Cultural Safety in Nursing: the New Zealand Experience

ELaine PAPPS* and IRIHAPETI RAMSDEn†

*Nursing and Midwifery Department, Otago Polytechnic, Dunedin, New Zealand
†Ngai Tahu/Rangitane, Nursing Educationalist, Wellington, New Zealand

The concept of cultural safety arose from the colonial context of New Zealand society. In response to the poor health status of Maori, the indigenous people of New Zealand, and their insistence that service delivery change profoundly, nursing has begun a process of self-examination and change in nursing education, prompted by Maori nurses.

Nursing and midwifery organizations moved to support this initiative as something which spoke truly of nursing and New Zealand society. Cultural safety became a requirement for nursing and midwifery courses in 1992. But its introduction into nursing education has been controversial. It became highly publicized in the national media, and the role and function of the Nursing Council of New Zealand was questioned.

This paper discusses the New Zealand experience of introducing cultural safety into nursing education. Copyright © 1996 Elsevier Science Ltd.

Key words: New Zealand, Maori, nursing, nursing education, cultural safety.

INTRODUCTION

In 1992 the Nursing Council of New Zealand made cultural safety a requirement for nursing and midwifery education courses which prepare individuals for registration as nurses and midwives. Cultural safety was defined at that time as

The effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on own cultural identity and recognizes the impact of the nurses' culture on own nursing practice [1].

The Nursing Council of New Zealand is empowered by the Nurses Act 1977 to govern nurses and midwives through setting and monitoring standards to ensure safe and competent care for the public of New Zealand. Cultural safety was seen as one aspect of safe nursing and midwifery practice and was introduced into nursing and midwifery education courses as one of the outcomes required of each applicant for registration as a nurse or midwife. It attracted considerable and unprecedented attention to the content and process of nursing education, and there was extraordinary public debate about this issue. There were claims that large amounts of time were being devoted to cultural safety in nursing curricula at the expense of more "traditional" aspects of nursing education and that, as a result, the standard of the graduates of comprehensive nursing courses was compromised. Public debate was fuelled by the media and cultural safety became associated with the terms "political correctness" and "social engineering" [2]. Between 1992 and 1995 the media focus on cultural safety raised doubts in the minds of the public and politicians about the quality of nursing education and the role of the Nursing Council of New Zealand in ensuring appropriate standards in nursing education preregistration courses. In July 1995 a Select Committee of the New Zealand Parliament commenced an inquiry into the cultural safety component of the nursing education curriculum. This paper discusses what cultural safety is, why

Received 3 April 1996; accepted 13 August 1996.
* Correspondence should be addressed to: Elaine Papps, 37 B Balmacewen Road, Maori Hill, Dunedin, New Zealand. Tel: 64 3 467 2608, Fax: 64 3 467 2608.

491
it is a quality issue and the controversy and confusion surrounding its introduction into nursing education in New Zealand.

BACKGROUND

Cultural safety addresses quality in health care through issues of communication and access to the health service [3]. Nurses may be the first health professional people meet, hence the attitude a nurse portrays, if it is one of criticism, blame or assumption, whether expressed knowingly or unknowingly, may make a person feel demeaned and engender feelings of reluctance either to seek health care or to return to a particular health service [4]. The introduction of cultural safety into nursing and midwifery education developed from a concern to develop ways of dealing with "social, economic, political, historical and often emotional reasons for the high incidence of rheumatic heart disease, the rates of asthma deaths, cot deaths, mental hospital readmission rates, uptake of tobacco smoking among young women, the rapid rise in high risk behaviours and suicide, in which one section of the New Zealand population far exceeds the rest. The people in this sector are Maori" [3].

New Zealand was colonized by Great Britain during the middle of the nineteenth century. In 1840 a treaty was signed, the Treaty of Waitangi, which provided guarantees that the indigenous people (the tangata whenua) would have certain rights. The Treaty of Waitangi Act 1975 and its 1985 amendment requires statutory bodies and government departments to conduct their activities in a manner consistent with the Treaty. In the health service all Ministry of Health policy documents specify the priority of Maori health and involvement of Maori and the funding of Maori health initiatives are requested in the four Regional Health Authorities which fund the provision of health services in New Zealand. In addition, the New Zealand Government has affirmed that the Treaty of Waitangi is the founding document of New Zealand and stated its goal for Maori health as

To improve Maori health status so that in the future Maori will have the opportunity to enjoy at least the same level of health as non-Maori [5].

Despite promises of equality embodied in the Treaty of Waitangi, there is evidence that the tangata whenua have not received the same benefit from the health service as non-Maori. A report on Maori standards of health published in 1988 identified that Maori were culturally, socially and economically disadvantaged. This was reflected in high unemployment levels, poor educational achievement and significantly high rates of physical and mental illness [6]. Soon after the release of the report, the Director-General of Health acknowledged that these statistics reflected the deterioration in Maori health after 150 years of European influence in New Zealand [7]. Clearly there was an urgent need to redress the status of Maori health and education was an obvious place to begin.

THE INTRODUCTION OF CULTURAL SAFETY INTO NURSING EDUCATION

Nurses in New Zealand had begun to identify the need to address problems of Maori health through the education of nurses, and through a commitment to biculturalism in the 1980s. A workshop in 1986 which reviewed the preparation and initial employment of nurses recommended that participation of more Maori nurses in the nursing workforce was essential [8]. In 1987 a Maori nurse advisor and educationalist was seconded to the Department of Education to assist in the development of guidelines for curriculum in nursing education. Various formal and informal hui (meetings), which were widely supported by nurse educators were held throughout New Zealand to discuss these curriculum matters [9].

Formalisation of the concept of cultural safety began in 1988 at a hui in Christchurch, which was attended by nurse educators and Maori student nurses. A further hui was held during 1989 for Maori nurse teachers, and from this hui a group of Maori nurses were nominated to prepare a set of cultural safety standards. The standards that were developed were known as "Kawa Whakaruruhau" which translates into cultural safety. In 1991 the Nursing Council of New Zealand resolved to make cultural safety a requirement in the state examinations for nurses and midwives and it commissioned the writing of guidelines to assist in the implementation of
cultural safety into the education of nurses and midwives. These guidelines and the term Kawa Whakaruruhau were formally adopted by the Nursing Council in February 1992 [10].

THE RATIONALE FOR CULTURAL SAFETY IN NURSING EDUCATION

On completion of a nursing education programme in New Zealand, generations of nurse graduates swore the (now obsolete) Florence Nightingale oath which stated that people should be nursed “regardless” of colour or creed. Traditionally, nurses were educated not to recognise people’s differences in the provision of nursing care. However, it is now believed that health professionals who operate from assumptions and stereotypical attitudes place the health of the people they care for at risk and seriously impair service delivery. Cultural safety requires that nurses care for people “regardless” of those things which make them unique [3]. The teaching of cultural safety is designed to challenge students to identify that there are other ways in which people experience life and view the world. The guidelines developed by the Nursing Council of New Zealand for the teaching of cultural safety to nursing and midwifery students makes this clear.

Being a member of a culture surrounds each person with a set of activities, values and experiences which are considered to be real and normal. People evaluate and define members of other cultural groups according to their own norms. When one group far outnumbers another, or has the power to impose its own norms and values upon another, a state of serious imbalance occurs which threatens the identity, security and the ease of other cultural groups, thus creating a state of disease [10].

Within an educational programme, students identify social and personal attitudes, and have an opportunity to examine their own beliefs, values and assumptions about other people. The focus of cultural safety teaching is to educate student nurses and student midwives:

— to examine their own realities and the attitudes they bring to each new person they encounter in their practice;
— to be open minded and flexible in their attitudes toward people who are different from themselves, to whom they offer or deliver service;
— not to blame the victims of historical and social processes for their current plight;
— to produce a workforce of well educated, self-aware registered nurses and midwives who are culturally safe to practice [10].

DEFINITIONS

It is helpful at this point to look at the way in which the concept of cultural safety has been constructed. The term “culture” is used in its broadest sense within the concept of cultural safety and incorporates many elements, such as a particular way of living in the world, attitudes, behaviours, links and relationships with others [10]. The nursing literature in New Zealand does not confine cultural values to the concept of ethnicity. Cultural values are defined as: “Morals, beliefs, attitudes and standards that derive from a particular cultural group. Culture is not seen as ethno specific, but must include groups from within cultures, e.g. cultures of class, socialisation, sexual orientation, age etc” [11].

The term “safety” is common in relation to the practice of health professionals to refer to whether someone is safe and/or competent in practice. The Nursing Council of New Zealand has clearly stated expectations of safety in nursing and midwifery practice. Safety is defined as “...nursing or midwifery action to protect from danger and/or reduce risk to patient/client/community from hazards to health and wellbeing. It includes regard for the physical, mental, social, spiritual and cultural components of the patient/client and the environment” [12]. Unsafe nursing or midwifery practice on the other hand is defined as “…any action or omission which endangers the wellbeing, demeans the person or disempowers the cultural identity of the patient/client” [12].

CULTURAL SAFETY AND QUALITY

Cultural safety in nursing and midwifery education and practice provides a focus for the delivery of quality care through changes in thinking about power relationships and patients’ rights. The skill for nurses and midwives does not lie in knowing the customs of ethnospecific cultures. Rather, cultural safety places an obli-
Confusion and Controversy

From the outset, the introduction of cultural safety into nursing curricula seemed to be surrounded by controversy. Much of this was a strong media reaction which represented ill informed and biased criticism. An example of the way the media portrayed the introduction of cultural safety into nursing education highlights its distortion:

From November, student nurses may fail their State Final registration exams if they don't follow the party line on Treaty of Waitangi objectives. From this year 20 per cent of the State Final examination will be on something called “cultural safety”, a concept involving sensitivity to Maori (but not Pacific Island, Indian, Chinese or any other minority) cultural differences, anti-racism, and a liberal interpretation of the Treaty of Waitangi [2].

Further media attention about cultural safety occurred in 1993 following the release of a letter to the media by an ex-student of a polytechnic's nursing course who had not met requirements for continuation in the course. It was asserted that the course requirements had not been met because of “failing a hui” [14]. The issue was fundamentally between the student and the polytechnic, but the media chose to incite public debate about “political correctness” in nursing education. The publication of the viewpoint of a tutor in a nursing department of a polytechnic in 1995 resulted in further media attention and again put the issue of cultural safety and the Nursing Council of New Zealand in a negative light. Attention focussed on the tutor's complaint that standards were not being met because large amounts of time were being taken up with cultural safety at the expense of some areas of nursing [15].

With the attention given to both of these situations the credibility of nursing education in general, and graduates of nursing education courses in particular, was compromised. In the sometimes vitriolic public debate that followed, there was little recognition given to the positive aims of cultural safety. Sadly, some nurses (either knowingly or unknowingly) provided neither support nor illumination to the concept, but instead referred to their own days of training when everyone was treated the same. Others provided anecdotal examples of their negative experiences as students. In addition, the content and number of hours of “nursing” in relation to the number of hours of “cultural safety” in nursing education courses was challenged. It was the content of nursing courses which seemed to be the issue of concern for a student in a nursing course at a polytechnic in Auckland, who at a regional conference of a political party, questioned the need to know about the relationship between colonization and disease in nursing and challenged the amount of time dedicated to cultural safety, which, it was claimed, compromised the important aspects of nursing education [16]. Not surprisingly, the result of this was further media attention to, and devaluing of, cultural safety. The efforts of the Nursing Council of New Zealand to provide factual information were thwarted. The press and cartoonists, combined with television and talkback radio, produced powerful negative and sometimes offensive images of nurses and nursing.
It was not long after this third outbreak of media attention to cultural safety that the Education and Science Select Committee of the New Zealand Parliament became involved with cultural safety. This Committee is able to hear public submissions on issues which come under its jurisdiction, in this instance the issue of nursing education and make recommendations to Parliament. This committee announced it was to investigate the cultural safety component of nursing education in New Zealand nursing education courses. In July 1995 the Nursing Council of New Zealand was called to account to this Committee. The Council had, however, taken note of the comments about confusion and controversy in relation to the teaching of cultural safety and established an independent committee to investigate concerns that had become apparent, particularly in the interpretation of the guidelines for the teaching of cultural safety. This committee, following its review, which included visiting all the 15 polytechnics which offer nursing and midwifery courses, reported its findings back to the Council in September 1995. Before this happened, however, the Select Committee called for public submissions on issues which come under its jurisdiction, in this instance the issue of cultural safety and nursing education in New Zealand nursing education courses [17]. The proposed enquiry into cultural safety by the Parliamentary Select Committee was suspended, until a report from the Nursing Council concerning the implementation of the eight recommendations of the review was received. A final decision was made about the enquiry proceeding in August 1996 [18].

The requirement for cultural safety to be part of the nursing curriculum and included in the state final examination clearly created controversy and confusion. The number of hours dedicated to cultural safety in each nursing curriculum provoked a great deal of distorted discussion and some untrue, grossly inflated figures were debated in the media, through letters to the editor and during talkback radio. These exaggerated claims of time devoted to cultural safety were publicly refuted [19]. The first group of students to undertake the registration examinations in which cultural safety was "tested" did so in November 1992. The examination questions did not directly assess Maori language (Te Reo) or customs (Tikanga), and this was made clear by the Nursing Council of New Zealand. Nonetheless this did little to dispel the confusion between the content of curricula and state final questions. There was a view that nurses were not able to be employed immediately following graduation. Rather than recognising that employment of new graduates was more to do with radical changes in the health system (the health reforms), employment issues were confused with a notion that cultural safety was replacing the "medical" aspects of nursing education, which made new graduates inferior [2]. Overlooked in the debate about cultural safety and nursing education is the right-wing conservatism presently apparent in New Zealand which has altered the relationship of the State to social services. Cultural safety has in one sense, been scapegoated.

IS THE NEW ZEALAND CONCEPT OF CULTURAL SAFETY APPROPRIATE?

Cultural safety does not place an emphasis on sensitivity or awareness. Cultural sensitivity and cultural awareness are both concerned with having knowledge about cultural but, more specifically, ethnic diversity. It is this that seems to be the basis of misinterpretation of the concept of cultural safety. The term "culture" is taken to mean "ethnicity", and in New Zealand culture is seen to be Maori. Cultural safety raises the issue of racism. It does address race relations, and this causes pain both for those who may acknowledge racism and for those who deny its existence.

The confusion about cultural safety, that it is concerned with students learning Maori customs and language and a concept known as "transcultural nursing" have become merged into the debate about what cultural safety means. An approach to ethnicity and nursing referred to as "transcultural" has been introduced through the work of Madeleine Leininger, an American nurse [20]. This, however, is a different concept from cultural safety. Transcultural nursing suggests that to work effectively with clients of other cultures it is necessary to include ethno specific knowledge. In the New Zealand context, and given the Treaty of Waitangi, transcultural nursing would be an example of continuing
colonial behaviour which acceptance of the Treaty endeavours to address. Nurses and midwives have developed the concept of cultural safety in the New Zealand context.

Since its introduction in 1992, the concept of cultural safety has continued to be refined. Its primary focus remains on improving the health status of all people of New Zealand through the relationship between Maori and the Crown based on the Treaty of Waitangi. But it has been further developed to include an emphasis on the relationship between nurses, midwives and health service consumers who differ from them by:

- age or generation
- gender
- sexual orientation
- socioeconomic status
- ethnic origin
- religious or spiritual belief
- disability [21].

The inclusion of these categories highlights the use of the term “culture” in its broadest sense. Nurses cannot provide quality, patient focused care if they have unconscious negative attitudes towards patients who are different from them in any of these categories.

CONCLUSION

There is a real paradox in the statutory recognition given to the Treaty of Waitangi, and reaction to the introduction of cultural safety into nursing and midwifery education. The Minister of Health for New Zealand, the Hon. Jenny Shipley, in endorsing draft guidelines for cultural safety in nursing and midwifery education commented that the nursing and midwifery professions in New Zealand are leading the world in addressing issues of transferring power from providers to consumers [22]. But it is a new concept which has yet to be fully evaluated. The Nursing Council of New Zealand plans to monitor the implementation of new guidelines which relate to the teaching of cultural safety [23]. The real test of its efficacy in nursing and midwifery will be in practice, where consumers will judge. That has yet to happen.

REFERENCES

20. Leininger M, Culture care diversity and univers-


