Chapter Four

4

CULTURAL SAFETY: CULTURAL CONSIDERATIONS

Over the course of your nursing professional education, you will study the developmental tasks and the principles of health promotion across the life span. You will learn to conduct numerous assessments, such as a complete health history, a psycho-social history, a mental health assessment, a nutritional assessment, a pain assessment, a suicide risk assessment and a physical examination of a patient. However, depending on *your* reactions to the person there may be wide variations in the information you gather in these assessments and in the findings of the physical examination. In the 1980s there was a change in western nurse education that recognised the interaction between culture and health and since then many nursing degrees include cultural considerations in their Bachelor Programs. It is now imperative that you, as a health care provider, come to understand how culture influences health care.

However understanding the notion of culture in relation to nursing can present a confusing picture for nursing students. There is considerable variation in how culture is defined and approached and terms such as race, ethnicity, cultural competence, cultural diversity, and cultural inclusion add to the complexity and confusion. Further there are two major approaches used in nurse education to address issues of culture and health; transcultural nursing and CULTURAL SAFETY. Madeleine Leininger is generally considered the pioneer of the approach called transcultural nursing. This approach argues that to offer effective nursing care you need to have knowledge of the cultural heritage, language requirements, and culturally based health and illness BELIEFS and practices of the people for whom you are caring. Our focus is not on the culture of others as such, as we agree with a comment in an Australian national review of multicultural nurse education in 2001 that reported that Leininger's work, was 'criticised as being too focussed on the culture of the "other": presenting cultures as static and deterministic' (DEST 2001).

This text uses an alternative approach called CULTURAL SAFETY developed by Irihapeti Ramsden in 1990 in Aotearoa (NZ), which is centred on the nurse's self-awareness. So you will ask—who am I? Where do I come from? What is my ethnicity and what is my social and cultural background? What are my beliefs and values? What prejudices, stereotypes and attitudes do I hold about those I consider different to myself? How might my cultural identity impact on clients? Have I really listened to how *this* person experiences pain or have I made assumptions about their behavior? So CULTURAL SAFETY is not about cultural practices as such and it has an additional element in that it '…seeks to recognise the position of certain groups in society and *how they are treated rather than how they are different'* (DEST 2001 authors' emphasis). A focus on the current social crisis in health care for groups such as immigrants and Indigenous[1] people in political terms is a central feature of providing culturally safe care, so you will also need to become

[1] The term Indigenous is used in this chapter for brevity however it should be noted that Indigenous people of mainland Australia and the Torres Strait Islands comprise many different groups with language group names and other terms that they use to refer to themselves. Indigenous people also use terms to refer to themselves that are roughly based on state boundaries: **New South Wales**: Koori, Goorie, Koorie, Coorie, Murri; **Victoria:** Koorie; **South Australia:** Nunga, Nyungar, Nyoongah; **Western Australia**: Nyungar, Nyoongar ; **Northern Territory**: Yolngu (top end); Anangu (central); **Queensland**: Murri; **Tasmania**: Palawa, Koori. The term Aboriginal and Torres Strait Islanders tends to be used most often but remember that both the Torres Strait Island context and the mainland context are informed by locally specific cultural and historical backgrounds and are extremely diverse.

knowledgeable about the history of your country and how it functions socially to impact on the health of those in your care. A comment from an Indigenous student following a unit on CULTURAL SAFETY reveals these concerns:

> *"The best aspect of this unit for me was having a subject that I understand and can relate to being Indigenous. We have came a long way from not being citizens in our own country and all the rest of it to have my people fight for rights and it is a huge thing for me as a Murri to see my people and culture be recognised and educating mainstream Australians about it because it obviously needs to be done."*

The purpose of this chapter is:

1. Introduce the population contexts of Australia and Aotearoa[2]/New Zealand (NZ)
2. To consider the relationship between health and culture in Australian and NZ demographic contexts
3. To define culture, race, ethnicity and health
4. To consider ideas of cultural competence and cultural safety
5. To describe the position on Indigenous issues and cultural assessment of the Australian Nursing and Midwifery Council and the NZ Council of Nursing
6. To discuss the steps to *CULTURAL SAFETY* and strategies to achieve it
7. To describe methods for cultural considerations in assessment

COLONISATION AND THE CURRENT POPULATION CONTEXT IN AUSTRALIA

Given the history of colonisation in the Australian context, the population is comprised of First Nations peoples; descendants of European settlement and migrants. Before discussing more fully how culture and health care interact it is important for nurses planning to work in Australia to understand the context of their work in terms of the populations they'll be serving. This is true for both international and domestic students.

In the author's experience the former often have little understanding of Australian populations and their histories and the latter have variable levels of historical knowledge and a mix of attitudes towards various population groups. Some students carry unhelpful, entrenched and unexamined attitudes toward Indigenous Australians, mainstream[3] Australians or migrants generally depending on their families' backgrounds as Indigenous people or as new or earlier migrants dating through the last two centuries to the first fleets of migrants. Few domestic students have a good grasp of Australian history and in feedback many express dismay and surprise that they grew up in Australia and yet so little of this information was presented to them at school. Further their experience of society more generally hadn't exposed them to

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[2] **Aotearoa** is the most widely known and accepted Māori name for New Zealand. It is used by both Māori and non-Māori,
The word can be broken up as: *ao* = cloud, *tea* = white and *roa* = long, and it is therefore usually glossed as "the land of the long white cloud".

[3] Mainstream is used to refer to members of the dominant culture in Australia.

Indigenous Australians or the issues many face, as reflected in this comment from a student: "I was surprised to see the number of students that had never had any interaction with Indigenous Australians or travelled outside their birth city. It was good to see them able to discuss their own culture and learn of the suffering still inflicted on Indigenous persons. I later saw it as a relevant topic to those students".

Most students however are well aware that Australia is now a multicultural society, but perhaps less well known is that before the British colonised Australia in 1788 some 500 Indigenous language groups lived here for up to 80,000 years (Crisp and Taylor 2005 p 123; Colbung 1988). Further they were not the aimless wandering nomads so often depicted but lived in 'well defined socioeconomic, political, land-owning units' as Crisp and Taylor go on to note. From the perspective of Indigenous people then, the 212 years since colonization is but a moment in their overall history. This point is important because it explains why it is that Indigenous Australians consider themselves to be First Nations or Status People i.e. they have specific and enduring rights in Australia.

Some nursing students find it difficult to understand why it is that historical issues are so fresh in peoples' minds as they see colonisation as happening over 200 years ago, however the experience of colonisation is an ongoing process not a single event and it continues to be played out in government approaches to Indigenous people[4]. Unlike the New Zealand context (see below) the colonisation of Australia was enacted under the legal fiction of *terra nullius* (empty land) which left the way free for the newcomers to take possession of the land and morally justify the impact on Indigenous peoples. Many Indigenous people lost their lives through massacres, starvation, neglect and introduced diseases.

Further it was said of the Australian Indigenous cultures and the incoming colonisers that it would be hard to find such differing understandings of the world and humans' place in it. Country for Indigenous people was and is the source of their identity and the basis of their cosmological understandings of the universe; for the newcomers it was merely a resource to be exploited. The current crisis in Indigenous health that we see today is profoundly related to dispossession and removal from kin and county and related traditions including language and ceremonial (religious) life, which often reduced Indigenous people to the status of fringe dwellers in their own land during the 19th century. Further many were unable hunt or gather traditional foods and instead were forced to live on poor quality rations such as white flour and sugar and substances such as tea, tobacco and alcohol were introduced.

The 20th century brought complex legislative frameworks in all states and territories that attempted to control every aspect of their lives firstly under the banner of 'protection' since the authorities assumed that Aboriginal people would "die out". As in Aotearoa the authorities were concerned about increasing numbers of those they conceived of as "mixed-race"[5] children and set about developing policy and practice to remove "fair-skinned" children from their Aboriginal parents and kinship groups: those now generally known in Australia as "the stolen generations". When the state came to terms with the fact of continued Aboriginal existence the policy changed to assimilation where the goal was to train the stolen generations and

[4] See for example the Northern Territory Emergency Response discussed in Taylor and Guerin 2010 p 81-84.
[5] The concept of race (a social construction) is discussed later in this chapter.

Indigenous people more generally, to live like whites. In these complex processes families were fragmented by institutionalisation on government or mission reserves and reformatory schools and marginalization from the workforce, education and health services (see Reynolds 1982, 1990, 1996; Rintoul 1993; Kidd 1997; HREOC 1997). Indeed health services were involved in some of these processes. The result is that since health services are largely run by governments, attending them is often resisted as the experiences are bound up in fear and a lack of trust toward health services (see Forsyth 2007; Cox 2007). Historical processes, such as deeming petty misdemeanors a crime under the special laws on missions and reserves, also saw the widespread criminalization of Indigenous populations that we still see today in the overrepresentation of Indigenous people at all levels of the criminal justice system (Cuneen 2001).

Although in the late 1970s these special laws in the states and territories for Indigenous Australians began to be changed, the ideal of true self-determination is difficult to achieve without a treaty or proper political representation. Space does not permit us here to discuss Native Title and Land Rights and the ongoing struggles for people to be recognised in these processes given the many different contexts in which they live. Students are referred to Ritter (2009) for further information on these topics. The federal government finally made a national apology to Indigenous Australians in 2008 however adequate concrete compensation has never been realized.

It is also important to understand that Aboriginality or Indigenous identity is not about skin colour but is about relationships. Because of the lack of trust between mainstream health services and Indigenous Australians the latter began to set up their own primary health care services from the 1970s. These are known as Aboriginal Medical Services and their peek body the National Aboriginal Community Controlled Health Organisation (NACCHO) supports the nationally accepted means of determining Aboriginality. The definition has three-parts and all are needed for Aboriginality to be recognised: descent (the individual can prove that a parent is of Aboriginal or Torres Strait Islander descent); self-identification (the individual identifies as an Aboriginal or Torres Strait Islander); and community recognition (the individual is accepted as such by the Aboriginal or Torres Strait Islander community) (NACCHO 2007).

The estimated resident Indigenous population of Australia as at 30 June 2006 was 517,000 people, or 2.5% of the total Australian population. Like many colonised peoples Australian Indigenous people still experience widespread poverty, have lower life expectancy and poor health and they are more likely to be unemployed, experience housing problems and have poorer educational outcomes. Of the states and territories, NSW had the largest population of Indigenous Australians (152,700 people), followed by Queensland (144,900 people). The Australian Capital Territory had the smallest population of Indigenous Australians (4,300 people), while Indigenous Australians comprised 30% of the population of the Northern Territory (ABS 2006a). An issue that many Indigenous and mainstream Australians have in common is religion as 73% of Indigenous Australians who answered the question about religion in the census were of a Christian denomination (ABS 2006c).

Another point of interest for students is that more than one in five Australians were born overseas which means that you, your colleagues and your clients will come from a range of ethnic and cultural back-

grounds. According to the 2006 Census, the proportion of the population born overseas hasn't changed since 1996 and is 22% of the total population. The overseas-born population increased in number between 1996 and 2006 by 13%, from around 3.9 million to 4.4 million. The two largest overseas-born groups were born in England (19% of all overseas-born) and New Zealand (9%). China overtook Italy as the third largest birthplace group (each country accounting for around 5% of all overseas-born). Around 2.1 million of Australia's overseas-born population is European. Of particular note for nursing is that a number of Australia's recent arrivals were born in countries recently affected by war and political unrest. Over 73% (or around 14,000) of Australian residents born in Sudan arrived in 2001 or later. Likewise, a high proportion of the populations born in Zimbabwe (48% or 10,000 people), Afghanistan (45% or 7000), and Iraq (34% or 11,000) arrived in 2001 or later. Since 1996, the groups which increased the most in number were those born in New Zealand (by around 98,000), China (96,000), and India (70,000) (ABS 2006b).

Since communication is central to nursing care it is important that students understand the diversity in this area too. The Australian Bureau of Statistics reports that there are over 60 languages spoken by Aboriginal people and Torres Strait Islanders and an additional 200 languages other than English spoken in the Australian community. The 2006 census found that 11% of all Indigenous Australians spoke an Indigenous language at home and in the Northern Territory 54% of Indigenous people spoke an Indigenous language at home. Further 16% of the total Australian population didn't speak English at home. There were also important variations in English proficiency amongst those who spoke another language based on their age and their place of birth. THE ABS estimates that 84% of all people younger than 25 years who spoke another language at home spoke English well or very well, compared with 60% of those aged 65 years and over. People born in Australia who spoke a language other than English at home could generally speak English well (ABS 2008).

COLONISATION AND THE CURRENT POPULATION CONTEXT IN AOTEAROA (New Zealand)

Most people living in Aotearoa/New Zealand (NZ) know something of the history of the land, in as much as Mäori settled Aotearoa [the land of the long white cloud] from the Pacific over 1000 years before European explorers started arriving. Pre European contact saw Mäori as a people deeply connected to the land and natural world around them (Consedine & Consedine, 2001, p 80). Their societal life structures were based on kinship and tribal affiliations, laws were based on custom. When the British began their antipodean colonising they initially opted for the larger continent of Australia and it was the sealers and whalers who set up temporary residence in Aotearoa/NZ. Eventually more settlers arrived and by the early 1800's population numbers of European were believed to be around 2000. Numbers of Mäori at that time are estimated be around 125 000 (Waitangi Tribunal 2010).

In 1838 the British sought to annex Aotearoa/NZ due to numerous unscrupulous purchases of Mäori land and the lawlessness that had arisen amongst the people. On 6 February 1840 a treaty was drafted (the Treaty of Waitangi) and signed by the English, and approximately 45 Māori Rangatira (chiefs). As well a

Māori text of the Treaty (Te Tiriti O Waitangi) was taken to northern parts of the country and copies were sent to other areas of the land to obtain additional Māori signatures. In signing the Treaty, the chiefs are believed to have yielded their sovereignty to the Queen of England in exchange for the Queen's protection and the granting to Mäori the same citizenship rights, privileges and duties enjoyed by citizens of England. Remember this is the land initially occupied by Mäori. The Treaty also guaranteed Mäori possession of their land however with a stipulation they could only sell their land to the Crown. The Treaty was to recognise Aotearoa/NZ at that time as one nation but two people: the indigenous Mäori people, and non-Mäori, mainly European settlers and their descendants.

Initial reading of the Treaty seemed to promise benefits for both sides, but when more and more settlers arrived they wanted to buy land. If Mäori did not wish to sell conflict would eventuate. Many lost their lives in the wars that erupted. But it was not only the wars that eroded the Mäori population as European introduced diseases to which Mäori had little or no natural immunity. Loss of land also saw many living in poor conditions in makeshift camps with poor sanitation. By 1900, the Mäori population had dropped to an estimated 45,000 (Consedine & Consedine, 2001, p 99) and Maori were seen by the settlers as a "disappearing race". Their tikanga (general behaviour guidelines for daily life and interaction in Māori culture, commonly based on experience and learning that has been handed down through generations) was also being eroded. This wearing down of the fabric of Mäori life has continued until today.

The intent and provisions of the Treaty of Waitangi were largely ignored until the 1970's, when legislation was introduced requiring statutory bodies and government to undertake their responsibilities in a manner consistent with the founding promises of the Treaty. In 1975 the Waitangi Tribunal (refer to http://www.waitangi-tribunal.govt.nz/) was established to consider claims by Mäori against the Crown regarding breaches of principles of the Treaty and to make recommendations to the government to provide recompense. Since 1985 the tribunal has been able to consider acts and omissions by the Crown dating back to 1840. This has provided Mäori with an important means to have their grievances against the actions of past governments investigated. Aside from these actions and grievances, attention and awareness is now also on the aforementioned health and social disparities and there is a focus on improving the health and social status of Mäori whilst recognising and respecting all aspects of cultural being.

The legacy from those early years has resulted in a society with "major ethnic and cultural disparities in health status and most other markers of Indigenous wellbeing" (Kearns, Barnes & McCreanor, 2009 p 124). Aside from the loss of land Mäori experienced loss of their language, and their cultural way of being. They are over represented in nearly all negative social and health statistics, for example unemployment, poverty, housing, income, education, youth suicide rates and general health and wellbeing. Kearns et al. (2009 p 124) suggest that the processes of colonisation such as that which Mäori experienced resulted in the "denigration, marginalization and alienation" of the very essence of their culture. Consedine and Consedine (2001, p 218) suggest that as a result of this colonisation there was only

> "…one way to deliver justice, health and education, one approach to conservatism and only one law and language that mattered. Assimilation was predicated on the assumption that Maori tikanga [cus-

toms] was irrelevant if Maori were to succeed; everything had to be done the 'white way. The result is that the infrastructure of New Zealand Society is structured to deliver white privilege. Only the exotic features of Maori culture were encouraged, where they benefitted the country in areas such as tourism and sport".

Whilst the majority of early settlers were British since then people have arrived from parts of Europe as well as Asia. In the second half of last century following the world wars a significant migration of people from the Pacific had begun (Khawaja, Boddington & Didham, 2007). The population of Pacific peoples grew quite rapidly during the late 1960's and early 1970's, and caused a great deal of racial tension at times with both Mäori and non Mäori groups. An important aspect in reducing this tension and ultimately accepting pacific groups was in the formation of partnerships with various community groups and activities as well as an increase in intermarriage. By the late 1990's a large proportion of Pacific people were born in New Zealand and increasingly their children were also of Mäori and other ethnic descent. The other major population group to appear was Asian. Arrival of Asian groups actually predates the Pacific groups although in much smaller numbers. Many arrived in the late 19th century during gold rush days. Later in the 20th century the number of different Asian groups increased dramatically and at the 2006 census they had exceeded the Pacific groups in population numbers. Much more recently, refugees and other settlers from Africa and the Middle East have arrived.

The diverse generations born and arriving in Aotearoa /NZ since the first colonial settlers have afforded opportunities for miscegenation [a very old term referring to the process by which children are born to parents who were assumed to be of different 'races'] of New Zealand's population groups (Khawaja, Boddington & Didham, 2007). As suggested earlier, although colonial thinking was that Mäori would eventually disappear or be absorbed into the European population this assumption has been discredited. However it is this thinking that firmly influenced the collection of official statistics for much of the 20th century. Khawaja et al. (p 5) refer to the routine assignment of "ethnic grouping on the basis of ancestry (degree of blood), with little or no regard to lifestyle, culture or beliefs".

The population census of 2006 (Ministry of Social Development, 2009) reveals almost 3 million (77%) European, just over half a million Maori (14%) and the rest made up of Asian (9.2%), pacific (6.9%) and other (0.9%) respectively. In considering these statistics and our previous comment about children being born to people of different ethnic identities can you see a problem? Think about the diversity of people reporting on a census. The numbers reported in any census are based solely on the number of people identifying with each ethnicity (Ministry of Social development, 2009). Therefore figures for the ethnic distribution can be assumed to be based on the number of people identifying with each ethnicity. Because people can identify with more than one ethnicity, the total number of ethnic responses may be greater than the number of people. Consequently understanding ethnicity is important and having a mutual understanding of this might be even more important. This is however not so simple and later in this chapter we explore the ideology of ethnicity.

Suffice to say in summary that Indigenous groups have their own structural, institutional and interpersonal philosophies and practices from which they operate. Nonetheless colonised societies such as Aotearoa/NZ and Australia develop to fit the lifestyle, values, priorities and beliefs of the incoming dominant cultures and so the culture of the colonisers becomes the "norm" in society's main institutions such as health, education, welfare, corrections, the media and so on. It is this kind of sometimes hidden but always present cultural dominance and unexamined privilege that the practice of cultural safety, to be discussed presently, seeks to overcome. For example in Australia the NHRRC (2008, p. 211) noted that "Generally, the health system delivers services in a way that is better suited to the needs of the broader population rather than the particular needs of Aboriginal and Torres Strait Islander people".

DEFINITIONS OF CULTURE, ETHNICITY, RACE AND HEALTH

Before we can begin to consider cultural assessment issues we need to be clear about what we mean by the various terms used in this context. The common terms used include; culture, ethnicity, race and health. Whilst there are numerous definitions of these terms we have taken a constructivist view, referring to the notion that humans create ideas about culture, ethnicity, race and health. That is such concepts don't just appear from nature but are constructed by humans to serve certain purposes at certain times.

Culture

Some definitions of culture focus on material culture: art, dress, artifacts and so on while others focus on the capacity of humans to symbolise their world and experience through language, religion, kinship and so on. Many definitions discuss cultures as bounded wholes where members share systematised/patterned values, beliefs and so on. We particularly like the definition in Kluckhohn and Kelly (1945, p. 97) as it indicates the **importance of history** for our cultural identity and it is clear that culture is created and acts as **potential** guides to action: "By culture we mean all those historically created designs for living, explicit and implicit, rational, irrational, and nonrational, which exist at any given time as potential guides for the behavior of men...culture is constantly being created and lost." Such definitions can be contrasted with other versions that suggest that cultures are unvarying bounded canons of beliefs and practices that all members of a society embrace to an equal degree.

Our view of culture is grounded in the idea that cultures are dynamic and adapt to new circumstances and that are learned…that is one is **born into a culture not born with culture**. Further we assume that culture is strategic as we emphazise or deemphasize aspects of our culture depending on current needs and circumstances. So we are less interested in Culture (for example high art or classical artistic traditions) and more interested in culture as the everyday meanings and motivations in peoples' lived experience and how they make sense of life experiences such as illness and explain it to themselves.

Further for our purposes culture includes but is not just about ethnicity and customs such as food, dress and religion, beliefs and values-it addresses differences in socio-economic status, age, gender, sexual orientation, ethnic origin, migrant/refugee status, religious belief, values, disability and power relations

(Eckermann et al. 2006 p 2). It is crucial that you can distinguish ethnicity from culture and to do this think about the culture of nursing or policing for example which have nothing to do with ethnicity, food and so on but are about ways of doing things and thinking about things. Does this mean all nurses do things and think the same things? NO! Culture is always learned, dynamic, changing, and strategic. It is negotiated and expressed and understood differently by individuals who identify with a particular culture. Culture is about everyday ways of doing things and is often unconscious as people cannot always tell you why they do things a certain way but will say that's just how something is done. Part of your challenge is to bring your cultural assumptions to mind, an issue discussed further below.

Ethnicity

As indicated above ethnicity is distinguished from culture and refers to socially constructed group identification or belonging based on familial descent (kinship) and history and traditions in language, food, dress and so on. In multicultural Australia—with Aboriginal people and Torres Strait Islanders being the only true Indigenous populations—mainstream Australians are still reluctant to speak of ethnicity and ethnic differences in relation to their own identities. At the beginning of one unit on CULTURAL SAFETY students are asked to tell the group about their cultural *and* ethnic identity. Many mainstream Australians often have difficulty doing this and say things like "I don't have an ethnic identity" or "I'm *just* Australian'. Consider this comment by a student in her reflection on a unit of study focusing on CULTURAL SAFETY: '*Learning about cultural safety, was great! Never actually sat down and thought about my own personal culture before. Very rewarding*'!

This stance of thinking that culture and ethnicity is only about 'others', stems from the fact that mainstream Australians come from generations of people born in Australia, a country with a long tradition of seeing ethnicity and culture as belonging solely to people of colour or to 'the others from elsewhere' not realizing that ethnically speaking this includes them. We only have to reflect for a moment on the term 'culturally and linguistically diverse background'. Commonly rendered as CALD in government policies in Australia, it is a hold all phase to describe immigrants and implies that culture and diversity belongs to immigrants not to 'us'. An Australian Google search using CALD will yield many hits that make this point evident. Further new comers are expected to assimilate to the mainstream culture which is particularly evident in the process of becoming an Australian citizen, where one has to undergo a citizenship test (see http://www.citizenship.gov.au/).

Early thinking in both Australia and Aotearoa/NZ around ethnicity was related to biological lineage only. To take the Aotearoa example, if your father was "full-NZ Mäori" and your mother non-Mäori you were considered by default ethically "half-Mäori" regardless of your cultural beliefs, upbringing or cultural affiliations. In current usage, the term ethnicity is generally used to refer to the ethnic group or groups a person identifies with or feels they belong to. It is also now recognised that individuals may identify with more than one ethnic group. Many New Zealanders, and Australians, no longer feel any links to the cultures to which their ancestors may have belonged but do not have a well established alternative ethnic identity either.

An example of this is the term New Zealand European often used on data collection sheets and there are now many generations of New Zealanders who feel no linkage to their European ancestors and express a reluctance to note this term in relation to their ethnicity (Statistics New Zealand, 2005).

RACE

Race is commonly perceived by many as a way to identify differences not only in skin color and physical attributes but also in language, nationality, and religion. According to Rapport and Overing (2007 p 15) the idea of race became strong in the middle ages from Greek and Roman travel lore. As they say 'the imagery of the brutish giant- the naked, cannibalistic, Wildman...caught the imagination of medieval Europe'. These images were applied to European lower classes and 'such "inferiorisation" of excluded others became a constant throughout the development of European thought' (Rapport and Overing 2007 p 15). Around the 1940's, scientists began to realise that the 'racial atlas' of humans did not match what was being learnt about human genetics (Montagu, 1962). There are no significant genetic variations within the human species to justify some kind of grouping of "races". Although the concept of race insists there is some genetic significance that creates variations in skin color, we know that race has no scientific merit outside of this sociological classification.

So just like the concepts of health and culture, race is a social construct and, since there are no distinct evolutionary lineages among humanity, there is no biological basis for race. In fact "there is more genetic similarity between Europeans and sub-Saharan Africans and between Europeans and Melanesians than there is between Africans and Melanesians. Yet, sub-Saharan Africans and Melanesians share dark skin, hair texture and cranial-facial features, traits commonly used to classify people into races" (Templeton 1998; also see Templeton 2002; 2007). Nonetheless race categories are often used as ethnic intensifiers, with the aim of justifying the exploitation of one group by another. Also referred to as scientific racism there is in fact no scientific basis to these ideas, as in evolutionary terms all humans are modern humans and there is therefore also only one human race genetically speaking.

In keeping with the above, historically the concept of race was used to support claims by Anglo-Saxons that they were superior to all other people and that this gave them the right to control other people and to take their land for example. This assumed superiority of some groups over others is also called 'social Darwinism' a theory advanced by Herbert Spencer by applying biological evolutionary theory to social life linked to ideas such as the great chain of being (Fig 1 below). Because dominant cultures are so used to thinking in terms of race, this information is hard for many to accept, but the variation in how humans look can be understood in terms of familial descent not discrete races of humans.

Figure 1 Race Overview

- Historically the concept was used to say some people were inferior to others
- At first women placed as inferior to men but then –people of colour lower than white women and so on
- 'Social Darwinism'-the idea that white races were superior
- Whites destined or had the right to rule over others
- At its worst ideas of the superiority of white people led to Hitler's fanatical eugenics and justified all forms of imperialism as happened in Australia.

Figure 2 The Great Chain of Being and misguided social hierarchy

Great chain of being	**Misguided Racial Hierarchy**
• God • Angels • Demons • Man • Woman • Animals • Plants • Minerals	• Anglo Saxons/Europeans • Asians • Africans • Aborigines

Some people such as Australian Indigenous people have been distinguished, categorized and subordinated across history due to notions of being of a certain race. This is racism; treating people not on the basis of their humanity but on the basis of 'race'. Health inequality is often seen as natural and inevitable based on so called 'scientific racism'. In fact social marginality is the result of specific policies, laws, historical events and cultural contexts. A "blame the victim approach" saying "they brought it all on themselves", just like ideas of race and racism, is used to justify or perpetuate structural inequality. Clearly there are differences between people in terms of culture, ancestry and language. There are also different nationalities depending on where one has full citizenship rights. Further as a **social construct** race is reclaimed by many of those who were categorised and inferiorised by the use of the concept. The use of the term race, identifying pride in belonging to a group long subjugated on this basis, is a strategic reversal of inferiorisation so when someone says that they are from a particular race based on history, nationality and geography, their right to reclaim this social construct and use it is this way must be respected**.**

HEALTH

Üstün & Jakob (2005, p 802) discuss the recency of notions such as 'health' demonstrating that concepts that we take for granted as givens are constructed by humans. These authors also critique the WHO definition of health. The WHO define it as: "a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity". They note that for anyone to maintain a *complete* state of well-being may not be realistic but for our purposes it is important that you understand that *health is not just about the absence of disease* as it may be defined in western medical terms, but is about the whole person within their life context. This contextual aspect is captured in the Australian Indigenous definition of health

also quoted by Üstün & Jakob (2005, p 802): "Health does not just mean the physical well-being of the individual but refers to the social, emotional, spiritual and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life".

For Maori "health" is also realised through an understanding of an holistic health model. Te Whare Tapa Wha the most commonly used (but not only) model is known as the four cornerstones of health. This approach compares health in relation to the four walls of a house where all four walls are necessary to ensure strength and symmetry (Durie, 1994, p 70). It can be applied to any health issue affecting Maori from physical to psychological wellbeing. Looking after all aspects of wellbeing (the four walls) are, **taha wairua** (spiritual), **taha hinengaro** (mental and emotional), **taha tinana** (physical) and **taha whanau** (family) considerations. Together all four are necessary and when in balance, they represent 'best health'. Accordingly if any one of these components is deficient this may impact negatively on a person's health (Durie MH and Kingi Te KR 1997).

Understanding health from a traditional biological model saw the attention on treating symptoms with drugs and or surgery. Today nurses are taught to care for people within an holistic model, where the focus is on finding the underlying cause of the symptoms and making life style changes that are conducive to health. There is a strong emphasis on personal responsibility where the client is encouraged to be an active participant in their health care plan. The relationship between the patient and the health care provider is co-operative and complementary. They work as a team. The patient therefore is the authority on their body and becomes the expert in caring for themselves. Mainstream holistic health care is similar to the Indigenous models previously discussed in acknowledging that all people have physical, intellectual, psychological, social, emotional, and spiritual needs. The neglect of any of these areas may reduce the ability to withstand the effects of stress and ill health.

CULTURAL SAFETY

"Maa te matatau, ka tau te whiringa – with awareness comes choice" (Clear, 2008)

Early nursing understandings in Aotearoa/NZ (late 19th to early 20th C) and Australia saw culture as a racialised term (the racialised other) used mostly to refer to the visible difference between the original inhabitants and settlers. Nurses were considered to be the "humanitarian bearers of civilised health care" for the natives who were in need of civilising to the perceived dominant culture (Spence, 2001, p 52). As the century went on, nursing interest in culture generally declined although some nurses chose to explore it further in university studies in the social sciences and anthropology.

As indicated in the introduction to this chapter, around the 1970's awareness re-emerged regarding the relationships between nurses and patients and the term culture once again devloped meaning (Spence 2001). A new ideology, 'transcultural nursing' arose, authored by Madeleine Leininger. Nurses were to learn the health care needs of specific minority ethnic groups. In transcultural nursing (where the articulation of cultural differences from the dominant group are exposed), perceived cultural differences are learnt and used

as a checklist of things to do and not do. In transcultural nursing the nurse undertakes study to learn the specifics of other cultures (mostly within an ethnic sense) and then is deemed to know what individuals from the culture need. The consequence of such an approach is perhaps best summed up in the following quotation:

> *No need to hear your voice when I can talk about you better than you can speak about yourself …. Only tell me about your pain. I want to know your story. And then I will tell it back to you in a new way. Tell it back to you in such a way that it becomes mine, my own. Re-writing you I write myself anew. I am still author, authority. I am still colonizer, the speaking subject and you are now the center of my talk.* (Hooks, 1994, p. 343)

The key point being made in this quote is that the unique experience of the client becomes that of the nurse and the person is expected to behave in a particular way because they belong to a particular group. Because the nurse has studied this group they assume they can determine what the person needs. This model was not fully embraced in Aotearoa/NZ or Australia, although one of the authors can recall her nursing student days being directed to visit various cultural (religious) sites to interview key leaders and ask them what their particular beliefs were around health care practices. As a student she then had to write a report describing particular health preferences for these groups. An assumption, made then by the students was that they would now know how to nurse a person from that group if they come into hospital. However, we don't accept this argument. We focus on holism where students are taught to assess and respond to the biological, psychological and social needs of clients. The transition to culturally safe nursing from this point is then seem much simpler.

> The Australian Nursing and Midwifery Council defines CULTURAL SAFETY as:
>
> 'a nurse or midwife's understanding of his or her own personal culture and how these personal cultural values may impact on the provision of care to the person, regardless of race or ethnicity. Cultural safety incorporates cultural awareness and cultural sensitivity and is underpinned by good communication, recognition of the diversity of views nationally and internationally between ethnic groups and the impact of colonisation on Indigenous cultures around the world'. (ANMC 2006, p 1)

Inherent in the model of CULTURAL SAFETY we are promoting is the position that efforts to describe the practices, beliefs and values of each culture should not occur, as this promotes an ideology of sameness and an erroneous assumption that culture is a simplistic concept which can be captured in lists of things to remember and do. It is this check-list mentality that is intrinsic to transcultural nursing. If this were true think then about yourself being the recipient of nursing care. What do you need the nurse to know about you? Will that be the same as the person next door who may come from the same ethnic group as you? What if there are two Vietnamese people in hospital and one happens to also identify as gay. Are their needs the same as they both identify as Vietnamese? We want to stress that each person is an individual with many unique ways of being. Therefore the underpinning philosophy of CULTURAL SAFETY is that each person should be nursed 'regardful of all that makes them unique', encompassing their cultural, emotional, social, economic and political contexts in which they live (Ramsden, 1993 & 2002).

CULTURAL SAFETY is a term initially unique to Aotearoa/NZ and nursing education. The pioneer of the concept is Irihapeti Ramsden. The concept of **kawa whakaruruhau** (cultural safety) arose out of a nursing education leadership **hui** held in Christchurch, NZ in 1989 in response to re-

cruitment and retention issues of Maori nurses. The CULTURAL SAFETY guidelines were initially written by Irihapeti in 1991 and further developed by a council committee and Irihapeti. By 1992 the Nursing Council of New Zealand had adopted the following definition of CULTURAL SAFETY:

> The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability (Nursing Council of New Zealand, 2009 p 9).

CULTURAL SAFETY relates to the experience of the recipient of a health care service. It provides consumers of heath care services with the power to comment on practices and contribute to the achievement of positive health outcomes and experiences. By this process the meaning and experience of their illness is validated rather than challenged by biomedical understandings. In doing this they also then have the ability to provide feedback on any negative experiences. The process inherent in CULTURAL SAFETY education includes exploring the culture of nursing, recognising the impact that personal culture has on professional practice and the subsequent power relationship between nurses and consumers of nursing care (NCNZ, 2005). CULTURAL SAFETY then "…contends that people are so diverse that teaching simple ritual and custom stereotypes and rigidifies ideas of culture and does not allow for human diversity (nurse or patient), nor does it take into account historical effects and socio-economic status" (Ramsden, 1996 cited in Ramsden 2002 p 110). Ramsden (2002, p. 109) explained that:

> "CULTURAL SAFETY is based in a postmodern, transformed and multilayered meaning of culture as diffuse and individually subjective. It is concerned with power and resources, including information, its distribution in societies and the outcomes of information management. CULTURAL SAFETY is deeply concerned with the effect of unequal resource distribution on nursing practice and patient wellbeing. Its primary concern is with the notion of the nurse as a bearer of his or her own culture and attitudes, and consciously or unconsciously exercised power".

Ramsden talks here about the nurse as a bearer of culture. Have you ever thought of yourself as a cultural being? Ramsden maintains that nurses must understand their own culture in order to fully respond to the culture of others. How do you do this? What do you need to do?

Self reflexivity and self-awareness

Self reflexivity or self awareness is the ability to locate oneself in terms of culture of origin and culture of choice. Self-awareness of one's own culture, biases, and beliefs is a necessary step in culturally safe practice. If we just learn about others in order to become culturally competent we are acting in a self limiting way and at risk of reinforcing stereotypes. To truly understand how to relate to others, you must first understand yourself which requires personal self-reflection and self-critique of the various personal, historical and social influences that impact on you. Do you know what cultures you identify with? Students often find this process of self-awareness highly rewarding as shown in this student's comment: The personal reflection that was common in this unit opened a side of myself that I had never ventured to, made me really think where I had come from etcetera.

In Figure 3 below are some guidelines to help you become self aware.

Figure 3 STRATEGIES FOR SELF AWARENESS

Think about your own cultural groups. List them. What is your way of living within your group/s? (Think about age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability). Are there groups within these ranges that you can identify with?
Think about the agents of socialisation that have impacted on you as you have grown up (family, school, peers, the media). What have you learnt from them regarding health care practices? What are the values you have learnt from your family? Do you still hold these values today? Do these values guide your decision-making and how you see the world? Are they something that (may) affect your practice as a nurse?
Think about the customs you and your family have around events such as birthdays, Christmas, funerals, weddings. What about the types of food you eat? How many people live in your house, is it just your immediate family or is it extended? Ask yourself: Are they different from what other people do? (Think about your friends, people you work with or people from a different culture). How are they different?

A newly graduated registered nurse in Aotearoa/New Zealand reflected on her CULTURAL SAFETY education stating:

> *"I can remember finding the concepts quite confusing initially. I think it was because I had trouble distinguishing them from a more transcultural perspective, as I thought it was concerned with learning about specific cultural differences and applying those in practice to various groups (i.e.: Maori, Muslims etc). My understanding of cultural safety now is about knowing my own assumptions and being mindful about how this might impact on interactions. There was an element of learning specific cultural requirements (like Tikanga protocols) and I remember enjoying this very much. On the whole though cultural safety prevents us taking a one size fits all approach to care."* (Personal communication, A Helen, July 10, 2010)

The misunderstandings

Many individuals when they first come across the term CULTURAL SAFETY immediately think about race and ethnicity. Common statements heard are "when I nurse people I don't see colour; we're all equal"; and "I treat everyone the same". The problem with this thinking is that treating everyone the same is a denial of inequality. If colour doesn't matter then why are there so many disadvantages or even entitlements that go with your skin colour or with your family's cultural membership? An individual's culture of origin and colour does matter in a culturally unsafe world as it brings different privileges, assumptions and varying levels of influence over health outcomes. Consider this story by nurse academic Professor Margaret Pharris (2209, p 10):

> Upon arrival at the ED, I took a report from an excellent White nurse, She and a very fine White physician had both been caring for two young women who happened to arrive to the Ed at the same time…both presented with 9 out of 10 flank pain, indicative of kidney stones. After receiving report, I went to assess the patients, The first…a White woman, was lying on a ED bed dressed in a patient gown and wrapped in a warm blanket. She had received a significant amount of morphine… The second… a Black woman, was in a fetal position in the procto room, was still in her street clothes, and had received nothing for pain…it hit me that I might not have noticed this inequality had I not come directly from the dialogue about racism and health care. I wondered how much else I was missing?

The power you have as a nurse in a health care relationship is well illustrated here and often is about your proximity to the cultural norms of the country you are in. Reflecting similar problems in Australia the National Health and Hospitals Reform Commission reports that: "Available data tells us that Aboriginal and Torres Strait Islander people don't systematically receive the levels of care, investigation and follow-up that clinical pathways recommend" (NHRRC 2008, p. 211).

Biculturalism is a key element of CULTURAL SAFETY theory and asserts that all encounters are bicultural as they involve the culture of the nurse and the culture of the client. This is in contrast to transcultural approaches that do not recognize the power differences inherent in approaches that always assume the client is the exotic one and that nurses and health systems are somehow free of culture. Further, individuals have different abilities to exert control and influence in situations or relationships. Many power relations exist within our social, economic, and political structures and institutions. Power and control are often hidden or unwritten and are usually vested in members of the dominant group.

Culturally safe nursing is the effective nursing practice of a person or family from another culture, and is determined by that person or family. The nurse delivering the nursing service will have undertaken a process of reflection on their own cultural identity and will recognise the impact that their personal culture has on their professional practice. This is about recognising our own values and beliefs and being able to acknowledge that others will have similar or very different values and beliefs to ours. That does not make theirs wrong. It is by acknowledging and respecting the beliefs of others that we minimise the impact of cultural dominance in health care.

Unsafe cultural practice is any nursing practice which diminishes, demeans or disempowers the cultural identity and wellbeing of the individual (Nursing Council of New Zealand, 2009, p. 4). CULTURAL SAFETY is about absence of discrimination and about behaviour that ensures that staff and clients are valued and respected and being included in decision making. The primary focus needs to be on the bi-cultural partnership where each nurse-client encounter is a genuine meeting of two different and unique cultures. Both parties engage in this meeting in the knowledge that they bring their own unique culture to the encounter (Ramsden, 1993).

CULTURAL SAFETY is underpinned by communication, recognition of the diversity in worldviews (both within and between cultural groups), and the impact of colonisation processes on minority groups. CULTURAL SAFETY is an outcome of nursing education that enables a safe, appropriate and acceptable service that has been defined by those who receive it. As Ramsden put it: "In the future it must be the patient

who makes the final statement about the quality of care which they receive. Creating ways in which this commentary may happen is the next step in the cultural safety journey*"* (Ramsden 2002, Chapter 11, paragraph 13).

A new graduate nurse reflecting on her experience learning about CULTURAL SAFETY as a student describes a clinical situation which helped her make sense of her learning:

> "Our cultural safety education was awesome; I just went to an in-service session at [hospital] a few weeks ago about cultural competency, and a lot of the stuff we were taught in nursing school was in there. Cultural awareness is a massive aspect of my nursing... the best point I took from it all was to take cues from the patient/service user. If I'm not sure, I ask the service user directly... they know their own culture best. I recently had a patient with a 'Buddhist outlook on life', I offered to access some support for him, but he declined stating that he doesn't practice; he just shares some of the same views. So it would have been inappropriate to access that support for him, however it was appropriate to ask. Another person might have the same view AND want to access spiritual support... I also think the biggest thing to cultural safety is being aware of my own culture. I'm working on this all the time and exploring it during my supervision". (G Yates, Personal Communication, July 1, 2010)

Figure 4 The process toward achieving cultural safety in nursing practice.

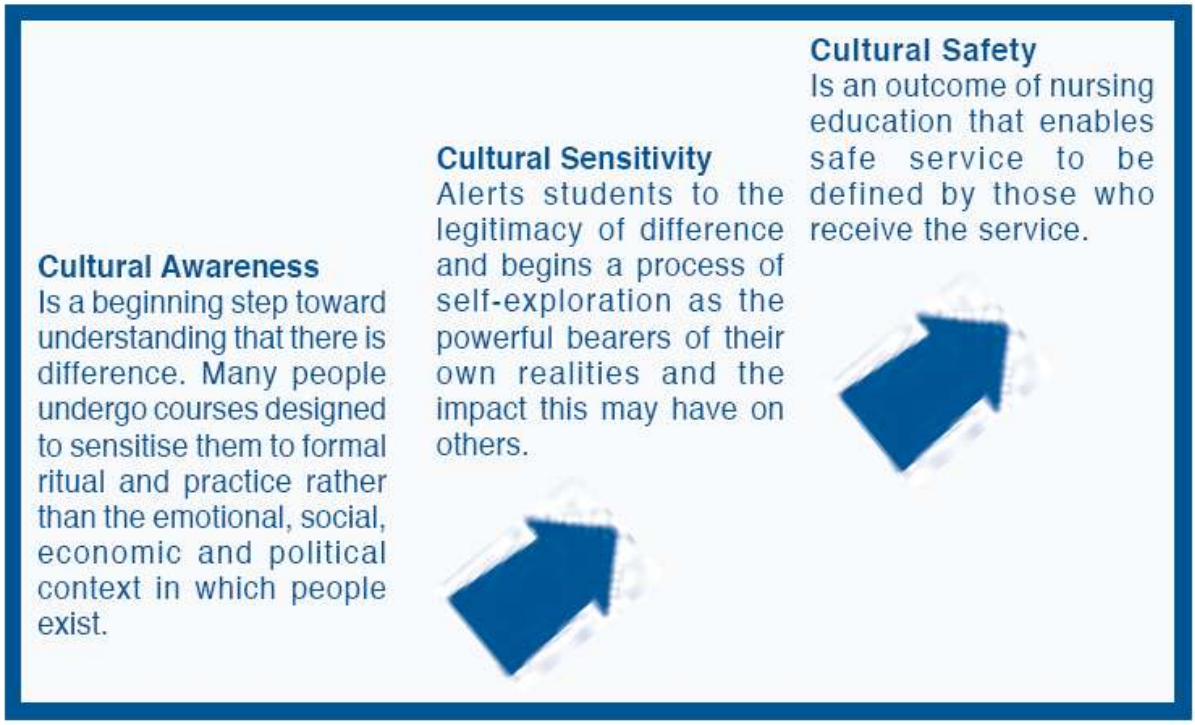
- Know your own journey and accept that your way of knowing and doing things is not the only way
- Seek relevant cultural knowledge – ask questions
- Never assume you know
- Show respect – ask permission
- Engage community accompaniment – find allies, contact cultural advisors
- Always be respectful and collaborative
- Remember that therapeutic nursing practice is grounded in relationships
- Be aware of your timing. Ask yourself "Is this the right time to be offering this particular form of service?"
- Focus on family-centered care, when possible
- Remember the best solutions are found through collaborative problem solving vs. expert/authority
- Every situation should be reciprocal and mutual
- Be aware that old and new forms of colonialism deplete cultures, communities, and roles for families
- Think about informed consent and what you may need to do to ensure it is understood
- Don't demean, disempower or diminish others' choices

Cultural Safety Education

The purpose of CULTURAL SAFETY in nursing education extends beyond the description of practices, beliefs and values of ethnic groups. As we now know, confining learning to rituals, customs and practices of a group can be misleading and does not address the complexity of human behaviours and social realities. This assumption that cultures are simplistic in nature can lead to a checklist approach by service providers, which negates diversity and individual consideration. CULTURAL SAFETY education is focused

on the knowledge and understanding of the individual nurse, rather than on attempts to learn accessible aspects of different groups. A nurse who can understand his or her own culture and the theory of power relations can be culturally safe in any context (see figure 5).

Figure 5 The process toward achieving cultural safety in nursing practice (Ramsden 1992).



According to Ramsden, cultural awareness is the beginning step in the process of learning CULTURAL SAFETY, which involves understanding difference, while cultural sensitivity is an intermediate step where self exploration by the student begins. CULTURAL SAFETY is an outcome of learning that enables a safe, appropriate and acceptable service, defined by those who receive it. CULTURAL SAFETY is underpinned by communication, recognition of the diversity in worldviews (both within and between cultural groups), and the impact of colonisation and ongoing marginalisation on minority groups.

CULTURAL COMPETENCE AND CULTURAL SAFETY

As we indicated at the beginning of this chapter there are many terms and approaches used to describe what is often called being 'culturally competent'; there are countless ways by which this can be achieved and here we've focused on the approach of CULTURAL SAFETY. Further there are many definitions of cultural competence that combine aspects of CULTURAL SAFETY and transcultural nursing, arguing that nurses need cultural self-awareness and knowledge about the health beliefs and practices of various cultures (See for example Munoz and Luckmann 2005 pp. 47-49; Hines-Martin and Pack 2009 pp.159-160). The aspect of cultural self-awareness fits well with the concept of CULTURAL SAFETY as 'cultural safety does not ask nurses to discover the cultural dimensions of any culture apart from their own' (Dowd et al. 2005, p 9 cited in Eckermann et al 2006, p 166).

Likewise Fitzgerald's definition (1999 cited in DEST 2001), says that cultural competence is 'the

ability to identify and challenge one's cultural assumptions'. The aspect of the definition of cultural competence, focussing on learning the cultures of others, is especially problematic for CULTURAL SAFETY and it is particularly evident in Munoz and Luckmann (2005, pp 277-95) where they list various cultural generalities. As Warren (2009, p 182) warns such generalities are dangerous and it is this 'othering' that attracted critique in Leininger's work (Carberry 1998 cited in DEST 2001; Culley 2006; Gray & Thomas 2006).

Many students come to courses on culture expecting to learn all about other cultures. One of the authors recalls one student who, that after doing a course on CULTURAL SAFETY complained, "I don't even know what that head dress that Muslims wear is called!" This of course brings us to the very crux of the matter that there are as many names for the headdress as there are cultural and linguistic groups who wear it. With so many different cultures and so much variation within culture it is actually quite impossible to expect students to learn about the diverse cultures that they'll encounter in their work. As Warren (2009) argues generalising approaches to cultural competence conceptualise cultures as bounded wholes that exist out there to be learned, rather than appreciating culture as a broad, dynamic relational concept as used in cultural safety (Gilroy 2000, p. 123 cited in Nairn, Hardy, Parumal and Williams 2004).

Becoming culturally safe is NOT a one-lesson program but rather a lifetime journey of study and learning. There are several discrete areas in which you must have knowledge:

1. Your own personal cultural identity
2. The culture of the nursing profession
3. The culture of the health care system
4. The cultural identity of the client as they describe it to you

Nursing students will notice that more and more institutions are mandating that those who practice must take cultural issues into account when providing health care and we turn to these requirements in Australia and New Zealand now after first considering some crucial aspects of nursing care.

COMMUNICATION

There are many forms of illegal discrimination based on ethnicity, color, or national origin that frequently limit the opportunities of people to gain equal access to health care services. It is said that "language barriers have a deleterious effect on health care, patients are less likely to have a usual source of health care, and have an increased risk of nonadherence to medication regimens" (Flores, 2006). The Australian and New Zealand Health Care Systems assume strong English proficiency in health care encounters. However, for people who don't speak English or for whom it is a second or third language, seeking health care in health care settings such as hospitals, nursing homes, clinics, day care centers, and mental health centers, language is a considerable barrier. As we saw in the section on population statistics for each context there is tremendous diversity in peoples' English language proficiency.

Those who are limited in their ability to speak, read, write, and understand the English language,

encounter countless language barriers that can result in limiting their access to critical public health, hospital, and other medical and social services to which they are legally entitled. Many health and social service programs provide information about their services in English only. When persons whose first language is not English seek health care at hospitals or medical clinics, they are frequently faced with receptionists, nurses, and doctors who speak English only. These language barriers severely limit the ability to gain access to these services and to participate in programs. In addition, the language barrier often results in the denial of medical care or social services, delays in the receipt of such care and services, or the provision of care and services on the basis of inaccurate or incomplete information. An example here is regarding medication. If a person who has a minimal understanding of English is not given clear understandable instructions regarding their medication, adherence to or incorrect dosage may be a problem. Services denied, delayed, or provided under such circumstances could have serious consequences for both clients **and** providers of health care.

Chapter 6 describes in more detail how to communicate with people who do not understand English, how to interact with interpreters, and what services are available when no interpreter is available. It is vital that interpreters be present who not only serve to verbally translate the conversation but who are also able to assist you with asking the assessment questions above.

FAMILY

We speak of families as though we all know what families are (Laing 1969)

Family means different things to different people and it is very difficult to provide one definition of family. One of the biggest mistakes made in health care is when the concept of family is considered only from a mainstream understanding or from rigid takes on Indigenous traditional kinship structures. In contemporary mainstream society, the concept of a nuclear family (mum, dad and children) remains the most powerful normative preference. There are occasions when clients' circumstances differ from this ideal where the people they designate as their family are not regarded as family at all by health services and, at times, are considered deviant.

As Dench et al. indicate (2007 p 75) it is crucial to think about how a client's family functions with regard to health care decisions and hospital visiting preferences for example. This is especially important for Indigenous clients who may designate next-of-kin and family relatedness in ways that are unfamiliar to nurses whose knowledge base may be grounded in the assumptions made by the cultures of medicine and nursing who traditionally focus their care decisions on individuals and for whom the idea of bounded nuclear families are entrenched. Consider the following scenario:

> A young Indigenous man was admitted to an intensive care unit (ICU) following a serious suicide attempt. His mother rang one of the authors (Cox, a non-Indigenous person) and requested that she go to the ICU to visit him. At the hospital ward, staff insisted that only close family could be allowed in to see the man. The problem was that the man's close family was several hundred kilometers away. An Indigenous health worker was at the ICU and knew of the authors' long term relationship with

the family and convinced the nurses that she should be allowed to visit. When the young man was moved to a general ward he introduced the author to the doctor as 'my sister'.

We encourage you to think very differently about family to encompass such circumstances. We know that in Australia and Aotearoa/NZ families are diverse so it is important we understand how to ensure family is considered in an individual's health care according to the context described by that individual. Think about who you include when you talk about your family? You might live with people you regard as family even though they are not blood relatives. Who can correctly say who a client's next-of-kin is? It might be the birth family or those who raised the person or perhaps the family they have created with a partner. There are numerous possibilities. How will you support homosexual relationships and struggles to have partners accepted as spouses and next-of-kin? How about those situations where children have two mothers or two fathers? Think about people with longstanding disabilities estranged from their families many years ago when institutionalised. There are times when the person with a disability wanted staff members contacted as their significant others rather than their birth families.

Making assumptions in this area of nursing care can bring significant distress for your clients. As nurses you must be aware that your cultural assumptions are just that-they are not universal ways of being and you need to be alert for alternative ways of understanding the world and social institutions such as the family. In sum, the concept of family and who is important and who can make decisions within a family can be decided only by individuals in the context of their particular family or in the face of their inability to do so by members of the family itself.

CULTURAL IDENTITY

Our identities as cultural beings are not only based on being born into a particular cultural milieu but are strongly related to our experiences as we go through life. Just as all members of a single family aren't exactly the same and in fact may hold quite different beliefs and values to their parents and siblings, those who identify as belonging to a particular culture don't experience or express that cultural identity in the same way. In line with the broad definition of culture used in CULTURAL SAFETY aspects of a person's cultural identity are influenced by their ethnicity, their gender, their ability or disability, their education and their status within society as members of either dominant or minority groups. In addition, many people socialised in cultures where traditional health care resources are used such as in some Indigenous communities, may prefer to use this type of care even when residing in a mainstream cultural setting with mainstream health care resources available. It is therefore not possible to teach you the cultures, religions, ethnicities that shape a person's world view as this will be unique to each individual. However it is important that you understand that differences exist and are legitimate.

SPIRITUALITY, RELIGION AND PHILOSPHY

One possible component of a person's cultural identity is their religion or spirituality but nurses must be mindful that many people hold a secularist philosophy and will not appreciate discussions of religion or

spirituality. This point is especially relevant for those nurses who hold strong religious or spiritual beliefs themselves as at times these may not appreciate how distressing it is to non-religious clients to have these issues raised. Nonetheless spiritual or religious factors are important to many clients but these dimensions are often overlooked in health assessment. If religion or spiritually are an integral component of a person's culture, their beliefs may influence their explanation of the cause(s) of illness, perception of its severity, and choice of healer(s). In times of crisis, such as serious illness and impending death, religion and spirituality may be a source of consolation for the person and for their family. Religious or spiritual leaders may exert considerable influence on the person's decision making concerning acceptable medical and surgical treatment, choice of healer(s), and other aspects of the illness.

Religion and spirituality then can play a most significant role in the ways people practice their health care. There are countless health-related behaviors promoted by nearly all religions or spiritualities. The following list presents selected examples: ceremonies and rituals, meditating, exercising and maintaining physical fitness, getting enough sleep, being vaccinated, being willing to have the body examined, undertaking a pilgrimage for health reasons, telling the truth about how you feel, maintaining family viability, hoping for recovery, coping with stress, undergoing genetic screening and counselling, being able to live with a handicap, and caring for children (Levin, 2001).

Religion and spirituality can give people a frame of reference and a perspective with which to organize information. Their belief vis-à-vis health can help to present a meaningful philosophy and system of practices within a system of social controls having specific values, norms, and ethics. These are related to health in that adherence to a religious or spiritual code is conducive to spiritual harmony and health. Religious and spiritual concerns evolve from and respond to the mysteries of life and death, good and evil, and pain and suffering. For example, illness is sometimes seen as the punishment for the violation of religious codes and morals.

In health care settings, you will frequently encounter people who find themselves searching for a spiritual meaning to help explain their illnesses or disabilities. Some health care providers find spiritual assessment difficult because of the abstract and personal nature of the topic, whereas others feel quite comfortable discussing spiritual matters. Comfort with and mindfulness of your own spiritual beliefs is the foundation to effective assessment of spiritual needs in others (Andrews & Boyle, 2003) including the ability to assess whether or not a client requires a discussion of this area.

Time Orientation

Inherent in socialization is the approach that people take to time. One of the major areas in which cultural conflicts between nursing culture and clients occur is the failure to understand each other's perception of *time.* According to Kluckhohn (1990), there are three major ways in which people can perceive *time.*

1. The focus may be on the *past,* with traditions and ancestors playing an important role in the person's life. For example, some people hold beliefs about ancestors and tend to value long-standing traditions.

In times of crisis, such as illness, a person with a value orientation emphasizing the past may consult with ancestors or ask for their guidance or protection during the illness.

2. The focus may be on the *present,* as in nursing culture with little attention being paid to the past or the future. Nurses and health systems are especially concerned with tasks and goals focused on "now," and the future is perceived as vague or unpredictable. Some clients will also be focused on now and nurses may have difficulty encouraging preparation for the future—for example, for discharge from the hospital or for future side effects or adverse reactions from the medication. In addition, some people may fail to see the value of childhood immunizations or those aimed at preventing the flu, hepatitis, or other conditions afflicting adults.

3. For some people, the focus is on the *future,* with progress and change being highly valued. The person may express discontent with both the past and the present. In terms of health care, they may inquire about the "latest treatment" and most modern equipment available for a particular problem and may express concern with nurses or physicians they perceive as old fashioned.

To take just one example, in the Australian and Aotearoa/NZ contexts the way different people value time may impact on the way they assess priorities to do with their health care. For example there could be problems with keeping appointments, adhering to medication regimes or differing priorities where family business may take precedence over appointments and the use of resources on personal health. It is important that nurses seek to understand what is happening in peoples' live to limit a sense of frustration and to prevent applying uncritical assumptions and judgments to peoples' health and illness behaviors.

CAUSES OF ILLNESS AND DISEASE INCLUDING THOSE IN BIOMEDICINE

Disease causation may be viewed in three major ways: from a biomedical or scientific, a naturalistic or holistic, or a magico-religious perspective.

Biomedical

The view that dominates in our health system is called the **biomedical** or **scientific** theory of illness causation, and is based on the assumption that all events in life have a cause and effect, that the human body functions more or less mechanically (i.e., the functioning of the human body is analogous to the functioning of an automobile), that all life can be reduced or divided into smaller parts (e.g., the reduction of the human person into body, mind, and spirit), and that all of reality can be observed and measured (e.g., intelligence tests and psychometric measures of behavior). Among the biomedical explanations for disease is the germ theory, which posits that microscopic organisms such as bacteria and viruses are responsible for specific disease conditions. Most educational programs for physicians, nurses, and other health care providers embrace the biomedical or scientific theories that explain the causes of both physical and psychological illnesses. When clients come to hospitals they may be react to this environment with the various stages of *culture shock,* that is, a state of disorientation or an inability to respond to the behavior of a different cultural group (in this case the culture of nurses and doctors) because of its sudden strangeness, unfamiliarity, and incompatibility to their perceptions and expectations.

Naturalistic

Another way in which people explain the cause of illness is from the **naturalistic** or **holistic** perspective, with the belief that human life is only one aspect of nature and a part of the general order of the cosmos. People with this perspective may believe that the forces of nature must be kept in natural balance or harmony. The naturalistic perspective posits that the laws of nature create imbalances, chaos, and disease. People embracing the naturalistic view use metaphors such as the healing power of nature, and they call the earth "Mother."

Magicoreligious

The third major way in which people explain the causation of illness is from a **magicoreligious** perspective. The basic premise is that the world is seen as an arena in which supernatural forces dominate. The fate of the world and those in it depends on the action of supernatural forces for good or evil.

Of course, it is possible to have a combination of world views, and many people are likely to offer more than one explanation for the cause of their illness. As a profession, nursing largely embraces the scientific/biomedical world view, but some other aspects are gaining popularity, including techniques for management of chronic pain, such as acupuncture, herbal therapies, hypnosis, therapeutic touch, and biofeedback. For CULTURAL SAFETY it is imperative that nurses engage in power sharing and be prepared to both listen to and respect how their clients understand their own illnesses.

Healing and Culture

When self-treatment is unsuccessful, the person might turn to the lay or folk healing systems, to spiritual or religious healing, or to scientific biomedicine. All cultures have their own preferred lay or popular healers, recognized symptoms of ill health, acceptable sick role behavior, and treatments. In addition to seeking help from you as a biomedical/scientific health care provider, clients may also seek help from traditional or religious healers. The variety of healing beliefs and practices used by the many populations found in Australia and New Zealand far exceeds the limitations of this chapter. It is important, however, that you are aware of the existence of various practices and recognize that, in addition to folk practices, many other complementary healing practices exist.

CULTURAL EXPRESSION OF ILLNESS

Expression of Pain

To illustrate the manner in which symptom expression may reflect the person's cultural background, let's use an extensively studied symptom—pain. Pain is a universally recognised phenomenon and it is an important aspect of assessment for people of various ages. Pain is a very private, subjective experience that is greatly influenced by cultural background. Expectations, manifestations, and management of pain are all embedded in a cultural context. The definition of pain, like that of health or illness, is culturally informed. The word *pain* is derived from the Greek word for penalty, which helps explain the long association between pain and punishment in Judeo-Christian thought. The meaning of painful stimuli, the

way people define their situation, and the impact of personal experience all help determine the experience of pain.

Some cross cultural research has been done on pain with the acknowledgment that it may be perceived as a multidimensional experience. For example Fenwick (2006) did work on the experience of pain amongst central Australian Indigenous people. Pain has been found to be a highly personal experience, depending on cultural learning, the meaning of the situation, and other factors unique to the person. Therefore pain should be explored not only in consideration of the physical or psychological experience but also the social, spiritual and cultural perceptions. Pain has been found to be a highly personal experience, depending on cultural learning, the meaning of the situation, and other factors unique to the person. Silent suffering has been identified as the most valued response to pain by health care professionals. The majority of nurses have been socialised to believe that in virtually any situation, self-control is better than open displays of strong feelings.

DISEASE PREVALENCE

It is well known that diseases are not distributed equally among all segments of the population. For several generations, the mainstream population in Australian and New Zealand has enjoyed improved health status. Despite this fact, as discussed previously there continues to be major disparity in deaths and illnesses experienced by Indigenous people and minority groups. Poverty, employment opportunities, housing, education and other socially marginalizing issues such as scientific, institutional and personal racism, play a central role in health disparities. Space does not permit us here to overview the many available health statistics for different population groups but links are provided at the end of this chapter.

AUSTRALIAN NATIONAL STANDARDS COMPETENCY STANDARDS FOR REGISTERED NURSES AND POSITION STATEMENT ON THE INCLUSION OF INDIGENOUS ISSUES IN NURSE EDUCATION

At this moment (July 2010) Australia is on the cusp of moving to a national registration system under the newly formed Nursing and Midwifery Board of Australia under the Australian Health Practitioner Registration Agency. However the standards for Registered Nurses set by the Australian Nursing and Midwifery Council in 2008 were adopted by the new organisation. According to the Australian Nursing and Midwifery Council's standards a registered nurse provides evidence based nursing care to people of all ages and cultural groups including individuals, families and communities (ANMC 2008, p. 2). Of particular relevance is the following (ANMC 2008, p. 12) in section 9.5 of their standards that a registered nurse:

Facilitates a physical, psychosocial, cultural and spiritual environment that promotes individual/group safety and security

- demonstrates sensitivity, awareness and respect for cultural identity as part of an individual's/group's perceptions of security
- demonstrates sensitivity, awareness and respect in regard to an individual's/group's spiritual needs

- involves family and others in ensuring that cultural and spiritual needs are met

For the full 2008 Registered Nurse Competency Standards go to:
http://www.nursingmidwiferyboard.gov.au/en/Codes-and-Guidelines.aspx

Further in 2003 the ANMC released a position statement for the Inclusion of Aboriginal and Torres Strait Islander Peoples Health and Cultural Issues in Courses leading to Registration or Enrolment and these were updated in 2007.

Figure 6 Summary of the ANMC's position statement on Aboriginal peoples' and Torres Strait Islanders' health:

The ANMC recognise that improving Indigenous peoples' health is a national health priority. Nurses and Midwives have a key role to play through quality, culturally safe health care.

The ANMC outlines the following needs for nurses and midwives:

- education in Australian Indigenous health, culture, and history;
- appropriate curriculum content and assessment with Indigenous people and professionals involved in teaching
- all undergraduate nursing and midwifery education includes a discrete unit on Indigenous health and culture including:
- overview of Indigenous peoples' history, culture, social and economic circumstances
- issues such as historical, sociocultural and economic determinants of current Indigenous health, cross cultural communication, primary health care, rural and remote issues, Aboriginal and Torres Strait Islander peoples' Community Controlled Health Services and strategies for delivering effective health services.
- expects that students of nursing and midwifery have appropriate opportunities for relevant clinical placements
- students will be able to demonstrate their understanding of cultural safety issues

The full position statement can be accessed at http://www.anmc.org.au/position_statements

NEW ZEALAND/AOTEAROA GUIDELINES FOR CULTURAL SAFETY, IN NURSING EDUCATION AND PRACTICE

Registered Nurses [RNs] are required to demonstrate competency specific to CULTURAL SAFETY both initially to achieve registration, and subsequently in order to maintain a practicing certificate from the Nursing Council of New Zealand (Nursing Council). The following principles underpin CULTURAL SAFETY education (Nursing Council of New Zealand 2009).

Figure 7 NZ/Aotearoa NCNZ Principles

PRINCIPLE ONE
Cultural safety aims to improve the health status of New Zealanders and applies to all relationships through:
1.1 an emphasis on health gains and positive health outcomes
1.2 nurses acknowledging the beliefs and practices of those who differ from them. For example, this may be by: age or generation gender sexual orientation occupation and socioeconomic status ethnic origin or migrant experience religious or spiritual belief disability.

PRINCIPLE TWO

Cultural safety aims to enhance the delivery of health and disability services through a culturally safe nursing workforce by:

2.1 identifying the power relationship between the service provider and the people who use the service. The nurse accepts and works alongside others after undergoing a careful process of institutional and personal analysis of power relationships

2.2 empowering the users of the service. People should be able to express degrees of perceived risk or safety. For example, someone who feels unsafe may not be able to take full advantage of a primary health care service offered and may subsequently require expensive and possibly dramatic secondary or tertiary intervention

2.3 preparing nurses to understand the diversity within their own cultural reality and the impact of that on any person who differs in any way from themselves

2.4 applying social science concepts that underpin the art of nursing practice. Nursing practice is more than carrying out tasks. It is about relating and responding effectively to people with diverse needs in a way that the people who use the service can define as safe

PRINCIPLE THREE

Cultural safety is broad in its application:

3.1 recognising inequalities within health care interactions that represent the microcosm of inequalities in health that have prevailed throughout history and within our nation more generally

3.2 addressing the cause and effect relationship of history, political, social, and employment status, housing, education, gender and personal experience upon people who use nursing services

3.3 accepting the legitimacy of difference and diversity in human behaviour and social structure

3.4 accepting that the attitudes and beliefs, policies and practices of health and disability service providers can act as barriers to service access

3.5 concerning quality improvement in service delivery and consumer rights.

PRINCIPLE FOUR

Cultural safety has a close focus on:

4.1 understanding the impact of the nurse as a bearer of his/her own culture, history, attitudes and life experiences and the response other people make to these factors

4.2 challenging nurses to examine their practice carefully, recognising the power relationship in nursing is biased toward the provider of the health and disability service

4.3 balancing the power relationships in the practice of nursing so that every consumer receives an effective service

4.4 preparing nurses to resolve any tension between the cultures of nursing and the people using the services

4.5 understanding that such power imbalances can be examined, negotiated and changed to provide equitable, effective, efficient and acceptable service delivery, which minimises risk to people who might otherwise be alienated from the service.

The Nursing Council of New Zealand (2009, p 8) also stipulates the expected outcome of nursing education in Aotearoa/NZ; that Registered nurses are to "practice in a culturally safe manner, as defined by the recipients of their care". They require that student nurses will:

> (a) examine their own realities and the attitudes they bring to each new person they encounter in their practice;
> (b) evaluate the impact that historical, political and social processes have on the health of all people; and
> (c) demonstrate flexibility in their relationships with people who are different from

themselves.

STRATEGIES FOR COLLABORATIVE ASSESSEMENT

One of the authors (Cox) was alerted to the difficulties students in Australian nursing contexts have when it comes to appreciating the need for cultural assessment. Students often marked 'not applicable' beside an item that asked whether cultural considerations had been included in their care on an assessment form used in clinical practicum. This was because students don't appreciate that every encounter has cultural elements even if the client has the same personal cultural identity as the nurse, so they would only include the item if the client was seen as an 'ethnic' other. CULTURAL SAFETY however teaches that all encounters are bicultural as they include the culture of the nurse (with aspects of their identity drawn from the culture of nursing and their personal cultural identity) and the culture of the client. As Warren (2009, p 197) notes information is not gained by specifically cultural questions and this is also an important tenant of CULTURAL SAFETY. One tool for assessment is the LEARN model.

Figure 8: The LEARN Model

L=Listen to the client's comments

E=Explain your interpretations of what you think they said and clarify if the interpretation is correct or needs to be changed

A=Acknowledge the importance of what the client is saying and what it means to them

R=recommend strategies and collaborate with the client to develop interventions that include the cultural perspectives of the client

N=negotiate and collaborate with the client and their significant others (e.g. family) to provide culturally safe care

(LEARN adapted from Berlin and Fowkes 1882 also cited in Warren 2009, p 197)

Various authors warn of the problem of trying to teach, learn or assesses cultural generalities (see Warren, 2009 p 182; Drench, Noonan, Sharby and Ventura 2007, p 74-75) and instead refer to the work of medical anthropologist Arthur Kleinman, who, rather than focusing on cultural generalisations, offers questions to elicit what he calls the client's explanatory framework. To help you elicit information of relevance to the client we suggest the following questions designed by Kleinman (1980, p 106).

Figure 9: Kleinman's Explanatory Framework

1. What do you call your problem? What name does it have?
2. What do you think caused your problem?
3. Why do you think it started when it did?
4. What does your sickness does to you? How does it work?
5. How severe is it? Will it have a short or a long course?
6. What do you fear most about your sickness?
7. What are the chief problems your sickness has caused?
8. What kind of treatment do you think you should receive? What are the most important results you hope to receive from the treatment?

In figure 10 below, we offer as an alternative some additional questions.

Figure10 Health Beliefs and Practices Assessment

1. How do you define health?
2. How do you rate your health?
3. Describe your illness to me?
4. What do you believe caused the illness?
5. How do you keep yourself from getting sick and what home remedies do you use?

In Figure 11 is the basis for all care of clients from any background what so ever.

Figure 11 Guide for care

Preparing
• Discover and understand your own social position, ethnicity, cultural values, biases, health beliefs and practices.
R.E.S.P.E.C.T.
Realize that you MUST know and understand your heritage
Examine the client within the context of their cultural and social position
Select questions that are not complex, and do not ask questions rapidly
Pace questions throughout the physical examination
Encourage the client to discuss the meanings of health and illness with you
Check for the client's understanding and acceptance of recommendations and build on cultural practices
Touch the client respecting their personal preferences and boundaries—manners are a vital component of the nurse-client relationship

CONCLUSION: CULTURALLY SAFE NURSING

There are several steps that you must climb on the journey to CULTURAL SAFETY. The integration of this knowledge into day-to-day practice will take time because many practitioners in the health care system are hesitant to adopt new ideas. CULTURAL SAFETY does not come instantly, certainly not after reading a chapter or several chapters or books on this specialized area. It is complex and multifaceted, and many facets change over time.

You are now learning the modern, scientific meanings of health and illness. But such knowledge is just one part of nursing care as - you must confront your own biases, preconceptions, and prejudices about specific ethnic, religious, sexual, or socioeconomic groups and explore your family's background and traditional beliefs and practices. The first step in understanding the HEALTH care needs of others is to understand yourself on the basis of cultural values, beliefs, attitudes, and practices that are relevant to HEALTH and ILLNESS. The second phase is to identify the meaning of HEALTH to the other person, remembering that concepts are derived, in part, from cultural meanings and definitions of health. Considerable research has been conducted on the various definitions of HEALTH that may be held by various groups-we discussed Indigenous definitions of health above.

Third, you must understand the culture of the health care delivery system, how it works, what it does, the meanings of various procedures and the costs and consequences to the clients and to you as a nurse. Fourth, you must be knowledgeable about the social backgrounds of your clients—the meanings of immigration, racism, socioeconomic status, aging, and so forth. Fifth, you must be aware if English is not understood and then be aware of the resources available to help with interpretation, and resources within the community.

This chapter was about developing a deep understanding that each client and nurse has their own reality, that these multiple realities are socially constructed and that they are informed by, but not reducible to, culture. A central aim of this chapter was to change the way that you see yourself and the world around you and to impact on the status quo of power relations between nurses and clients and between clients and health services. Further we aimed to establish an appreciation that there is as much within culture variation as between culture variation and health contexts such as hospitals and health professions such as nursing/medicine also have cultures. Your challenge is to work within these systems without diminishing, demeaning or disempowering any individual.

The reference list has several books and selected websites you are provided to link you to introductory material related to this content. Remember, everything is connected to CULTURAL SAFETY; culture, ethnicity, religion, socialization, population diversity, immigration, religion, demographic change, globalisation, health and illness, modern and traditional beliefs and practices, sociopolitical issues, education, sanitation, housing, and infrastructure.

The reflections of eminent medical anthropologist Professor Arthur Kleinman arose from his own experience of caring for his wife of 40 years who developed a debilitating neurological disorder in recent times. His words sum up perfectly the enduring need for self-awareness in caring professions such as nursing:

> ‘I*n my view, what is needed is reform of the very culture of contemporary biomedicine. We must train students and practitioners in critical self-reflection on that which limits their care-giving; in strategies and techniques aimed at opening a space for the moral acts of care-giving; and in the most concrete and practical acts of assistance, so that they never forget what care-giving actually means*’ (Kleinman 2009).

REVIEW

- CULTURAL SAFETY requires that nurses become respectful of nationality, culture, age, sex, political and religious beliefs. This notion is in contrast to transcultural/multi-cultural nursing care, which encourages nurses to deliver service irrespective of these aspects of a client.
- CULTURALLY SAFE CARE empowers the client because it reinforces the idea that each person’s knowledge and reality is valid and valuable. It facilitates open communication and allows the client to voice concerns about nursing care that he or she may deem unsafe.
- CULTURAL SAFETY involves recognising the nurse as the bearer of his or her own culture and attitudes.
- CULTURAL SAFETY is a political idea because it attempts to change health professionals’ attitudes about their power relationships with their clients.
- CULTURAL SAFETY doesn’t focus on how clients are different but how they are treated in society
- Care may be deemed CULTURALLY UNSAFE if the client feels diminished, demeaned or disempowered or directly or indirectly dissuaded from accessing necessary care.

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Cultural Safety – A link to Irihapeti Ramsden's thesis **http://culturalsafety.massey.ac.nz/thesis.htm**

National Council of Maori Nurses **http://www.maorihealth.co.nz/**

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