sup>st</sup> Century. The development of a praxis which speaks of New Zealand nursing could evolve from this. The time has arrived for the collection of exemplars from teaching and practice and the writing of a New Zealand text book on cultural safety.

There is now an emergent academic literature on cultural safety across a range of areas. Papers have been written in *Medical Geography* and the *New Zealand Medical Journal*, references to cultural safety are appearing in material published in sociology and education as well as in nursing and midwifery. The report of the English Florence Nightingale Scholar who visited New Zealand to explore cultural safety in 1999 is expected early this year. There is growing enquiry from other countries, particularly those with histories of colonisation. The International Council of Nurses through New Zealand representation from NZNO has begun to consider the issue of cultural safety in education as an issue.

The extensive collection of media material including newspaper and magazine pieces, cartoons, letters to the editor, film and skits, will provide much fertile material for future scholars interested in issues of autonomy and the role of the media in the professional education of nurses and midwives.

In response to the Education Act 1989 the Treaty of Waitangi should be effective in all educational institutions which are funded by the Crown, but because this has not happened, the Treaty has not been translated into measurable actions by many polytechnics and universities. This has made it difficult for nursing and midwifery to gain support for Treaty based activities and for Maori to make the institutions accountable for their own decision making processes and outcomes.

The cultural safety ideas and development of pedagogy and praxis have been nurtured and matured over ten years by committed and increasingly able nursing teachers supported by their vision of better service delivery and a safer future for people who are different from the cultures of nurses and midwives. There are still few of them and they rarely have the opportunity to meet and compare experience. Their skills have been developed over a tough course.

It is not surprising to me that nursing has continued to address the issues of cultural safety. Nurses are at the forefront of social stress and are daily reminded of the human cost of power and resource differential. The sense of social justice in nursing has not been fully activated by nursing education but cultural safety has gone some way toward stimulating it.

My observation has been that the position of cultural safety is constantly being redefined to meet educational rather than service needs. In some places nursing education is still



meeting its own rather than community requirements. Negative Maori health indices have increased, very notably in mental ill health, as well as in conditions influenced by lifestyle and health care access. These facts have structural causes and continue to exist at the institutional level. They are based on ideological constructs which come from people. Nurses who have been educated to think critically should be able to identify such structures and their causes and create ways to transform them.

Looking back, appearing at the Select Committee of Education and Science in July 1995 and twice subsequently alongside friends and colleagues to present the case for cultural safety in nursing education was a pivotal experience for us all. As nurses we were clearly committed to the future of nursing and midwifery education and the autonomy of professionals to define it. As we worked together to demonstrate our expertise I was aware

of a modelling of a Treaty relationship as part of a process, still unmapped but full of powerful potential.

As a Maori woman, supported by our ancestors and by Maori people who accompanied us, I spoke for Maori autonomy, tino rangatiratanga as guaranteed in the Treaty of Waitangi. That work will continue.

The challenge for nursing to recognise that things have been wrong and need to change has formed the basis of cultural safety. Over the last decade many teachers and practitioners have risen to that challenge and created an educational response which is unique and committed to positive change. Cultural safety is part of the maturing of attitudes in our country and will continue to evolve. The process needs to be informed by practice supported by academic proof and rigour. Mostly it needs to be supported by our own ongoing search for excellence in service to other human beings.

## References:

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