Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu

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Abstract

The research on which this thesis is based involves both a private narrative and a public narrative. It traces a personal history in order that the story of Cultural Safety can be told and the history, theory and the future direction can be gathered into one qualitative work.

The work is divided into three sections. The first is entitled, *Ko Wai Matou? The Private Narrative*. This section seeks to explore the historical, social, educational, physical, emotional, political and moral influences and ephiphanies which brought about the personality which introduced Cultural Safety ideas into nursing and midwifery. Early nursing practice is investigated and examples from practice are used to illustrate learning and consolidation of the ideas which led to Cultural Safety theory.

The second section is entitled *He Huarahi Hou: A New Pathway*. This section explains the progress of the theory and its relationship to education pedagogy and to nursing practice. Comparison between the work of Madeline Leininger and the Transcultural Theory of Nursing and the New Zealand concept of Cultural Safety is undertaken. The role and application of the Treaty of Waitangi to the theory of Cultural Safety is explored in this section.

The third section, entitled *He Whakawhanuitanga*: *The Public Narrative,* looks at the introduction of Cultural Safety into the nursing education system and its implementation. The public and media reaction to the inclusion of Cultural Safety in the national examination for nursing registration and the subsequent parliamentary response are noted. The interviews with nursing and midwifery leadership, Maori and pakeha key players in the process and consumer views of the ideas are documented and pertinent excerpts have been included.

The work concludes with a discussion on the likely future of Cultural Safety as a theory and in practice and outlines several issues which represent a challenge to the viability of the concept in nursing and midwifery education.

The story of Cultural Safety is a personal story, but also a very public one. It is set in neo-colonial New Zealand, but has implications for indigenous people throughout the

world. It is about human samenesses and human differences, but is also a story about all interactions between nurses and patients because all are power laden. Finally, although it is about nursing, it is also relevant to all encounters, all exchanges between health care workers and patients.

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Chapter One

Introduction

"You people talk about
legal safety, ethical safety, safety in clinical practice
and a safe knowledge base, but what about Cultural Safety?"
(First year Maori nursing student, Christchurch Polytechnic, 1988)

As the voices of the world's First Peoples are beginning to be heard internationally this thesis adds another voice to the global debate on the current status of indigenous peoples, the historical and socio-economic processes which brought about those human states and the way in which such issues are approached by people in power. In a post modern context this work does not situate itself as *the* voice of indigenous people in New Zealand but rather as one voice which is subject to a range of experiences which has come to a range of conclusions, all of which have come to form a complex and mobile whole.

This work is set in neo-colonial New Zealand and seeks to explore nursing service and delivery through the recounting of a personal history which is set in a context experienced by colonised peoples. I have used the term neo-colonial because I do not believe that New Zealanders have reached a state of post colonialism while the indigenous people are still struggling for change in a climate of colonially inherited institutional racism. While Maori people protest against colonialism and its fallout and attempt to make change, I maintain that we remain in a state of neo-colonial interactions between the Crown and Maori people.

The manipulation of New Zealand history is a clear example of management of knowledge by a colonial system of information dissemination. The fact that student and graduate nurses could not therefore make the correlation between historical events, political agendas, economics and ill health was not their fault but rather the fault lay

with those individuals who had the power to design the policy resulting in the curricula of educational institutions. Issues of deprivation of economic resources, land, people and identity, that is, of colonisation, have major health and disease outcomes which had remained largely unrecognised and unanalysed in nursing and midwifery education until challenged by the ideas of Cultural Safety.

This thesis examines my personal history as an indigenous woman who became a nurse and my response to the educational process designed for student nurses who did not, and could not, share my experience of the colonisation of land and people and history. The role of the Treaty signed at Waitangi in 1840 between the British Crown and Maori hapu is addressed in this work in terms of its relationship to nursing politics, the education of nurses and current practice. In 1988 the Nursing Council of New Zealand required all schools of nursing to demonstrate their commitment to the 1840 treaty agreement. The responses were variable and inconclusive. The dream of Cultural Safety was about helping the people in nursing education, teachers and students, to become aware of their social conditioning and how it has affected them and therefore their practice. It was also critical to alert them to the health and disease issues for the indigenous people of the New Zealand islands.

The result of my work and the support given by other nursing and midwifery individuals and institutions over these years has been the development of an educational model and pedagogy which has become known as Cultural Safety. The term, *Kawa Whakaruruhau,* relating to Maori issues in Cultural Safety, was bestowed by my grandfather, Te Uri o Te Pani Manawatu Te Ra, and endorsed by his generation of peers, most notably Hohua Tutengaehe.

Anecdotal and empirical observation has been upheld by research that demonstrated the serious health disparities between Maori and other New Zealanders from the 1970s onward (Pomare et al. 1995). Prior to this period there had been little Maori specific research although the largely rural based Maori population was clearly underserved by the health and education systems of the country. The omission of the colonial history of New Zealand in the basic state education system had led to a serious deficit in the knowledge of citizens as to the cause and effect outcomes of colonialism. Without a sound knowledge base it seemed to me that those citizens who became nurses and

midwives had little information of substance on which to build their practice among this seriously at risk group.

It was necessary to address issues of attitude and prejudice formation on the part of people in the health service because they held a great deal of power in the form of knowledge and other resources. This meant dealing with such social mechanisms as personal and institutional racism in the context of a violent colonial history and coming to terms with the inherent power relations, both historical and contemporary. Locating them in the health service became the challenge, finally locating them in the individual health worker, while obviating the nurse of past historical guilt and its crippling emotional outcomes, was essential.

Consciously or unconsciously such power reinforced by unsafe, prejudicial or demeaning attitudes and wielded inappropriately by health workers could cause people to distrust and avoid the health service. Nurses needed to understand this process and become very skilled at interpretation of the level of distrust experienced by indigenous people when interacting with a health service which has its roots in the colonial administration. The vast majority of undergraduate and postgraduate student nurses come from the non-Maori population. A type of education which enabled them to understand political issues in health in relation to the indigenous people was clearly required.

Cultural Safety advocated and then implemented the replacement and demystification of the colonial history in terms of its development of attitudes and beliefs toward indigenous peoples. The inevitably created stereotypes were often all that nurses had to work from as contact with Maori was relatively low for the first part of the twentieth century prior to Maori urban migration. The educational process of Cultural Safety caused stress and some chaos in the classroom and the country as we did not have a skilled nurse/midwife teacher workforce to present and manage such critical and delicate material or to support and evaluate student responses. There were no nurse/midwife teachers with experience in antiracism work nor many with an academic understanding of the colonial history or experience in teaching it. History and the economic and socio-political context of Maori experience was simply not envisaged as relating to nursing and midwifery practice.

The early attempts on the part of the Nursing Council of New Zealand to incorporate Cultural Safety into classroom teaching lead to some outraged responses on the part of some students and some teachers. The notion that students were being "socially engineered" by indigenous interest groups led to a media generated uproar in 1993 followed by another in 1995. This resulted in four major inquiries into Cultural Safety in nursing education as well as three appearances by the Nursing Council of New Zealand and myself before the Parliamentary Select Committee on Education and Science.

Maori Nurse Recruitment and Retention

Alongside Cultural Safety rests a question of recruitment and retention of Maori nurses. Some efforts have been made to investigate increasing the Maori nursing workforce on the premise that more Maori nurses could give better service to Maori. Currently these good intentions may not succeed for a range of reasons. The political will to create a funded campaign to attract Maori to nursing is not evident at the local or national levels. An effort needs to be made to take education to areas where Maori are located geographically. These areas tend to be associated with social and economic deprivation and mature age students established in families. They require a series of undergraduate preparatory programmes followed by nursing degree programmes which are based on outreach learning located where Maori people live. Currently, individual nursing schools are showing interest in setting up such programmes in partnership with communities, but there is no national policy to encourage recruitment of Maori into the nursing service and therefore little funding to encourage creative recruiting or maintenance of potential nurses in their communities.

Ethnicity figures have not been kept as to the numbers of people who enter nursing programmes and who choose to change their identity during the course of their education. It is therefore very difficult to assess the rates, by ethnicity, of final passes of people leaving programmes. A 1998 poster publication of the Ministry of Maori Development gives a breakdown of Maori health workers, medical and others, including nurses, psychologists, physiotherapists and occupational therapists, as 4% of the New Zealand graduate community in 1996 (Te Puni Kokiri, 1998). It was and remains unrealistic to expect Maori to provide a nursing workforce when Maori made up 14% of

the New Zealand population in the 1996 census (Statistics New Zealand, 1997) and Maori entry to and exit from nursing is extremely difficult to assess.

The right of Maori nurses to choose their practice location also needs to be taken into account. Graduates should not be expected to work among Maori people if that is not their choice. It is also naïve to assume that all Maori are subject to a form of socialisation which is homogeneous and enables them to nurse other Maori in a culturally safe manner. There is still major debate about the definition of Maori let alone what might comprise Maori nursing practice. A critical mass of defined Maori doing "ethnonursing" (Leininger, 1991) could therefore not be reached in sufficient numbers or time to make a significant difference to Maori health.

Cultural Safety and Perspectives

Cultural Safety became concerned with social justice and quickly came to be about nurses, power, prejudice and attitude rather than about the ethnicity or cultures of Maori or other patients. Papps (2002) sees Critical Theory as examining and questioning, that frameworks within which people's lives are organised are in terms of sources of repression and social domination and are located in terms of structural variables such as class and power. The critique or emphasis of Critical Theory is oriented toward the way in which values of freedom or democracy are impeded by social structures that are constructed socially (Habermas, 1987).

The consistent focus of Cultural Safety as originally envisaged was to be grounded in the Critical Theory approach constantly questioning power relations between nurse and the person being nursed with the emphasis on the attitudes and behaviours of the nurse. Constant redefinition of Cultural Safety into descriptive ethnicity based cultural checklist approaches created a bias toward Transcultural Nursing (Leininger, 1991, 1997).

Later, Maori health in all its diversity came to be acknowledged as a specialised area in nursing and is usually known by its Maori name, Kawa Whakaruruhau. While protecting the unique issues of Maori through the Treaty of Waitangi relationship with the Crown, Cultural Safety has been expanded to include all people encountered by nurses who differ in any way from the nurse. It is concerned with the unique, individual

and bicultural (ie one person to one person) relationship between the nurse and the patient. However difference is expressed, whether by gender, sexuality, social class, occupational group, generation, ethnicity or a grand combination of variables, difference is acknowledged as legitimate and the nurse is seen as having the primary responsibility to establish trust.

Cultural Safety is therefore about the nurse rather than the patient. That is, the enactment of Cultural Safety is about the nurse while, for the consumer, Cultural Safety is a mechanism which allows the recipient of care to say whether or not the service is safe for them to approach and use. Safety is a subjective word deliberately chosen to give the power to the consumer.

This history is based in nursing practice over twenty-three years and a further sixteen years as a nursing teacher concerned with education as transformative change. Throughout the text I have drawn from clinical and classroom practice to illustrate the ideas which were developing out of those settings. This work is a history based in nursing and teaching practice. It has been of the greatest importance that the work remains practice based and that examples from practice underpin the process of my intellectual and emotional engagement with the need for change in the pedagogy of nursing education and in practice. The academic tools used to achieve this qualitative research are historiography, reflective topical autobiography, critical social theory, formal interviews and their analysis, and feminist analysis.

Throughout the process of developing Cultural Safety, reflecting on the process and telling its story in this thesis, I have chosen theorists who have been concerned with social boundaries and margins. As issues of paternalism and racial, sexual, generational and class boundaries became more obvious and developed into ongoing challenges for me to understand, I sought theorists who could help me unravel their complexities. These writers have often been marginalised themselves for investigating tender areas of their own societies. Although such people as bell hooks (1990; 1994), Patti Lather (1991), Paolo Friere (1973; 1985), Fritjof Capra (1989), Henri Giroux (1992) and Trinh T. Minh-ha (1995) are not able to walk in my shoes, nor I in theirs, each has been able to give me ideas and information which has helped me to create this work. National (Kearns, 1997; Walker, 1998) and international writers who are not nurses have picked up the ideas of Cultural Safety and applied them to their disciplines and professions.

Lyman and Young (2000) applied the basic tenet of Cultural Safety to research which locates power in the investigator/nurse rather than the participant/patient.

Some nursing theorists such as Nina Bruni (1988), Lorraine Culley (1996), Annette Browne and Jo-Anne Fiske (Browne & Fiske, 2001) have attempted to address the structural inequalities which lead to the construction of health by people from marginalised groups. They have challenged the notions of Transcultural Nursing and multiculturalism (Leininger, 1991, 1997). The debate between the ideas of Transcultural Nursing and Cultural Safety has taken place at conferences and in nursing literature in New Zealand (Cooney, 1994; Coup, 1996; Smith, 1997) and will be further discussed in the body of this work.

The research on which this thesis is based involves both a private narrative and a public narrative. It traces a personal history in order that the story of Cultural Safety can be told and the history, theory and the future direction can be gathered into one qualitative work. The underlying methodological approach uses Reflective Topical Autobiographical Narrative (Johnstone, 1999). Johnstone argues that this is an under-utilised research method in nursing. Narrative serves to make the lived experience of the narrator directly accessible to the lived experience of others. Narrative is also particularly suitable to convey the experience of indigenous peoples. The work of indigenous theorists has been used throughout the study to help explain and support the experiences described.

The work is written in the first person, incorporating the voices of interview participants from New Zealand as well as Maori and international indigenous theorists and those representing marginalised views which relate to the premises of Cultural Safety. Few of the international theorists have been nurses, rather they are located in the literature of the experience of colonised or otherwise marginalised peoples and are examining the politics of power acquisition, retention and distribution. Their experience, views, ideas and analysis are consistent with Maori.

Nursing and midwifery input is from within the New Zealand context. Most of the indigenous work has only been available since the end of the Second World War and is still difficult to obtain since indigenous writers often do not have access to traditional academic pathways to publication.

Ko Wai Matou? The Private Narrative

Section I follows through the process of intellectual and emotional politicisation and the contextualising of my family experience into that of New Zealand history and the local history of Ngai Tutehuarewa and Irakehu. This section seeks to explore the historical, social, educational, physical, emotional, political and moral influences and ephiphanies which brought about the personality which introduced Cultural Safety ideas into nursing and midwifery.

This first section traces the private narrative and the origins of the ideas that led to Kawa Whakaruruhau and then expanded into Cultural Safety. It is both a private and a professional story which sets the scene for those things which were to become central to my life and work, upheld and nurtured by the experiences and socialisation of my childhood which is presented in Chapter Two. The development of these influences and how they shaped me as a student nurse, new graduate and maturing practitioner are explored in the latter part of Section I. The culture of nursing was a new and at times immutable force in my life which taught me some significant lessons about power and how power was managed. It is these lessons which are the focus for the work presented in Chapters Three and Four.

He Huarahi Hou: A New Pathway

Section II of the thesis addresses the development and evolution of Cultural Safety focussing on the transitional journey and context from the private and professional story which was featured in Section I, through to the building and movement forward of the concept which is the theme in this second section. Chapter Five commences by providing some background to the impetus for the development of Cultural Safety focusing particularly on the poor health status of Maori people and the clearly expressed demand by Maori that health services improve to meet their needs. The Treaty of Waitangi is the key to the application of Cultural Safety in the New Zealand context. Since the mid-1980s the treaty has steadily become the principal negotiating basis for the relationship between Maori and the Crown. In terms of Cultural Safety education, the Crown represents policy-making bodies and their institutions as providers of education resources for nurses and midwives and, later, as the primary employing organisations for trained nurses and midwives.

Chapter Six presents some of my early experiences as a teacher and my attempts to introduce an analysis of racism in New Zealand to nursing and midwifery students. The initial responses were not all positive. Examples drawn from the practice situation are used to illustrate the way in which the fledgling pedagogy of Cultural Safety, as it was at that time, needed to be approached. It was to be in this teaching context, relating theory to nursing and midwifery practice, that the primary objectives of Cultural Safety were developed.

Chapter Seven provides a chronological overview to the evolution of Cultural Safety following through the period from 1988-2001. This chapter refers directly to the supplementary material contained in Volume Two which accompanies this thesis and is a compilation of some of my published and unpublished documents including speeches, presentations, papers and submissions. Permission to reproduce previously published work has been sought and received from all the relevant journals, publications and organisations.

Chapter Eight concludes this section with a broad comparison of the American theorist Madeline Leininger's ideas of Transcultural Nursing and Cultural Safety positions. Prior to the develoment of Cultural Safety, the concept of Transcultural Nursing had been widely accepted as an approach to nursing people from other cultural groups. This chapter outlines the philosophical and consequent practice related differences which underpin these two theories and presents an argument for why Transcultural Nursing in current colonial New Zealand society should be constantly examined and debated.

He Whakawhanuitanga: The Public Narrative

Because narrative as a methodological tool is necessarily subjective, it has been essential to check data with people involved in the activities over the period described. I conducted twenty-four interviews that have been very useful in this process and these interviews are the focus of this section.

All the interviewees have given permission for their identities to be used and their material to be videotaped, audiotaped and transcribed, with the material to be stored as an archive in relation to this project and as a record of the period. A biosketch of all the

interviewees is attached as Appendix 1. Copies of the ethics approval, information sheet and consent form for the project are attached as Appendices 2a, 2b and 2c.

Along with the documentation and analysis presented within the body of this work, a comprehensive collection of newspaper clippings, film and television clips, cartoons and correspondence has also been collated for addition to the archive. While extensive use of the interviews have been made throughout the thesis, there was still a great deal of material which was unable to be included. That material will form a valuable basis for further post doctoral research which I hope to undertake, or to the work of other students.

Chapter Nine documents the introduction of Cultural Safety into the curricula of fifteen schools of nursing and presents an overview of the responses to the Nursing Council of New Zealand directive to do so. The public and media reaction to the inclusion of Cultural Safety in the national examination for nursing registration and the subsequent parliamentary response are noted. The interviews with nursing and midwifery leadership, Maori and pakeha key players in the process and consumer views of the ideas are documented and pertinent excerpts have been included.

All Maori interviewed for this project, as well as some pakeha commentators, expressed anxiety about the future of Kawa Whakaruruhau and Cultural Safety. In Chapter Ten, I discuss the likely direction of Cultural Safety as a theory and in practice and outline several issues which represent a challenge to the future viability of the concept in nursing and midwifery education.

Chapter Eleven concludes the thesis with some final thoughts, hopes and questions to promote further discussion and debate amongst those nurses and midwives, consumers and policy makers, researchers and theorists who may follow after me.

SECTION I

KO WAI MATOU?

THE PRIVATE NARRATIVE

To deny the importance of
subjectivity in the process of transforming
the world and history is naïve and simplistic.
It is to admit the impossible: a world without people.
(Freire, 1996, p. 33)

Why and how did Cultural Safety as a set of ideas evolve? What were the historical, social, physical, political and moral influences which contributed to the ideas? And what were the subjective and personal influences and epiphanies, which brought about the personality which nursed Cultural Safety into nursing?

This section is an autobiographical narrative theoretically informed by work by Megan-Jane Johnstone (1999) in which she argues that reflective topical autobiography is an under-utilised research method in nursing. Johnstone further argues that autobiographical narrative serves the revelatory purpose of attempting to make the lived experience of the person directly accessible to others.

Christine Webb argues the case for academic writing in the first person. She writes that:

> The use of the neutral, anonymous third person is deceptive when applied to quantitative research because it obliterates the social elements of the research process.
> (Webb, 1992, p. 747)

It is appropriate that this narrative be told in the first person so that the social and personal context of the history of Cultural Safety can be established. In a study of this kind the narrator has a critical place, indeed an obligation to provide some insight into the personal, social and emotional processes which have lead to the particular intellectual and behavioural outcomes.

Reflective topical autobiography may be seen as a method which investigates the responsibility of the narrator to explain his or her own role as human conduit for ideas based on personal experience. Johnstone says that reflective topical autobiography enables the self-researcher to:

> … return at will to his or her life story again and again to re-read, re-vision and re-tell the story in the light of new insights, understandings and interpretations of meanings acquired through ongoing lived experience. (1999, p. 25)

This argument is upheld as I read my own early work on Cultural Safety and see how it has changed profoundly in content and meaning as I have investigated new experiences and theory and combined them to enhance my own understanding of the world around me. In her broad discussion Johnstone warns that "*researchers who are brave enough to write about their own emotions risk being ridiculed, dismissed and marginalised"* (1999, p. 26), but encourages the search for the existential moment which Moustakas and Perry (1973) describe as a sudden understanding of life where one is aware of the rightness of a value or conviction or decision.

For me to be able to respond to the range of situations, at times painful, ridiculous and essentially human, which have been the Cultural Safety journey, has taken a consistent type of energy and commitment as well as a personality able to persist in the face of constant multifaceted challenge. It is relevant to this study to have some insight into that personality and the context in which it developed.

Chapter Two

Early Years, the People and the Places

The New Zealand into which I was born in 1946 was a raw place. The land had been largely stripped of native people, trees and birds over the preceding century. Swamps and wetlands had initially been drained to accommodate a sheep based economy. Buildings were mostly of wood painted in pale and unobtrusive colours. Stone buildings had yet to acquire the patina of weather and age.

The efflux of people from the United Kingdom since the late 1830s were mainly poorly educated and of working class origins. They were leaving a largely conservative, apparently conformist European based society. The social and moral climate was oppressive and paternalistic for many British citizens, men and women. The puffery or advertising of the virtues of emigration to New Zealand was often very enthusiastic:

> Not a farm labourer in England but should rush from the old doomed country to such a paradise as New Zealand. Away then farm labourers, away! New Zealand is the promised land for you. (Labourers Union Chronicle, 1873)

People were still emotionally and socially tied to England in 1946 and the government of New Zealand remained dependent on its traditional economic arrangements with Great Britain. New Zealand had recently sent troops to participate in the 1939-45 war thereby continuing to consolidate the relationship with Britain and the Empire.

A Governor-General appointed from England represented the English monarchy and most people stood solemnly and respectfully in picture theatres as God was enjoined to Save the King. The judiciary and rule of law culminated in the Privy Council based in London and the parliamentary system and constitution remained modelled on the English Westminster structure. The morals and mores of urban reformist Protestantism disapproved of Roman Catholicism and the High Church of England still held

considerable social, moral and political sway. State school children often threw stones at Roman Catholic school children, a biblical form of punishment which horrified me as a schoolgirl.

The New Zealand self image was dominated by rural imagery although the majority of the population was urban based. Halls and gathering places were dim and heavy with tobacco smoke. Apart from a male mania for rugby, people appeared to be conformist to the mores of the time: foreigners, eccentricity and other forms of difference were often regarded with suspicion. By the late 1940s people did not appear to have the energetic drive and passion which propelled their progenitors to the New Zealand islands. Immigration from basically the same sources continued throughout the twentieth century.

The indigenous people were still largely rural and mythologised as simple, jolly, irresponsible, good singers, good at driving heavy machinery, formidable warriors (not soldiers), potentially savage, but no threat to the general population. David Ausubel, visited New Zealand in 1957-1958 as a Fulbright research scholar in psychology from the University of Illinois. Based at Victoria University of Wellington he recorded his impressions of Maori pakeha race relations in his book, *The Fern and the Tiki,* first published in 1960.

> One of the most surprising but also one of the most prevalent attitudes toward Maoris *[sic]* that I encountered in New Zealand was a feeling of complete and utter indifference about the welfare of the Maori people. Many persons hardly seemed aware that Maori persons existed and apparently cared even less. It was thoroughly incomprehensible to them that any sensible person in his right mind would travel 10,000 miles and spend a year of his life studying the Maori people when they themselves couldn't be bothered to give Maoris a second thought. They took Maoris for granted as part of the general environment in much the same manner as they did telephone poles except for some vague awareness that the former were somewhat more of a tourist attraction. (p. 168)

Henrietta Merenia Manawatu Te Ra: 1918 - 1953

My family belongs to several Maori families who have retained some traditional social outlines over the last two hundred years. The roles of our families from both sets of grandparents have remained relatively static from pre-colonial times until a generation

ago. Men and women in our direct lines, both Mananui Te Ra, Te Awe Awe of Rangitane and Tikao of Ngaitahu, have been priests and spiritual and political leaders. From childhood they have been trained in these matters and have taken their place in their communities alongside other specialists. Throughout the juggernaut of colonisation they adjusted their roles to help people work with the ravages brought about by social and economic deprivation. Two of our great grandfathers took responsibility for removing sacred sites and objects from colonial access.

One of Merenia's grandfathers, Hone Taare Tikao, became Chairman of the last Maori national parallel parliamentary movement, Te Runanga o Te Kotahitanga mo Te Tiriti o Waitangi, in April 1892 until it closed in 1902 to allow members of the Young Maori Party to enter the pakeha parliament. As well as his work in political activism, Tikao was concerned that the histories and traditions of our people were to some extent preserved. He dictated material that was compiled into a book which is currently used as a text in Maori studies courses and programmes. Tikao told his daughter that he had to edit the information he gave Herries Beattie, the local pakeha historian, because Beattie could not grasp the sophisticated concepts of Maori thinking and philosophy (Erana Tikao, personal communication, Rapaki, Christchurch, 1978).

Through the activities of our ancestor Piuraki Tikao, a signatory to the Treaty of Waitangi at Onuku in 1840, our family managed to retain a little land. This Tikao, trained in surveying and mathematics in France, experienced in land values while resident in England, challenged the purchases of the Crown and the New Zealand Company in 1848 (Tikao, 1990). The land retained is unproductive and dry but it is unalienated Maori land and has never been owned by others. As such it provides a place for our family to be ourselves. It is called Koukourarata.

This place is a major factor in the formation and retention of our identity. Many of the people of the tiny hapu of Ngai Tutehuarewa consider Koukourarata to be their central reality. Without the focus of this place and the people there, our family would have long dispersed under the pressure of colonialism and urbanisation. The settlement is matrilocal. Houses were built alongside each other on the seafront by Tikao for his daughters and the husbands were selected for political purposes and married in to the family. The daughters owned the land and our meeting house is named for a woman ancestor. Sons of the family had their land elsewhere. The social and political status of

these women was unquestioned. These were capable, strong women who exercised the rights and responsibilities in relation to their land and their people confidently and with a great deal of tolerance, humour and interpersonal skill.

Like many Maori families, the roles of men were more eroded than those of women. Both men and women had superb group and team skills although each also contributed to hapu life in a specialised way according to their individual personalities. Women spoke and still speak on the marae atea despite contemporary ideas that this activity is restricted to men. People contributed to the community in various ways according to their talent, preferences and birth roles. Some were excellent speakers, some excelled at managing daily life or special occasions. They cooked, cared for the ill, gardened, fished, preserved and distributed produce as in any close knit kinship based community. They sang for each other, played the piano in particular, wove people and flax, worked with the spirit, loved, fought, sorted, started and stopped disputes. Some dug the graves for the rest of our family. There were and still are too many graves for those who continue to die prematurely and are lost to the community which has great need of their contribution. Alcohol and relative poverty have had their colonial effect on the human potential of Koukourarata.

The grandmothers and aunts had a major impact on the children of my generation. Their assumption of their places at the centre of things and their skill at being part of a group as well as their sense of continuity gave us emotional places to be ourselves. Coupled with the land, they provided us with their continuity and we took our emotional positions accordingly. Like the land, their lives were also marginal. The aunts and grandmothers were also casualties of the colonial history of this country. Our great great grandmother lived until 102 years, well predeceased by her Jewish American whaler husband. Their daughter lived for only 40 years, her daughter until 43 years and my mother lived until 35 years. Tuberculosis and a poor public health service were responsible for their early deaths.

Fortunately I belong to people who consider kinship to be paramount and who absorb orphaned children if they can. Merenia's death when I was seven years old afforded me several mothers as her cousins and aunts nourished me. Merenia and two of her young cousins were buried on a cold Canterbury afternoon as Christchurch prepared for the visit of a new English Queen. Those deaths and particularly the death of my mother

created a resentment in me as a child, which continues as an adult. This energy has been a major motivator in my activity toward helping to improve Maori health status.

The aunts tell me that Merenia was a charming woman, very tiny of stature, who did not upset people in any way and had a beautiful singing voice. Her brother told me that Merenia was a woman who was full of fun and mischief and delighted in style, people and family. My father said that she was highly intelligent but informally educated and she certainly upset him. I was the only one of her four children who attended her tangihanga at her death. I do not remember her in her coffin although I do remember other parts of the tangi very well.

Merenia represents a transition. The eldest born in her line she inherited the gifts and responsibilities of priests. Life in the first third of the twentieth century did not offer a place for a young woman grappling with the responsibilities of generations of conditioning and spiritual practice. The ghosts which were her proper inheritance were also in transition after six thousand years in the Pacific. My mother was the last of her line to know them well and to speak to them as though they were normal. Later, we became afraid of them. Part of the healing of Irakehu will be the reclamation and reintegration of our ghosts.

Within Ngati Irakehu we lived what we considered to be a proper life. There was nothing exotic or different in my perception of family and home and the way things were done. I believed that we were normal and that it was decent and honourable to be Irakehu. ‘Maori’ as a wider concept was something that pakeha said. My mother was the first of her family to refuse the marriage which was arranged for her. Her brother went through with his but Merenia chose another direction. The children of her second marriage, my brother and I are infused with genes from England and just a drop of Portuguese according to my father. My father’s genes were unknown to the genetic planners of my mother’s people and outsiders and their unpredictable genes were not approved of, but we children are still the beloved mokopuna of Ngati Irakehu, thoroughly known and thoroughly at home. My own children, at home in café society, smooth urban dwellers, also regard Koukourarata as one of the centres of their reality.

George Eric Oakes Ramsden: 1898 - 1962

It was vaguely embarrassing to hear my father refer to England as home, especially when he had never been there. Later when he visited he said that he wept when he first saw the White Cliffs of Dover and I thought that was the very most squirmingly embarrassing thing I had ever heard. My grandmother Sophia Jane (Jennie) Harris was born into a very large Martinborough farming family whose people came to New Zealand via the New Zealand Company in 1839. This was the voyage which accelerated missionary anxiety to establish a treaty between New Zealand and Britain. Family story has it that when the Abraham Harris family left London they were Jews, on arrival at Britannia (Petone) they were Christian. The stresses they must have encountered will probably not be known by their descendents as all references to Jewishness were expunged from the family record.

Our English grandfather emigrated to New Zealand in the 1860s. A younger son in a society in which primogeniture determined destiny, Henry Oakes Penlington-Ramsden tried his hand at a range of occupations for which he was singularly unfitted by his traditional education. Eric Ramsden admired and respected his father. Henry brought a set of *Encyclopaedia Britannica* with him and, according to Eric, father and son spent long hours drinking remedial sherry and port in order to avert tuberculosis and asthma while also imbibing the worthy encyclopaedia. From his father Eric certainly learned the values and ideologies of the English upper classes which he could not readily express in his daily life on the farm in Martinborough, Wairarapa, near Wellington.

At age fourteen, Eric left life in the country eventually becoming an apprentice journalist. Highly competent and very ambitious he worked on several newspapers in New Zealand before becoming a sub-editor on the *Sydney Morning Herald*. He married the daughter of the Australian Minister of Mines and set up home and family and baby nurse in a smart part of town. While in Sydney he attended university focusing on anthropology and Pacific history.

Upon his return to Auckland in 1927, Eric went to Turangawaewae in Ngaruawahia, Waikato, to report on the activities of Te Puea Herangi of the kahui ariki of the Kingitanga. This political movement, originally set up to resist pakeha land acquisition and sale in 1858, was now occupied with the survival of the Tainui people. Te Puea was attempting to reinvigorate the people of Tainui devastated by colonial war and land

confiscation and now impoverished. Among her efforts were land clearance and farming schemes, the establishment of a health service and hospital and reinstitution of traditional Tainui social, musical and religious forms. Michael King (1977) records the beginning of Eric's relationship with Tainui in his biography of Te Puea.

> The meeting house Mahinarangi was conceived as a hospital. When Eric Ramsden visited Turangawaewae in the late 1920s, standards of health in Waikato were little better than they had been twenty years earlier. The pa itself was a model of sanitation and cleanliness. But other settlements had poor sanitary facilities or none at all; living quarters were crowded, unventilated and frequently dirty, the perennial nightmares of typhoid and tuberculosis were undiminished. In addition Waikato people were still reluctant to accept medical care or hospital treatment. (p. 127)

The Tainui experience of pakeha activity, including the health service, had induced profound distrust and avoidance of contact. Like most young New Zealand people of his time Eric had little real knowledge of matters Maori or of the history of the last eighty years in New Zealand since the signing of the Treaty of Waitangi.

The stark suffering of the Tainui people and their determination to survive stirred a sense of sympathy and obligation which he later described as *noblesse oblige*, an attitude learned from his father. His Victorian patrician and patronising views combined with romantic passion and a sense of social justice compelled this intelligent man to take up the cause of the Kingitanga. For the rest of his life Eric remained committed to articulating Maori issues and taking up political cudgels on behalf of Maori. The Maori leadership of the period creatively used his skills and contacts to their advantage.

Becoming aware of New Zealand history and the formation of New Zealand identity led Eric to write the biographies of James Busby (E. Ramsden, 1942) and Samuel Marsden (E. Ramsden, 1936) involving the lives of other missionaries and their association with Maori. Although crammed with fact, these histories are not analytical of the race relations of the period. This work led him to become one of the few contemporary authorities on the Treaty of Waitangi between 1930 and 1960. As one of the few pakeha who had intimate access to Maori politics, spoke Maori and also moved in privileged and powerful government circles, Eric occupied an interesting and influential place in the New Zealand society of his day.

These driving passions did not help his marriage. Manpowered under wartime legislation to Christchurch in 1943, Eric contacted the Irakehu family recommended to him by Te Puea and was introduced to their daughter Merenia, at lunch. My aunts and uncle attended my birth in Wellington in 1946 and took me home. My father was at Ngaruawahia strategising with Te Puea and besides, my parents were married to other people when I was born. Eric was in his late forties at the time. Merenia, in her mid twenties, was taken to a tuberculosis (Tb) sanatorium unable to nurse her baby. I was born into Maori/ pakeha politics and have stayed there.

Wellington: 1946 – 2001

An atypical New Zealand childhood

My brother was born in 1948 after which my parents were married, they separated when I was three and were divorced when I was five. Our sickly mother was unable to live with us except for short periods and our grandparents and aunts, pakeha and Maori helped Eric or took the children for months or years at a time.

We children accompanied our father to many places where children would not normally be seen in the 1940s and 50s. As a sole parent Eric was unusual in New Zealand and even more so as a sole father who maintained a demanding professional role as well as living with chronic and debilitating asthma. I often sat in the studio while he made calm and measured radio broadcasts, but Eric could be volatile. I recall as a preschooler being in the office of the Prime Minister of the time, Sydney Holland, who commented to my father that I had a touch of the tarbrush. That caused an explosive reaction on the spot from Eric, which is etched on my memory. Sydney Holland probably remembered it for a while as well.

As I grew I accompanied Eric to films and very often to the theatre in his capacity as theatre critic for his newspaper. I saw my first Moliere play in the Concert Chamber of the Wellington Town Hall while in primary school. These activities developed my life long love of opera and ballet and particularly of the music of Beethoven and J. S. Bach (whose revolutionary thinking I admired) from Sunday night radio broadcasts on the Concert programme in the 1950s. Later I partnered my father at lunch at Government House during visits from various English royals. Eric was the speechwriter and advisor

on Maori issues for a string of Governors General. My father's role as art critic for the *Evening Post* for many years saw me attending openings of exhibitions and being part of the community of artists where I was often a model and later became a painter, exhibiting and even selling my paintings.

Eric's secretaryship of PEN, the New Zealand writer's organisation, involved us in the writing scene as well. As diplomatic roundsman for his paper Eric spent a great deal of time within the diplomatic communities and we children were favourites particularly among the Russians, the Indians, the Americans, the Japanese and the French. Every three weeks Eric and I would select books from the public library, five books for Papa and three for me. My books were carefully chosen by my father and I was expected to read and report on them. Like many Victorian parents Eric made no concessions to childish behaviour or to childhood. I was expected to front up with considered opinions and not waste intellectual time. There were no terms of endearment or praise, but I knew when I had done badly and suspected that from time to time I may have done moderately well.

Our speech, pronunciation, grammar and vocabulary were constantly monitored and corrected. The same occurred in our Maori family where our most formidable aunt was a broadcaster on National Radio, impeccable in Maori and in English. Table manners were of paramount importance and our manners and behaviour toward others were the subject of constant review by both families. Our Wellington home was full of wonderful food and wine and very interesting people. An inveterate traveller, Eric recreated the food of each country he visited which was not easy in the conservative culinary climate of the 1950s. He was involved in constant diplomatic deals and intrigues to obtain good coffee, Pomodoro sauces and decent wine. These he shared with us, teaching us how to enjoy them fully by recounting their history and explaining their flavours.

The railways were the hub of activity for people who travelled inside the North Island. For we South Islanders the Lyttleton ferry was a fundamental part of our lives. My big boy cousins fetched me home to the aunts and grandparents in Christchurch on their way from Te Aute College, and dropped me off in Wellington at the end of their holidays as they travelled by train back to school.

Our young lives were also very involved with the Ngati Poneke Young Maori Club in Wellington. At a few weeks old I was baptised as a Christian there. I later came to identify the formal structures of the Christian churches, their politics and their processes as a major tool of the colonial process. The national urban migration of young Maori gained rapid impetus after the war and one of the places they gravitated to, in Wellington, was Ngati Poneke. In 1951, 57 percent of the Maori population was 20 years old and younger, as compared to 34.8 percent of the pakeha population (King, 1977). Although New Zealand had full employment the Maori rural labour force was seen as semiskilled and was encouraged by the government to migrate to urban areas to work mainly in manufacturing, and agriculturally related industries.

Translated and named after the English Port Nicholson by Apirana Ngata in 1937, the Ngati Poneke Young Maori Club provided a social and family focus for rural Maori away from home, often for the first time. For some the pain of separation was acute. Witarina Te Miriarangi Parewahaika Harris of Te Arawa recollects her experience of moving to Wellington in 1929 in *The Silent Migration* (Grace, Ramsden & Dennis, 2001):

> Sometimes I'd leave work and go to the continuous pictures, at the Roxy in Manners Street, and I'd cry. I used to go in there and cry and cry, you know? I was so lonely. And I'd think to myself, 'Please, just to see a Maori face, that's all I want to see. (p. 28)

People gathered for recreation and religion at Ngati Poneke. Everybody sang and took instruction in Maori and generally spoke conversational English. Sometimes we sang American Marine songs and young women looked nostalgic. Church was at Ngati Poneke, Evensong always in Maori. Matins was at St Peter's in the city, always in English. We children moved easily between. Sunday at 6pm was reserved for listening to the news in Maori on the National Programme. Bill Parker told us what was happening in the only Maori language available in the public arena. Ten hard won minutes, once a week, fought for by Eric and Bill.

My brother and I were part of a very small group of Maori children in the city before the urban migrants began to have their own families. We filled a gap. To this day we belong to a network of people all over the country who are now kaumatua, who mothered and

cared for us when they were new to Wellington and we were the only available babies to cuddle. They are dying in their cohorts now.

Our home was rarely empty of visitors or family. We were located at the axis between ferry and railway, parliament and the political decision makers. Family, students, academics, diplomats, passing travellers, Maori and pakeha politicians, Peking and Maori opera singers, visiting artists, writers, Colombo Plan students and theatrical people, all visited or stayed.

The 28th Maori Battalion loomed large as our family men who had been officers in the Battalion became Maori welfare officers and public servants in Wellington. Friends and colleagues of my father, now almost mythologised, were frequent visitors. Apirana Ngata, Te Puea Herangi, Te Kani te Ua, Hone Heke Rankin, the Bennett brothers of Ngati Kahungunu and Te Arawa and the Mitchell sisters of Te Arawa. Many, many, vibrant, energetic and exciting people who were committed to the viable and healthy future of Maori. Maharaia Winiata, the first Maori to obtain a PhD, stayed with us when he received his award. His academic regalia hung on the back of my bedroom door and looked luxurious.

The conversations in our home to do with matters Maori were passionate and always pragmatic and critical. There was little ritual but much dignity, determination, energy and intellect. Concerns were for the physical and moral impact of urbanisation on young Maori, housing and sanitation, infant welfare and the physical status of the people. Strategising for change and the political implications of actions were constantly discussed. We children saw daily activism from a wide range of people. Maori health and education statistics were not usually extrapolated from the national information of the day.

The general public was not aware of the gross discrepancies between Maori and other New Zealanders in all social indices because they were not recorded or available for public discourse. The national mythology of excellent race relations persisted while most Maori remained rurally based and Maori/pakeha contact was physically limited. Listening to adult conversation about race politics was a major theme of our childhood. It was not possible to accept the pervasive, passive, patronising and simplistic imagery of Maori when the daily conversation and activity in our home demonstrated otherwise.

The Maori Women's Welfare League was formed in 1951 as a partial response to Maori social and welfare needs. The two vice-presidents were our aunt Mairatea Tahiwi and the exquisite young university graduate from Nga Puhi, Mira Petricevich (Szaszy). I thought then and still do that Mira was one of the most beautiful and clever people I ever saw. She had mana. Eric abhorred her, she was too confidently clear of her direction and not prepared to be directed by a pakeha man. A wonderful role model for young, urban Maori.

Figure 1
Mira Petricevich – A role model

A photo of Mira Petricevich who was born in August 1921 and died December 2001. (Source: Awatere, 1984, p. 91)

The Hunn Report (1960) attempted to define a system of principles on which the Department of Maori Affairs should be based. It attempted to develop a policy for the races (Wetherall & Potter, 1992). This was a benchmark document in that it accomplished a shift from the nineteenth century view of race to the more contemporary notion of culture and, therefore, from the previous government policy of the assimilation of the Maori race to the idea of integration of distinct Maori culture as a social policy. This attitude marked the official recognition that Maori would not now quietly die away and laid the groundwork for future government policy and acceptance of Maori activism toward cultural maintenance.

Irihapeti Merenia Ramsden: 1946-

Multiparented and exposed to a multifaceted world, I developed into a serious and careful child. My nickname in Maori was Taua, old lady.

Illness dogged my brother and me including, for me, tuberculosis as a preschooler. We were hospitalised frequently. I am told that I was relentless in protecting my baby brother from nurses and usually had to be restrained when he needed intramuscular antibiotics. My favourite trick was to feign sleep until the nurses were upon him and then leap to his defence. There are family stories of my dressing him and putting him into his pram and pushing him to town asking people to direct me to Mr Ramsden at *The Evening Post*. I got there once legend has it.

I was my grandparents' favourite, a pretty child with brown eyes and ringlets. Childhood photographs show me dressed in exactly the same types of outfits only grown taller in each photograph. Twin set, tartan skirt, pearls, hair ribbon and brogues, while Eric had sartorial control. One photograph in particular, my sister and I dressed carefully in velvet edged, superbly cut, patterned tweed hounds tooth coats and velour Panama hats, from Kirkaldie and Stains, the upmarket store in Wellington. We are standing on the marae atea at Toa Rangatira pa, Porirua, circa 1950, the old meeting house behind us, perfectly at ease in a transitional world.

Early memories for me are of riding with Apirana Ngata on his horse over the bare lands at Tikitere and other Maori Land Schemes. A small girl in Ngata's arms clutching the pommel of the saddle while my father and brother rode another horse. Dreams and

Figure 2
Transitional World

A photo of myself with my brother and sister at Toa Rangatira pa, Wellington, (circa 1950).
Source: Ramsden – Private Collection

plans for the future prosperity of the people were discussed over our heads as they rode. Te Puea Herangi and her old friend and political colleague Eric Ramsden huddling together, both coughing, in the shelter of Parliament Buildings out of the bitter wind saying their final farewells. The next time we saw Te Puea she lay in her coffin. Te Rangihiroa, Peter Buck, godfather to my brother, discussing Polynesian anthropology with my father, both excited about navigational methodology.

A further very early memory, cuddled into beds made over great, warm, sweet piles of straw which filled our meeting house at Rapaki. Sandwiched between aunts and cousins listening to the family discussing land issues and again strategising for change. People comparing experiences of the Land Court and lawyers, the role of the Ngai Tahu Claim and the Treaty of Waitangi. As I write I see the flickering light from the hurricane lamps reflecting on the bald head of our uncle, Te Aritaua Pitama, it seemed that they spoke all of the night. My brother and I attended many, many tangihanga, and other hui all over the country with our parent or our grandparents.

Determination and passion were early traits for me but they were tempered by the search for constancy. I learned to become my own person, adaptable and sociable but contained. I had a very interesting internal world fed by literature. Books were and are my constant friends and after reading them I glean great pleasure from their presence and the potential to re-read and handle them.

Schools

Schools, there were many of them, were usually a good experience because I enjoyed learning and liked people. Racism in various forms manifested itself either in the form of paternalism or, at another extreme, being stoned after school for being Chinese. How did all those New Zealand children learn those hateful lessons so early and so well? I do not remember any other Maori at any primary schools and few at secondary schools. I certainly colluded with the museum view of Maori presented to us at school and did not associate the information about Maori with my life or any of the people in it. The Maui "legends" and sanitised Maori stories of the School Journal may as well have been about dead people in another country, in another time. We were completely dislocated by the colonial information system from the real history of our country and its effects on the real people currently living in it.

Though the process called education in relation to Maori had little meaning for us, its effect in creating stereotypes and constructing a version of Maori culture became very powerful in the formation of the public view of Maori.

> The ultimate outcome of colonisation is when the colonised believe the stories told to them about themselves by their coloniser.
> (Moana Jackson, personal communication, Wellington, 1990)

Eric's ambition was to see me established as an anthropologist working within Maori communities to record the probable end of the people, communities and ways of life that he knew and had come to idealise. Under the pressure of accelerating urbanisation, Maori society was reshaping and responding to the powerful impetus of the last of the migrations of the indigenous Polynesians of New Zealand, that from the country to the towns. The first urban born child of my Irakehu family, I was now in the early cohorts of the new American instigated 'betweenager' culture as children entered a more prolonged era of education. We were the Beat Generation.

In 1954 the Government had commissioned a report on the sexual activities and promiscuity of secondary school children, adolescents, which confirmed the worst suspicions of right minded New Zealanders that moral decline was upon them and focussed in the adolescent population (Special Committee on Moral Delinquency in Children and Adolescents, 1954). This Mazengarb Report assumed national importance and a copy was sent to every household in New Zealand which received the Family Benefit allowance. This report had a profound effect on the New Zealand public, already in a moral panic about the changing status of young people and the responses of adolescents to the authoritarianism, paternalism and the benevolent despotism characteristic of New Zealand society from government through to family structures.

My father, raised in a Victorian patriarchy did not cope with the rapid social evolution of his daughter. There were few precedents for this strange culture. Like the rest of New Zealand society he was alarmed by the Mazengarb Report and caught in the moral panic. Teenage music was perceived as provocative leading inevitably to sexual promiscuity and pregnancy. To Eric, imminent promiscuity was signalled by wearing matador style trousers, reading comics, listening to Elvis Presley and going to milk bars. I did not have easy access to those commodities, but I tried. Friction marked our

relationship. Trained by Eric to question and resist situations and ideas I thought unethical, I fought with my father. Black and white teenage morality and opinions ruled. I was relentless. Exhausted by the fray, Eric surrendered me to Jewish friends who had escaped the Nazi occupation of Europe and were early practitioners of psychoanalysis and psychiatry in Wellington. We made a contract about my behaviour and activities and I lived a wonderful life alone for several months in a bush studio eating what I wished (frankfurters and mustard, sauerkraut and oranges), attending school and keeping to my part of the contract.

Back at home, the passionate and mutually stubborn and futile relationship between my father and me deteriorated further. Finally, it resulted in my being committed to a psychiatric hospital for several months at aged twelve years. There were no adolescent health services. With a diagnosis of 'Adolescent Instability', I languished in the gothic hospital among psychotic and very disturbed women. Locked in the dayroom, smoking tobacco with the other women, I listened to the wedding of Princess Margaret Rose of England on the radio.

My father announced that I would remain there until adolescence was well and truly over. Although I was not treated with medication or other therapies, I was required to help restrain people undergoing the primitive, unmodified ECT of the day. I cleaned brass and scrubbed floors until my father had that stopped, and watched nightly as people waited with horror to know whether they were to go without breakfast. That meant "treatment", ECT, in the morning. Later, after absconding from the hospital, I was kept occupied in the sewing room where I became particularly adept at making shrouds which had straight seams, not so good at pyjamas. Meantime, I tried to do Correspondence School with little success. This continued intermittently over two years. Because I did not have a psychiatric diagnosis several of the teachers from my school took up the cause of having me released from the hospital. I then lived with a teacher, his wife, who was a whanaunga, and their family, and continued school. This complicated state of affairs ended when my father died very suddenly. I miss him to this day.

My brother and I were now orphaned. Peter was sent to boarding school and I was again absorbed into part of our Irakehu family who now lived in Australia. After attending school in Sydney I decided to return to Wellington in 1963 and undertake nursing

training against the advice of my family who did not see nursing as suitable for a bright young woman of the middle class. The intention of my family had been to see me through university.

Like all young children I had little insight into the context into which I was born and was to grow up. I had no idea that my mid 1940s and 50s childhood was unlike that of most other Maori children of our times. While the historical, political, social and moral settings into which my generation was born have been broadly described, there were a range of powerful influences on my life which contributed to the kind of educator I was to become. Powerful role models who were women, plus my father's expectations of success which were gender free, have been a major influence in my own selection of factors which gauge success. Socialisation into a kinship and community based group taught me to think and behave co-operatively while appreciating individual contributions and skills.

Exposure to a wide range of human activities and constantly stimulating environments have led me to expect my life to be challenging and creative. Contact with people who talked about social injustice and made things happen on a range of levels has taught me that people make change and that change can happen with the right ingredients in the right amounts and at the right time. For me those ingredients are curiosity, vision, passion, critical enquiry, energy, consistency, integrity, relevance and excellent alliances. I was fortunate. There was much to draw on from my early life experience which would stand me in good stead as I entered the world of nursing in New Zealand.

Chapter Three

Nursing

My motivation was not to be a nurse but to be near my brother whose boarding school was along the road from the nursing school. There were few other occupational opportunities for girls which provided lodging and education. Nursing education and training offered a whole different way of looking at the world. Being an individual for the first time apparently unattached to a hapu and without a family or a past was exhilarating. I was out of the social class in which I had been reared which was interesting in itself. The possibility of creating another identity, not Irakehu, was seductive. My grandmother sent me small letters on lined Croxley paper reminding me of my responsibilities in relation to our land throughout my training. I sent my proxies in to the land meetings but otherwise tried to keep out of traditional matters. Although Maori people still had a low demographic profile in Wellington, Ngati Poneke Young Maori Association flourished and I continued to be a member of the Association and part of kapa haka. Church activities were relinquished by my brother Peter and me within months of my return.

There were few Maori in the hospital as employees, I was the only apparent Maori student nurse. Thirty years later, two other students in our intake discussed their Maori descent with me, one from our own hapu. Their family socialisation was not Maori and they were not physically distinguishable as Polynesian. It was not important to them to identify as Maori, and remains so. I consider myself to have been alone as a student.

Other Maori were in the kitchen, laundry, garden or working as orderlies. My attempts to blend with the nursing student world were constantly foiled by Maori people who knew that there was a Maori nurse in the hospital. One notable day I was escorting a patient to theatre in what I fondly imagined was my neutral student nurse identity, the orderly pushing the trolley removed his mask, it was my mother's brother. He winked, I

laughed. Because our family was well known in the small Maori community, people sought help from one of the few sources of contact they felt that they knew and could anticipate some degree of trust from in the local health services.

This situation continued throughout my student years and into the early years of my new graduate practice. I was called upon by relatives, friends,and also people whom I did not know, who were Maori. They wanted me to be at the front door when their ill relative was admitted to hospital, to be waiting for them in the Intensive Care Unit, to mediate between them and the staff. I was constantly asked to reinterpret the information which medical and nursing staff thought that they had given, into more accessible English. Sometimes people asked me to wash the bodies or hair of older family members, alive or dead, or simply to sit with them. Once I was asked to sleep beside a treasured grandmother while family travelled to be with her. Anecdotally, people expressed extreme anxiety about entering the hospital system. Hospital was viewed as a place where people went to die and was regarded with consistent misgivings. The experience of many Maori of secondary care as a final option after poor access to pakeha sponsored service had led to generalised suspicion of the institutions.

My roles were to anticipate tension and stress, protect, interpret and mediate. To help to create a border, a safety zone, a place where trust could happen. There were legacies at work which I did not fully understand but whose shapes I recognised very well. Henri Giroux (1992) discusses the politics of location of knowledge, ideologies, histories, and the boundaries that claim the status of master narratives.

> At stake here is deconstructing not only those forms of privilege that benefit males, heterosexuality, and property holders, but also those conditions that have disabled others to speak in places where those who are privileged by virtue of the legacy of colonial power assume authority and the human agency. (p. 27)

Not only was I suddenly responsible for negotiating the invisible boundaries of history and ideology but the tangible borders of the geography of contemporary hospital realms. This was very difficult indeed for a teenage student nurse socialised into the hospital hierarchy. I was very well aware of the restrictions on movements and the provincial boundaries invisibly maintained by each ward and department, guarded by Ward Sisters and patrolled by Staff Nurses.

In a social climate which contended that there was no difference between Maori and others, and that people should be nursed regardless of who they were, it was also very difficult to validate any role as mediator and to justify the rights of Maori people to have access to service which needed in some ways to be different. I did not have a political vocabulary that could explain the needs let alone the rights of the tangata whenua. I needed the proper words to create a praxis to help me to understand what was happening around us all. Later when I began to read the work of Brazilian liberatory educationalist Paolo Freire (1996), the words came and the meanings were finally accessible.

> Human existence cannot be silent, nor can it be nourished by false words, but only by true words, with which men and women transform the world. To exist, humanly, is to name the world, to change it. Once named the world in its turn reappears to the namers as a problem and requires of them a new naming. Human beings are not built in silence, but in word, in work, in action - reflection. But while to say the true word - which is work, which is praxis - is to transform the world, saying that word is not the privilege of some few persons, but the right of everyone. (p. 69)

Maori political status was something of which I had more experience than most young women of my age but I had no way of analysing or explaining the situations of which we were inevitably a part. It was clear to me that different things worked for different people and there was an obligation on the part of those of us with the power to do so, to instigate change.

As a young Maori woman reared in a gerontocratic society I had little choice but to respond to the clear needs expressed by Maori who were almost all older than I was, and as a student nurse I also had few choices. A large part of my life was occupied with avoiding overt racism, trying to be as inconspicuous as possible and being part of my peer group. Negotiating my way through the morass of situations exercised the diplomatic and people skills that I had observed in the aunts and from all the human diversity of my childhood. This experience stood me in good stead later when negotiating for change became a way of life.

New Graduate

Early attempts at nursing leadership and transformative activism

Early practice was interesting and stimulating. Working in Accident and Emergency suited my personality until I felt that I was losing sympathy for the less dramatic situations in which people found themselves. I then enjoyed being Charge Nurse of a very busy medical ward but was prevailed upon by my family to take my skills into an area where there were more Maori. In 1970 that area was respiratory medicine, more particularly caring for men who had pulmonary or renal tuberculosis. The wards were separated from the rest of the hospital and the people in them had developed a distinctive culture of their own. I learned a great deal about nursing from the men who were confined to hospital for a basic twelve weeks and often for a great deal longer. Many were Maori. I also learned a great deal from the nurses whom I was supposed to lead.

Long term hospitalisation presented special issues for which I or indeed the culture of nursing was not prepared. Often young and feeling comparatively well but requiring stabilising on very repellent medication, these men became easily bored and recalcitrant. There were issues of sexuality that were not addressed as well as the simpler matters such as appealing and familiar food.

Most significant of all were the power relations between medical and nursing staff, and the men. Because I was from the marginalised group, as a Maori but was also part of the inner professional group, I was in a position to identify the symbolic margins and boundaries between each group although I still could not name them. I recognised that these men had rights, which were undefined, and that the inactivation of these rights were related to the health service culture and ideology, autonomy and control.

Slowly, from my position as Charge Nurse with some authority in our own little province, I realised that the major right of patients was to information and that we health professionals were manipulating information for reasons that related more to our need for routine and control than they did to empowerment of the people we were there to serve. It was also obvious that the control was unsuccessful because many of the men were not taking their medication and were occupying themselves in very non-theraputic

ways such as disposing of their unpalatable medication in very creative ways, absenting themselves from the ward for long periods and enjoying vast amounts of alcohol.

With the men and one supportive staff nurse we embarked on a process of giving them information. They enjoyed learning to read their serial x-rays and interpreting their laboratory forms. We used teaching examples from their normal lives to explain the process of tuberculosis. I also encouraged people to show their families their data and films to trace the progress of their recovery. Most people had worked in freezing works and were familiar with Tb in the animals they handled. It was simply a matter of obtaining sheep lungs with tuberculous cavities and caseinous material, having them preserved by the mortuary technicians and making them available for people to examine and to show their families along with their films and notes. It gave me pleasure to hear men explaining to families, in Maori, in the inner sanctum of the ward, the office, using the equipment to view their films and reclaiming their own information. They were becoming powerful. People did not abuse their access to information, times and situations were negotiated so that the flow of the ward was not interrupted.

There was a clear and consistent change in the attitude of the men toward their unpleasant medication once they were clear about its effect on their disease. They could evaluate the information for themselves in a framework of their own lives. With their agreement I backed up their new compliance with a new system of drug administration.

Matters of sexuality were recognised and given the importance that they should in the presence of highly infectious disease. Nurse and patient roles at this time maintained a neutrality of sexual identity that made it very difficult to address fundamental human issues. With the co-operation of the younger members of the nursing and medical staff and the men, we established a system of anonymous question and answer sessions in a weekly staff and patient forum. The questions the men asked were often so simple and so obvious that their reluctance to discuss them said a great deal about our denial of their sexuality, our poor communication and facilitation, and the moral climate of the mid 1970s.

I was also greatly concerned with tobacco use in a respiratory ward. It seemed a contradiction in terms to admit people who were gasping for air, running oxygen and smoking tobacco simultaneously. Cigarettes and tobacco were sold daily from a trolley

wheeled through the ward sponsored by the Returned Servicemen's Association. The hospital did not have a policy on tobacco use and smoking was institutionalised. A supportive staff nurse and I created an admission cubicle which was smoke free. Perhaps it was the first in the country? When people were over their acute admission phase they would move to another cubicle and resume tobacco smoking. Of all the change I attempted to institute, this met with the most resistance from nurses and from the men. When I left the ward the non-smoking cubicle was dismantled.

A further concern to me was the education of student nurses. Formal clinical teaching had not been established in wards at this time. I believed and still do that the education of our potential professional nurses should be as wide, as varied and as well informed as possible. The clinical area should hold stimulating challenge and excitement and should be a constant site of learning, with such learning being a privilege and a pleasure, underpinned by the responsibility for the care and wellbeing of other human beings. To this end I provided as much variety and information for students as possible, taking the responsibility for education very seriously. Two staff nurses of my own age assisted with this aspect of our work. Other nurses devalued and undermined it. We found clinical teaching material which we had carefully prepared for each student nurse and sent on to our supervisors, in the rubbish bin more than once.

Team Building?

As a young and new charge nurse I had not developed the team skills necessary to bring all the members of staff along with these radical changes. Tuberculosis and long term respiratory wards tended at that time to be staffed by older conservative nurses who were very skilled in their area but were rapidly depleted of the technical knowledge and ideas that were then entering nursing. For example Cardio Pulmonary Resuscitation was being introduced to general wards but there were no staff development opportunities provided which would have given our nursing colleagues confidence. The physical isolation of the Tb wards, generally uncomplicated technology (but very complex pharmacology) held low status and enabled them to avoid the mainstream of change for a considerable time. Nurses working in these wards long term became nervous of being identified as needing to increase their general knowledge, competencies and clinical skill base.

My socialisation as Maori required me to see all contributors to the hospital community as valuable. Therefore occupational therapists, social workers, the cooks and orderlies were people without whom the wellbeing of the patients would be directly affected. As the nurse leader it was essential for me to respect and work with them. This redefinition of hierarchy and role also caused strained relationships within the nursing staff.

On a personal level medical staff were very supportive to me because they could see positive change in the response of the men. They did not see it as their role to take part in nursing interactions and tensions. "Doctor power" and "nurse servant/good wife" behaviour was deeply embedded in the hospital culture and the stratification between professional groups was formally maintained against my efforts to integrate them. Other staff members were also supportive because they were now included in the culture of the ward. This led to a high level of communication with allied staff, for example my time spent listening to the men about their food preferences translated into discussions with the cook who had no difficulty changing menus to provide emotional as well as nutritional sustenance. Boil-ups entered the regular diet as did rewana bread and other delicacies provided by the Tb Association. Occupational Therapists provided carving tools and wood. The men carved a tekoteko which stood at the entrance to the ward to welcome patients and visitors. When I left the ward the orderly told me that this carving was put into the boiler.

One response of nursing colleagues to my attempts to create what I saw as progress and to my poor management skills, was to ostracise me at communal gathering times. There was a quiet and steady resistance to any variation I and my younger colleagues might attempt. It was significant that the resistance came only from nurses. Medical and other allied staff as well as patients responded well to new ideas and changes. At one stage the pakeha story of the mysterious elves who cleaned the house and made shoes overnight came to mind as the changes we made during the day were quietly reverted during the night by the long established night staff. The horizontal violence I experienced was a useful early lesson although at the time it led to severe depression.

Quality Assurance

Both my grandmother and my whangai mother visited the ward, knew several of the men and their families and checked with them about the quality of the service they were

receiving from the staff and from me. The men were frank and supportive and made helpful suggestions which my family relayed to me. After three years, illness and subsequent surgery took me out of the Tb and respiratory environment. My reputation preceded me and I was not permitted to resume the status of Charge Nurse although medical staff and patients attempted to influence my return. I was offered a position in the Milk Room making up milk mixtures for babies. It was well known in the nursing world that this was that an area where aberrant nurses tended to be employed when their difference was obvious in the dominant professional environment. The Milk Room was known to be a place where identifiable lesbian nurses, Samoan nurses, nurses with poor English language skills or other apparently different nurses often worked. A nurse who was comfortable and open in her lesbian identity applied for employment in 1974 and was offered only the Milk Room, ultimately staying there for three years.

In a letter to me about her experience in the milk room, which she has given me permission to publish, Tighe Instone (personal communication, Christchurch, Wellington, 2001) says;

> My introduction to Wellington Hospital led me to believe that the milkroom must be a holding pen for deviants…the tangible prejudice and veiled hostility left me with a feeling that I had been betrayed by the nursing profession…the relationships that my son, my friend and my neighbours forged with the Samoan milkroom staff and the wider Samoan community will always be treasured.

A process of refusing my applications to work in areas of my choice finally saw me working in the Fracture Clinic where I stayed for eight years, eventually working several evenings a week while my children were small.

Lessons learned from these experiences

- That leadership is as much about timing as about the quality of ideas.
- That the ideas which potential leaders wish to convey must have beneficial meaning for most of the people for them to risk becoming involved in the process of change.
- That ideas must be marketed in a way which motivates people to create and adapt to change.

- That institutions consist of cultures within cultures.
- That the attitudes held by health professionals have a direct impact on the wellbeing of the people in their care.
- That frequently professionals are not alerted to their own attitudes.
- That horizontal violence in nursing extends beyond racism and sexism to homophobia and resistance to the wide spectrum of human difference, and is also institutionalised.

Expanding Horizons/Epiphanies Etcetera

The birth of my son was the powerful catalyst for the intellectual, emotional and political examination of what it meant to be Irakehu in 1973. Later my daughter's 1977 birth consolidated the commitment to extract a viable legacy for them from the colonial chaos. Now I understood the political action of my grandmother in keeping me linked to the land through the little Croxley letters. It was also time to go home regularly to Koukourarata with the children. Realisation that our reserve land was the most marginal in the area and that the rest of the land was in pakeha ownership, and that those pakeha had benefited generationally and my people were generationally poor, led me to investigate Land Court records and legal activities according to the pakeha law. Although the daughter of an historian I had little knowledge of the political history or the legislative manipulation of the ownership of Maori land and the social, economic, educational and legislative processes which led to the poverty of Maori people.

I did not understand why Maori were stereotyped as unintelligent, irresponsible and lazy. Why Maori were demonised in the media, filled the prisons and hospitals and were told that they had the same opportunities for successful social accomplishment as everyone else. My whole experience showed me that there were fundamental and brutal injustices in our society and I wanted to know how and why they got there, how they worked and how they were sustained.

The Crown, a local family firm of lawyers (again through three generations) and local farmers contributed to a story of deliberate and regular deprivation of land from my family. Interviews with family members revealed stories of land shares signed away

while owners were drunk or unable to work or borrow from banks, and a dependence on local farmers who were always able to supply cash in exchange for a few more land shares. Having to walk with my children past the house which my great-grandfather built for my grandmother and her family, knowing the history of the illegal purchase and immediate resale in 1943 verified through the records of the Maori Trustee, caused me physical and emotional anguish.

It was a lonely time because my family had coped with the facts in a range of ways, most commonly by ignoring and often denying or forgetting the history in their helplessness to confront it and to change the outcomes. As their world had become smaller they seemed to have shrunk with it. They appeared to accept the processes of economic colonisation and social deprivation as natural. I was shocked and saw this outcome as the ultimate colonisation, that of the memory and therefore of the mind. Like bell hooks (1994) I often felt alien in both my families. Her experience of trying to articulate what was happening to her family through theory as a child had ringing resonances for me. hooks' mother wondered how she had come by the subversive ideas that threatened to undermine the constructs by which her people had enabled themselves to live. In frustration her mother wondered where hooks had appeared from and wished she could be "*sent back*" (p. 60).

Those were sentiments which I heard from my father's and my mother's people as I tried to make sense of what was happening. The most common phrases were about my being 'different', a dreadful indictment in a kinship based and highly co-operative setting. In later years my family became dependent on my skills in the Land Court and in formal settings, as well as supporting my undertakings greatly, but the apprenticeship was arduous. I had to be very careful indeed to allow the erasure of institutional memory to regenerate in a manner which my family members could control at a pace which was safe for them. For some it was rapid, violent and shocking, for others it did not happen at all. The manifestation of powerlessness and helplessness as anger and grief and its progress to transformative intellectual activism was a process which I had to experience in order to rearrange my realities so that I could survive the transition and be intellectually and emotionally intact. This has happened to me several times, each time refining my emotional and political identity as an Irakehu woman more clearly.

Like hooks I learned that theory could be a healing place. bell hooks discusses her initial response to the work of Paulo Friere in her book, *Teaching to Transgress*, published in 1994. She identifies Friere's work as giving her a language as a young student when she began to think deeply about the construction of an identity in resistance.

> And so Friere's work, in its global understanding of liberation struggles, always emphasises that this is the important initial stage of transformation - that historical moment when one begins to think critically about the self and identity in relation to one's political circumstance. (p. 47)

The motivation to understand was now an imperative. I knew that the pain, anger and grief I was experiencing were potentially detrimental to my functioning. My peers, my husband and most of my family had no apparent understanding of this pain. Those who did have insight also could not articulate its political origins and its social presence. Seeing what was happening to my mother's people and its structural inevitability was enraging. The energy from that rage and grief needed to be harnessed constructively because it was isolating me from objectivity. Without some distance I could not view the realities around me let alone attempt to change them. By this time I was seeking to grasp the reasons for the depth and breadth of racism in New Zealand society and to comprehend the nature of its institution. I thought that university was the route to the theoretical insight I needed. Those evenings in Fracture Clinic proved very profitable for me because I was able to use the quiet time to study. I completed my undergraduate degree in Anthropology in 1983 specialising in Maori Studies, Criminology and Women's Studies. Learning to use the university system and to order my thinking gave me the tools I needed to observe the world and to consider the possibilities for change.

At this point the most useful analysis came from feminist theory because it examined power relations and the patriarchy and with little modification could be applied to the English colonisation of New Zealand. Our cousin, Miriama Evans, joined me in Women's Studies and together we found that we had to defend the histories, social class experiences and identities of Maori women from being subsumed by the analysis of pakeha feminists. This was very useful practice for future work. Again, bell hooks (1994) comments on the same experience:

> Though the call for sisterhood was often motivated by a sincere longing to transform the present, expressing white female desire to create a new context for bonding was no

> attempt to acknowledge history or the barriers that might make such bonding difficult if not impossible. (p. 102)

Now I was able to move from curiosity to investigation. From being integrated into a wide range of circumstances in which I was relatively comfortable I had now experienced what Trinh T. Minh-ha has called a "mutation of identity" (1995, p. 216). By defining the '*other*', I had begun to define myself. Henri Giroux (1992) writes of Eurocentric culture and its assumption that its own meta-narrative can ruthlessly expunge the stories, traditions and voices of those who by virtue of race, class, and gender constitute the '*other*'. Although I could not agree with the definition of my mother's people and myself as *'other'* since I consider ourselves to be normal, residing in our own country and living in our own history albeit in grotesque circumstances, I could certainly see where Giroux derived his thinking from and knew that those with the power to call our people '*other'*, would continue to do so as a function of their power.

the bone people/The Spiral Collective

In 1984 as a new graduate from university in the formidable company of Marian Evans and Miriama Evans, I entered the world of publishing books. It was not an unfamiliar world and as the daughter of a wordsmith did not hold many mysteries for me. I was fortunate not to have been brought up with the awe of printed words and their perceived authority which many New Zealanders' recency of literacy, created. The opposite was true for me. Words were to be protected and viewed cautiously if I suspected that they were being overused until their meanings vanished, or that they were cynically employed to sell newspapers or advertising or were being manipulated unethically. For me books and the words in them are potential friends and tools to be mindfully selected, examined and chosen for their perfection of expression, their potential for joy, as well as their prosaic function. They are above all human constructs employed for human purposes. Making a book is part of that process.

Our small collective was named "Spiral". We undertook to physically create and publish a book while maintaining its integrity which we believed in as literature. The manuscript written by our cousin, expressed a series of realities that had rarely appeared in New Zealand writing. Physical and mental domestic violence, Maori allegory and metaphor, and recipes, did not fit the standard novel form and the manuscript had been

regularly turned down by several publishers. The author had given up and had decided to encase the manuscript in resin and use it for a doorstop.

Once between covers '*the bone people'* swept most of the major literary prizes available in New Zealand, went on to collect the Pegasus Prize for indigenous literature sponsored internationally by Mobil Oil, and then won the English Booker McConnell Prize which remains the major award in English literature. Our whanaunga Keri Hulme has her place in the New Zealand literary firmament and I learned very valuable lessons from the experience about pushing out parameters, staying true to beliefs, and hard nosed international literary contract negotiation. *'the bone people'* took us to England to attend the Booker Prize presentation dinner and to receive the prize for Keri at the Guildhall in London. I was astonished and irritated to see that the very English weeds between the railway lines had their counterparts between railway lines in New Zealand and that the streets of wealthy Kensington were lined with houses bearing the dates of the colonial economic stripping of the country of our whakapapa and those of other native peoples. I was reminded of Barry Barclay's words: *"Stone by stone, grain by grain, stone by stone, grain by grain"* (1993, p. 204).

The colonial office was of great interest to me but in five subsequent visits to England I have not been able to bother myself to look at Buckingham Palace. That symbolism I understand very well. In the United States I helped negotiate Keri's contracts with Baton Rouge University and Mobil Oil. They were creative contracts because we held the rights to the greatest literary prize of the year. I had some time with African American writers in New York and later worked with indigenous and feminist writers in Norway and Spain. In later years I became a regular judge of literary awards in New Zealand and have contributed to many publications. Although I was grateful for the solid grounding in literature and the classics in English which I had from my father, I was also profoundly grateful for the classics in the Maori song record which our childhood grounding in Ngati Poneke provided us with.

The social institutions of the times taught me that punishment could be swift and enduring for perceived transgressions or the threat of destabilisation. The systems and culture which were called "nursing" taught me about inflexibility, conformity, control

and oppression and fear of change. Those were significant lessons because they made me think critically about power, how it was managed, and who the beneficiaries of power and control really were. This exploration led to further formal education and enabled me to recognise and analyse personal and institutional racism as well as the ambivalence of social and cultural boundaries and the issues they represent for nursing practice.

This information was invaluable in providing me ways to view challenge and change and how that might be achieved at both a personal and systems level. The next movement in my nursing career would take me out into direct contact with families in their personal home and community environments. With this move would come further practice experiences requiring other skills and considerations in terms of negotiating power and moving between borders.

Chapter Four

Community Health and Nursing

Professionally it was time to move out of secondary care and investigate nursing practice in a primary health care setting. The position I applied for as a Public Health Nurse was in a socially disadvantaged and economically impoverished area outside Wellington. The nurse manager advised me strongly not to work there because my skills and education would be wasted in such communities. Nurses with university degrees were not common then.

For all the liberatory education, professional and human experience I had, working in Porirua was again an exercise in learning about myself, my professional power and my own entrenched attitudes. Examining myself as a culture bearer I was astonished at the level of racism and victim blaming attitudes that I carried with me as part of the social class in which I had been raised. I was grateful for the education which enabled me to understand the origins of these attitudes and for the insight which helped me to think them through and to do something about them. I had no guilt about their presence because I understood them as social constructs but I knew they had to go if I was going to be effective as a nurse. As a member of the marginalised group I was well aware that people at risk automatically run emotional security checks on all strangers. Being among people who were trapped in cycles arranged outside their lives and devoid of almost any vestige of control gave me insight into global economic and political power. It was obvious that my education had given me a ticket into and out of their communities every day, that realisation was deeply humbling.

My view of what I was bringing into their communities began to pivot. I thought that I knew what my skills were and that I could be of some use to people. What I discovered about myself was close to the same set of insights which the patients in the respiratory and Tb wards taught me. My role and stereotype as a nurse did not make me

automatically trustworthy and I could not assume that I could set up co-operative alliances (which at one level could be called friendships, culturally unprofessional at another) with people. Already I knew that I held power and controlled many resources and that the cultural institutions of which I was a member placed many people at risk because my attitudes would inform the selection and allocation of resources. Unless I understood myself very well as the bearer of culturally derived attitudes such as internalised racism and ideas of social class, I could very well become the oppressor of Maori and others who were less powerful than myself.

The tensions identified by Paolo Freire (1996) in his seminal discussion of the duality of discoveries for oppressed people who begin to think critically about oppression were very real for me as I entered parts of the Porirua communities as a Maori who was also a nurse. The expectations of my professional colleagues were that I would be a nurse who was also a Maori. Herein lay a profound ethical dilemma.

> The central problem is this: How can the oppressed, as divided, unauthentic beings, participate in developing the pedagogy of their liberation? Only as they discover themselves to be the "hosts" of the oppressor can they contribute to the midwifery of their liberating pedagogy. As long as they live in the duality in which to be is to be like, and to be like is to be like the oppressor, this contribution is impossible. (p. 30)

By this time Irakehu had become a very personal and protected reality as others now defined me publicly as Maori. Shared ethnicity and in some cases kinship with the people I was serving was not the critical factor in my relationship with them. Unless ethnicity held mutual meanings there could be no assumptions that I could be safe, I did not live in that community and had not grown up there. I did not speak English or Maori like they did and I was a Practising Certificate holding member of an authoritarian system which had not traditionally been beneficial to Maori or other Polynesians.

The critical factor required was trust. Over the years of teaching and learning I have compiled a list of factors which I believe contribute to setting up trusting relationships. They are defined in terms of expectancies and beliefs. Here are some words which describe perceptions of trust as I have come to understand them. Safety (this includes keeping confidences), benevolence, caring, concern, honesty, integrity, sincerity, competence, ability, capability, good judgement, credibility, predictability, consistency,

goodness, morality, goodwill and intentions, shared understandings, reliability, dependability, open mindedness, personal attraction, responsiveness and dynamism, the idea that things will happen.

It was not difficult to see that the people I was working for might not trust me. What was much more complex was the examination of my own psychological and emotional interior. I was aware that there were expectations on the part of my pakeha managers that I would be able to gain access to people and places that they were unable to access and that I would be exposed to, and to some extent, participate in, what bell hooks has described as "*cultural criticism*" (1990, p. 9). I entertained uncomfortable visions of the Judas sheep kept at freezing works which lead the other sheep to the killing chain keeping them calm while turning away at the last minute to lead in the next batch of sheep.

There was a clear expectation on the part of my employers that I would reveal and describe the discoveries I would make in the communities from which most nurses were excluded. By virtue of my shared ethnicity I would be able to bring to the corporate consideration of my colleagues the information to which they were not privy. hooks (1994) warning is clear:

> If there is not a mutual exchange between the cultural subjects…that are written about and the critics who write about them, a politics of domination is easily reproduced wherein intellectual elites assume an old colonising role, that of privileged interpreter, - cultural overseers. (p. 9)

It was at this juncture of beginning practice that I found the work of Paolo Freire (1985) again illuminating the invisible, shaping my attitudes toward the people and the communities I had decided to enter. The people there had not invited me. I had selected them. There was no initial nursing partnership. Why had I done this? Because I wanted to help? What did help mean? Friere discusses armchair revolution. He is clear that what he calls "*true reflection*" leads to "*transformative action*" (p. 48). Authentic praxis for Friere happens only if its consequences become the object of critical reflection. My entering the communities of people whom I saw as oppressed had the potential to fulfil needs, but whose needs were they? Fresh from university with a liberatory analysis, was I going to free people from their oppression and go home to my middle class

environment daily and at weekends while they stayed there potentially for generations? I had some thinking to do. The last thing these people needed was another form of missionary. Freire warned against action without critical reflection simply becoming activism. As an activist nurse I could rush around all day being helpful within the range of my skills and job description, but what difference would that ultimately make? Already I was aware that nurses leave such communities and the social waters close behind them as another nurse with another job description and another set of attitudes, moves into place.

> … it is necessary to trust in the oppressed and in their ability to reason. Whoever lacks this trust will fail to initiate (or will abandon) dialogue, reflection and communication, and will fall into using slogans, communiqués, monologues, and instruction. Superficial conversions to the cause of liberation carry this danger. (p. 48)

It was clear that I must therefore also ask myself whether I trusted the people I worked for to use their realities (where I could not go) as the templates for their lives and learning. That meant that I needed to divest myself of the ideas that I had the answers to their needs or that indeed I fully understood their questions. It further meant that I should see myself as a privileged stranger in their landscape to be guided at significant points by them. It was necessary for me to understand the rights of people to their full humanity and to learn, as I did from the Tb ward men, that I had power and the proper use of that power should be a negotiated process. As a Maori those ideas were very easy to accept because they are encapsulated in the concept of mokai.

Mokai

There is mana in the concept of mokai, in being able to give skilled and valued service which makes life easier for others. The concept of mokai differs from the notion of servitude in that the mokai is valued as a professional community member who has a set of skills which enhance the quality of life of individuals and the collective. The mokai can be a powerful and beloved servant. The familiar sight of aunts, uncles and grandparents performing quiet and thoughtful tasks was a normal one for us. However exalted they may have been in their birth status or their formal roles and however skilled in the performance of ritual and solemn observances they may have been, it was beneath none of them to wash dishes, clean tables or to see to the most minor comfort of

their guests. While visitors were to be cared for none of them sat or saw to their own needs. If food was short they did not eat until guests were satisfied. It was done quietly and without fuss. We children were disciplined to wait until all others were served and comfortable and then our needs were met. Everybody knew that in the long scheme of things such consideration would be reciprocated when roles were reversed and visitors became hosts.

It was very easy for me to translate those life examples and concepts into practice as a nurse. The skilled servant concept was and remains comfortable to me because I understand that in the long term I, and those I care about, will one day be the recipient of nursing service which I hope will be based on such concepts.

Practice Issues and Ethical Dilemmas

My responsibilities and contacts as a Public Health Nurse in the 1980s extended from newborn infant welfare service, family liaison, through preschool health to primary and secondary education institutions, families, refugees, immunisation, vision and hearing testing, plus assisting with tracing contacts of communicable diseases. I claimed and was given, responsibility for Maori specific organisations, kohanga reo, urban marae and the two major Maori gangs resident in Porirua. It was not difficult to assert professional contact. These were not popular institutions with my colleagues although the health needs of their members were great. The issues and lifestyles associated with the generational entrenchment of poverty and poor educational opportunities were normalised, obvious and grossly unfair. The decision makers in these communities, school principals, medical doctors, business owners and administrators were men, almost totally from the non-Maori population along with several recent migrants from Asian countries. Polynesians indigenous or migrant were not well represented in the decision making positions.

The basis of any productive relationship with people who perceived me as the powerful carrier of a range of potentially risky differences was whether or not I was trustworthy. Would I do what I said that I would do and would I do it in a way that did not place people at risk?

> "What hours do you work here in Porirua?"

"By the time I get here and then leave to go back to town, 9am to 4pm."

"Oh, pakeha hours."

Initially the differences between myself, as a Maori person, and the community Maori people were greater than our similarities. It was clear to me that I was being often, pleasantly, tested for trustworthiness. I was more of a potential liability to people in some ways due to my ethnicity. At least pakeha attitudes were a known entity, assumptions could be made about interaction with pakeha power holders until proven otherwise, but one of their own was a much less predictable proposition. As a member of an professional outsider group and an outsider social class it was possible with my insider socio/cultural knowledge that I might lead people into conflicts with authorities such as the Social Welfare system, Inland Revenue Department or the police.

Trinh T. Minh-ha (1995) observes:

> Whether she turns the inside out or the outside in, she is, like the two sides of a coin, the same impure, both-in-one insider/outsider. For there can hardly be such a thing as an essential inside that can be homogeneously represented by all insiders; an authentic insider in there, an absolute reality out there, or an incorrupted representative who cannot be questioned by another incorrupted representative. (p. 216)

Working in this environment offered some of the most rewarding as well as some of the most frustrating times of my twenty-three years of practice. Community trust came quickly in some cases and more slowly in others. Word spread that I was non-judgemental and did not appear to abuse power. Doors opened. Entry to many places was enhanced by being previously known to significant community people, having good Maori manners, personal maturity and my own skills and personality. My formal education as a nurse and my job description had none of these factors integrated into them.

My practice differed from that of my non-Maori colleagues. Often it was essential to manage time quite differently. Time was allocated in ten minute sections on time sheets as part of time management and costing of nurses' activities. This type of time management was simply not possible with the people of Porirua. To earn their trust I needed to work for the duration which people chose to take over their initial contact

with me and it was essential to work at their pace. Although I knew that a morning spent with a matriarch would give me access to her whole family, if she approved of me and judged my skills as useful, that use of time was not factored into my management schedule. This necessitated my having to regularly falsify the timesheets because there was no professional opportunity to create another way to manage time. I saw the refusal of my manager to consider my version of effective practice as institutional racism in its most entrenched form.

Borders and Frontiers

The concept of borders is used in this work to convey distances between actors, and locations. The locations are physically geographical but also intangible, consisting of personal locations in intellect, emotion, attitude and politics. They are always political and consist of notions of history and power, justice and equality, which distil into local everyday activity as well as global webs of economic control. Henri Giroux (1992) has written extensively about the notion of borders and is concerned with the development of a critical pedagogy for teachers and students. He discusses the border metaphor as a series of ideas or ideological codes which must be recognised by those attempting to work across borders:

> Cultural workers need to unravel not only the ideological codes, representations, and practices that structure the dominant order, they also need to acknowledge "those places and spaces we inherit and occupy, which frame our lives in very specific and concrete ways, which are so much a part of our psyches as they are a physical or geographical placement." The practice of social criticism becomes inseparable from the act of self criticism; one cannot take place without the other. (p. 79)

Practice Examples

Throughout this chapter I have identified issues of trust and safety as they became insights for me in relation to working with people in the community. Freire and others have helped further shape my understanding of these issues and the way they need to be regarded as central to effective health care. In reflecting on my early practice as a nurse, the connections between these issues and the emergence of Cultural Safety as a

concept is clear. The following examples illustrate the necessity to think differently and to act differently in order to demonstrate trustworthiness, which is so central to safety.

Practice Example One: Informed consent on the border

Although I was extremely diffident about taking nursing students into the homes of disadvantaged people, it was part of the responsibility of Public Health Nurses toward the professional development of our potential colleagues. For a while I managed to deflect students into institutions such as schools, kindergartens and medical centres but the time came when I could no longer do that.

I asked permission of a young Tuhoe mother to bring a student into her home to observe my work in infant welfare. I also warned her that the student was likely to be a pakeha who would have her own opinions about the family and their environment. Neither the mother nor I could predict what those opinions might be, nor should we, but the potential for tension and stress was real. Although we did not discuss it, shared ethnicity did make a difference here. Both the young mother and I understood the politics and the experience of exposure to a pakeha stranger and the watchfulness which we would both be required to undertake. It was an extra tension in her day that I was asking her to accept and a series of borders that I was asking her to negotiate.

I learned that it was essential to establish informed consent in community nursing just as in secondary care. In a clinical environment informed consent is potentially less complex than in the community. Clinical, biological and technical boundaries maintain the cultural power called professionalism in secondary care. The selection and editing and language of clinical information enables the status of the actors to be maintained: doctor, nurse, patient, family roles are clearly delineated and the geography of the transaction, often in a hospital, usually favours the health professionals who can therefore sustain the locus of power with ease. Community settings require more negotiation since the nurse is essentially a mokai, a skilled servant or has a quasi guest status in a private home. Differences in social class and ethnicity where people have been exposed to a lifetime of racism, homophobia or other predetermined attitudes from authority figures require a degree of insight and skill on the part of the nurse for which our professional education does not prepare us.

The subjective response to the idea of bringing a student nurse, someone who was destined to have skilled employment and a very different future from this young sole mother of three preschoolers, could be predictable and understandable. I was an unsafe factor in this equation which required me to exhibit nursing skills to a pakeha stranger at a potential emotional cost to the young woman.

With grace, I was given permission to bring the student into her home. The trust relationship we had built up had worked for me but it carried with it reciprocal responsibilities. The setting was one of poverty and economic deprivation when viewed from one perspective, from another it was a site of integrity and creative energy and fierce commitment to motherhood.

It was winter. The family lived in a semi-detached state house with no garden, plenty of mud and minimal household effects. There were no curtains and no carpet. The mother smoked tobacco and both her toddlers had upper respiratory tract and chest infections. Their clothes were ragged at the edges. The new babe was thriving, there was no sign of the father. All the children wore disposable nappies and there was a VCR monitor with videotapes in the corner. I weighed the baby. His mother asked me to take her to the medical centre with the toddlers. We did this despite the rule that only international refugees could travel in Public Health Nurses' cars. I was seen and later reprimanded by the nurse manager. My view that the indigenous peoples of this country are refugees from the process of colonialism would have held little water. The toddlers were prescribed antibiotics and their immunisations were updated. Payment was waived by the doctor and the pharmacist.

We debriefed and I asked the student to describe what she had seen and to feel able to be as frank as possible. Using the framework of her own realities the student made her assessment. The description of external deprivation was accurate. The tobacco use, chest infections, the presence of a new baby while the mother was receiving state funding, in the form of a Domestic Purposes Benefit (DPB), and no potential for a male contribution to the household economy, were all noted. The VCR and tapes were also discussed as being unnecessary items when there were curtains and carpets required. I saw one of my responsibilities to nursing and to that little family and to future families that this nurse might encounter, as helping the student to think critically about the situation of which she had just been a very brief part.

We reviewed the observations and reframed them positively in light of the assets available to the mother. It was important that the student realised that she and I were privileged to have been invited into other human beings' lives and to be aware that we had the opportunity to leave if we were uncomfortable. The little family did not have that option. The young mother had chosen to keep her three children and to parent them as well as she could within the limits of her resources. Curtains, carpets and regular new children's' clothes were not available to people on the DPB who did not have sufficient discretionary money to allow accumulation of capital. The essentials were there, food was refrigerated, lavatories flushed, there was hot running water and the children's heads, chests, genitals and feet were covered and warm. Although the mother was addicted to tobacco, there was a great deal else in that neighbourhood to which she could easily have become addicted if she had chosen. She did not choose to become involved with the marijuana and hard line drugs which were procurable. Tobacco smoking took place outside the house and away from the children.

Disposable naps were used throughout the Porirua area in preference to cloth as easier to handle, less fuss to care for, not requiring hot water, washing and drying facilities. They had become part of the culture of the poor. Environmental issues were of secondary concern to ease of daily survival. No telephone and no transport meant that this parent could not easily get her children to the medical centre. Knowing that I was coming she waited, trusted me to arrive and exploited her opportunity for assistance very well and to the advantage of her family. And the VCR and videotapes, the luxury items? The mother chose to use the small amount of money available at the end of each payment to hire the VCR and tapes to keep her children inside and amused during winter. Whether her choices fitted our middle class value system was not the issue. To her credit the student saw what I was trying to say and began the process of critical examination in practice and in the evaluation of her education as a nurse.

What did this family teach me?

From that experience I began to explore the issues of informed consent in the community. The overwhelming importance of establishing and maintaining trust was again demonstrated. I became very interested in the assumption that the role of the nurse could be managed to facilitate entry to peoples' lives as of right. The notion of the power underlying those assumptions was disturbing. There was little question that

nurses believed that they had the right to enter the environment of the powerless in the name of public health and the public good and that those social practices were sustained by an ethical ideology which would support them. The issues of reciprocity were highlighted for me in the interaction with the young mother in gaining her permission to introduce a person who represented the *'other'*. This Tuhoe woman had experienced a lifetime of '*other'* figures who were in positions to make a difference to her life: religious figures, schoolteachers, shopkeepers, doctors, pharmacists, Social Welfare workers, Work and Income assessors, and nurses. Taken in that context the trust she placed in me, was very great.

Of further interest was the idea of symbolic interaction between the nurse and the person to whom service is offered. The student nurse was unknown to the mother and also unknown to me, but she symbolised a system with which the young mother and I were both very familiar and which we needed to accommodate in our negotiation. This interaction was facilitated by our shared experience as Maori who had experienced marginalisation. There was little direct discussion but complete understanding.

The collective understanding of power held by another group and the potential for an encounter with personal and institutional racism was very real for us both. Here was an example of Fritjof Capra's concept of "*shared meaning, unanalysed and mutually recognisable*" (1989, p. 73). This experience stands out for me as a formative experience in the process of defining the ideas which came to contribute to the pedagogy of Cultural Safety in nursing education.

Practice Example Two: Doing things differently

A laboratory form describing gonorrhoea in a nine year old girl came my way accompanied by a very anxious GP. The family was Maori. The child had been raped by a family member and was now very ill. I was asked to become involved in supporting the family and helping to trace the contact. Her parents had no idea of the situation or the circumstances and it took a great deal of time to explain the condition of their daughter and then to mediate between the distraught parents and the equally distraught child who had been silent and blaming herself. Eventually the child confided in me and pleaded with me not to tell the by now enraged father, fearing his temper. She was happy to have her mother involved.

I arranged the admission to hospital for the girl and her mother and I sat with the father through the night. Eventually I persuaded him to phone older members of his family who lived rurally to come to be with him. Although I could not break the child's confidence and name the rapist at that point, I thought that could I work with older and experienced family members whom the father respected and who could apply restraints on the murder threats which were being made in the heat of the moment.

When the distant family arrived and were able to take over the support of the local family I was faced with a new dilemma. Everybody was very clear that this matter was to stay within the kinship group and that the criminal activities of the rapist would be dealt with by his people. In their view my role as a Maori was to protect the family from pakeha intervention. Passions were running high. I explained that gonorrhoea was a notifiable disease and that the hospital people and the general practitioner were obliged to report it and would already have done so. The contact of the child would have to be traced because he was a danger to others. Although I had every confidence that the family would deal with the perpetrator, that did not solve the issue of the disease and other possibilities of infection and criminal behaviour. It was made clear that I was not expected to betray this family to the pakeha system in their distress and to add to their worries. They were united in that opinion. My whole being wanted to shield them from the system, especially the child, but I knew that this would not work eventually and that for the sake of others time was of the essence.

I decided to speak to the local policeman who was a colleague of many years and from the same area as the family. He went to visit informally out of uniform and as a relative, I went informally as another Maori person, we were both mokai of this family. We sat and answered questions, again stayed over the night, reassured the father and the rest of the family as they went through the normal process of discussion and decision-making. They eventually gave us permission to follow through with the tracing. The offender had raped other children who also were infected.

Had the policeman and I not used Maori process, involving trusted people who had authority, allowing time for the family to gather and come to their own decisions while giving them information and eventually obtaining their informed consent to activate the follow through process, there may have been other and more dramatic outcomes. Working this issue through required me to give a great deal of "off duty" time to the

family, including two overnight sessions. To alter my preset timetable as best I could and to use my informal networks to help find a resolution required me to work in a covert and undeclared way.

Such situations place border workers in acute dilemmas. I did not report the matter in any depth because my use of time would have been questioned and the professional boundary issues would have been identified. At that stage I did not know how to explain or defend my actions nor did I have a network of colleagues to consult who could support my practice choices. It was unheard of for a Public Health Nurse to sit with a family through the night. The nurse manager noted that I had the official car out of the base for two nights that week and I was reprimanded. Again I saw the inflexibility of the system to allow these dilemmas to be identified and legitimated, as unethical and institutionally racist. Had I acted in any other way I would have rapidly lost trust in that community and become almost non-functioning. People would have become politely formal but trust would have been lost as word spread.

The question of an ethic of care as a moral dilemma situated in a framework of institutional racism was an obvious one. Although I had behaved in a caring way according to ideals of right and wrong behaviour, how the values of right and wrong were defined and by whom became a major practice issue. Giroux (1992) describes ethics as "*a social discourse that refuses to accept needless human suffering and exploitation*" (p. 74). It seemed to me that more suffering would have been induced by following established policy and formally initiating the reporting of sexual abuse and the consequent follow-up by police and health authorities, than by taking a little more time and using a different process to achieve the same ends.

In this case the values which underpinned the process we used were set by the family in reciprocal negotiation with the health professional and later, the policeman. They were processes which we all understood as Maori, but Maori of the same rural background and from the same age cohort. Other Maori, socialised differently may not have been able to draw on the mutual and shared understandings. The outcomes were eventually satisfactory for the parties involved. Ideally this was a valid resolution, except that every aspect of the process contravened departmental policy.

The very meaning of nursing care was highly ambivalent in these situations and could not meet the professional needs of workers needing to act in complex and non-linear ways in order to respond with relevance to human realities. I was attempting to practise what Potter (2001) describes as an "*ethic of care*" (p. 108) which I believed met the requirement to maintain high standards of practice and the ethical guidelines of beneficence, non-maleficence, justice and autonomy. Potter further describes the development of nurses as caring professionals:

> As nurses deal with health and illness in their practice, they grow in the ability to care. Expert nurses understand the differences and relationships among health, illness and disease and become able to see clients in their own context, interpret their needs, and offer caring acts that improve clients' health. (p. 109)

However, it was not possible for me to access resources that would normally be available to nurses working in the community, including the advice of experienced nurses, without compromising them.

What this interaction clarified and confirmed for me

- That formal and informal networks are utilised to help resolve many practice situations.
- That these networks are visible and systematised or invisible and unsystematised.
- That the invisible and informal networks can be highly effective, at times more effective than the formal ones.
- That the use of invisible networks leading to invisible solutions requires the redefinition of accepted codes of ethics and creates further ethical dilemmas.
- That such dilemmas often remain invisible of necessity because the formal systems of nursing policy and management do not accommodate them.
- That nurses are not able to be prepared for these practice dilemmas in their formal education because such situations are not formally acknowledged.

- That nurses are highly at risk personally and professionally when they are placed in situations where trust is a negotiable factor and the boundaries of trust are indefinable except by testing at the time of interaction.
- That the silences which are required to maintain trust are compromising for all people involved.
- That nurses from the marginalised insider group experience ethical dilemmas of which the health service is unaware.
- That institutional racism underpins the need to invisibilise the professional activities of border workers in cross cultural environments.
- In order to grow in their ability to care, nurses need to be able to discuss their practice, consult their peers and expert practitioners and to have the confidence that their experience and views will be respected. This is often very difficult for nurses who differ philosophically and politically from their colleagues.

Practice Example Three: Establishing and maintaining trust

A Maori woman who had never given birth had raised thirty-six children. She was very well known in the community for her philanthropic life but was adamant that she had never received any state funding to help her with these children and was not about to start asking for it at this late stage of her life. She made it clear to me that if I wanted to work with her I had to undertake to support her and her very mobile family (my family was known to her), but I was not to introduce any outside agencies or to let them know what she was doing in relation to the several children and one disabled young woman whom she was currently caring for. Her income was minimal and the family often ate food which was not nourishing such as flour and water pancakes sprinkled with sugar cooked in fat, three times daily. There was little I could do but monitor the situation.

While I was working in the area, a baby girl of about three months was left on her doorstep during the night with a label around her neck which said, "My father is a Korean sailor, my mother is a Maori." That was that. The child was absorbed into the home. Because I thought that I might be of some use I accepted her terms but would dearly have loved to have intervened in a range of ways. The old lady began

complaining of abdominal pain and I suggested a visit to the GP. That was not acceptable until she became acutely jaundiced. Still she refused. Eventually she agreed to allow me to bring the GP to her and it became clear that she needed admission to hospital for investigations.

Her refusal was based in distrust of state/pakeha interference in her way of life. This mistrust of state intervention was based on her personal experience but she made it clear as well that as a woman of Tainui, the history of land confiscation after the Anglo-Maori wars and the desperation which resulted from that experience had created a legacy of suspicion of pakeha activity in her family. She was able to recite each piece of land which had been confiscated from her hapu and describe the resultant effects on her people. By this time I automatically sought help from the Maori policeman in such situations. He knew the old lady well and tried to persuade her to enter hospital. When she had extracted a promise from us both to see that the few children at home were well managed, that there was sufficient food and competent care, and no state interference, she agreed. We then embarked on a community gathering up of people who knew and respected this extraordinary woman. The policeman sold cuts of meat in pubs and dug vegetables donated from home gardens. People gave liberally of their time and energy, I co-ordinated activities and helped where I could, managing to get the children to Health Camp. Two weeks later she emerged from hospital, sadly with a very poor prognosis, but thankfully with some time to put her affairs in order.

What did this family teach me?

Again my job description said nothing about being enjoined to silence by the people I served if I wanted to work among them. And again the ethical dilemma of keeping the promises which we made to her while trying not to contravene our own professional rules had created obvious stresses. The policeman and I did not overtly discuss these matters. The complexities of establishing and maintaining trust and the wish to protect people from the power of entrenched racism of the health system are crucial issues for people who work on social and emotional borders. They are subjective experiences which are integrally related to the emotions as well as to the intellect.

Practice Example Four: The power of attitude

This example was related to the Maori Asthma Review Team of which I was a member, at Maraeroa Marae, Porirua, November 1990. The purpose of this Review was to report to the Minister of Maori Affairs on evidence and public submissions about asthma among Maori people (Pomare et al. 1991). Although I was no longer practising as a Public Health Nurse, this was my former practice locality and the people and places concerned were well known to me.

A Maori mother of three children, two of whom were at school reported to the Review Team that she had decided to take the baby to the Medical Centre and enquire about immunisation. She escorted the older children to school and carried the baby on to the Centre, without an appointment. Dressed casually she entered the Centre and approached the nurse at the reception area. At first the nurse ignored the mother until she had completed her current task and before the young woman spoke the nurse turned to her with an expression of impatience and distraction.

The mother said that she felt so uncomfortable that she shrank away, excused herself and left. There was no exchange of words yet the interaction had been so powerful that it completely blocked access to health service. The young woman said that she felt shy and ambivalent, did not feel able to assert herself in the Centre and in the presence of the nurse who was exhibiting behaviour which the mother felt was an unspoken commentary on her care of her baby, her casual appearance, her social class and her being Maori. Whether the nurse had intended to convey a negative message was not the issue, her professionalism should not have permitted her to behave in a way that could have been interpreted as obstructive to contact by the mother seeking her assistance.

What this example clarified and confirmed for me

- That it is very possible to create active barriers to service without recourse to spoken words.
- That there are other discourses which are unarticulated and unanalysed but inform the behaviour of patient and professional.
- That the influence of attitude can be a powerful inhibitor, or initiator of professional interaction.

- That it is the responsibility of the nurse as the power holder to create an environment which enables people to feel safe in the presence of the nurse.
- That unfavourable attitudes are easily recognised by those who have been exposed to their negative effects.
- That those who have experienced the power of attitude imposition are always vigilant to the possibility of its presence.

Hence my concern with the construction of trust. Most nurses who have worked in the community have stories such as these to tell which have aspects of the stress and dilemmas in which I constantly found myself. I suggest that they do not happen in the way that they do for nurses who belong to marginalised groups. Because these issues are not addressed in nursing education or in the realities of clinical experience, nurses from the border realms are still required to say one thing officially and often to do another in practice.

Practice Example Five: Practice and research

My education in anthropology stood me in useful stead in asking questions of new admissions of five year olds to the public school system in Porirua. It was part of my role as a Public Health Nurse in 1985 to undertake a physical examination of all new entrants to the public school system. Included in the assessment were measurements of weight, height, gait and the usual physical attributes of children of that age. Also included were checks on the status of the testes of boy children. I had extreme difficulty in carrying out these checks because I regarded them as an unethical invasion of the privacy of these five year old sons of the poor. Very few children had available parents who could comfort and support them while a complete stranger handled and investigated their genitals. Their looks of discomfort and their utter powerlessness will not ever leave me. Finally I refused to put children in the helpless position of having to allow a stranger to require them to take off their underpants. Eventually I complained to the Chief Nurse Adviser at the then Department of Health and the health check was later revised.

Part of the assessment involved checking for head lice. I encouraged children to check my hair in return for my being permitted to look in theirs. If we found lice in each

other's hair (and mine was often infested) we celebrated the opportunity to have special shampoo. One day a small boy who was checking my hair asked me if I was from a Maori, noting a Maori ornament which I was wearing. I replied that I was and that I thought it was a very good thing to be from a Maori. He said that he did not think so but could not say why. From then on I added a question about ethnicity and identity to my assessment of five year olds. In a completely informal and undesigned survey of five year old views of their identity, I found some interesting consistencies. There were 58 children in a two-year period.

If they were Samoan I asked the child whether they thought that it was a good thing to be from a Samoan. Each Samoan child regarded me as though I had asked them a ridiculous question and answered in the affirmative. No Samoan child expressed discomfort about being Samoan. Pakeha children generally did not understand the question and Maori children answered consistently that they did not think that it was a good thing to be from a Maori. It seemed to me that further research into the construction of identity in preschoolers could be encouraged and could lead to some very useful findings in relation to parenting, the influence of the television media on identity in children, and pre-school education. These were exciting opportunities for nurses to undertake research which directly related to practice. I noted the responses in a special notebook and discussed my findings with my manager. The manager spoke to her manager and I was asked to hand over my notebook and informed that such activities were not part of the role of Public Health Nurses and that I should confine my investigations to the physical health checks of the children.

What this experience clarified and confirmed for me

- In that period of nursing in New Zealand post graduate education was not fully established, and its necessity in practice was not understood by nursing management.
- That the relationship between research and practice was not understood.
- That the relationship between the biomedical model of disease and health and the integrated notions of holism were not generally understood and were therefore unable to be included in nursing practice.

- That the design of national health policies although well intentioned required a more thorough process of community feedback, consultation and evaluation with the nurses required to implement them.
- That nursing colleagues did not see themselves as practising in a political context.
- That nurses were not comfortable when political action was taken and if possible would take steps to inhibit actions that they saw as likely to create future difficulty.

Although I found practice as a Public Health Nurse to be fulfilling in the short term, on another level it was profoundly frustrating. Systemic institutional failure of many of the New Zealand citizens I worked with was profoundly obvious, normalised and repetitive. I saw the chronic disadvantage in this community as an indictment of the New Zealand social structure but other nurses did not appear to see their work in the same context.

Moving On

I was in the unique position of working in the preschool, primary school and secondary education system simultaneously and daily. The older siblings of the families I visited to help with infant welfare were in the colleges euphemistically called *educational* institutions. Their health status was impaired from babyhood. Dentition, nutrition and hearing were all compromised, but probably the most severe impairment was in the collective ethnic and emotional identity of specific groups of children. These children were Polynesian, immigrant or indigenous their fate in terms of social indices appeared to me, to be sealed. By repeating its patterns I felt that I was colluding in the generational entrenchment of disadvantage in the future of the people for whom I was involved in caring. Again I questioned the meaning of care and whether the work of nurses in those communities was in fact making a difference in the long term. Despite the grim realities for many in this community there was and is a spirit of resiliency, vigour and energy to survive and to prosper. There are few existing resources on which to build but they have been identified, used to their advantage and in some places increased.

Among my colleagues there were no nurses with whom I felt that I could discuss these experiences and the concerns which arose from them or explore the ideas which might offer solutions. Our English born and educated manager attached a note to my file which was stored in the Department of Health to the effect that I spent too much time working in what he termed were "*bicultural"* environments. I felt that this comment was unjustified because it could not be explained and I discussed the matter with the senior nurse employed by the Department as advisor to the Minister of Health (Trixie Bradley). With the help of the anthropologist then employed by the Department (Dr Patricia Kinloch) and the Director-General of Health (Dr George Salmond), the note was removed.

One morning as I was testing the vision of new entrants, especially enjoying testing the Kohanga Reo children in Maori, at a local primary school, I was approached by the Head of Department of the newly established School of Nursing at Parumoana Polytechnic and invited to apply for a full time teaching position. After consultation with my family I decided to apply to become a nursing teacher. A family vote was taken and mine was the only one against leaving practice in public health. It was not a sense of vocation which induced me to leave Public Health nursing but family opinion and a belief that I could eventually be of more use teaching others to nurse as a result of my own learning than trying to help stem the social tide of disadvantage and the resulting human struggle, as a practicing nurse.

I joined the inaugural second year of the nursing course of the polytechnic. Here was an opportunity to help create a course with a curriculum which could address those health and disease issues experienced in colonial countries throughout the world. By understanding the problems which beset indigenous peoples we could design and teach educational material that would alter nursing service and therefore make a difference to the health status of all New Zealanders. Surely, I thought, if a country is to be judged by its service to the most vulnerable members of its communities then excellent nursing service for the tangata whenua would have the effect of reaching others who were also in need of excellent care. I believed, as hooks has said, that "*the classroom for all its limitations does remain a location of possibility*" (1994, p. 206).

Bright eyed I commenced work at Parumoana Polytechnic with recent education in liberal social science and a complementary practice base, only to be asked to teach

surgical nursing, an area in which I had last had experience almost twenty years before. Working in formal education began the public section of my activities.

I look back on my nursing training and years as a practitioner first in hospital and then later as a Public Health nurse and try to remember the questions I asked myself over that time. One of the questions was: how could I offer some insight and ideas about positive change in the health service to those people working in proximity to Maori? The conclusion I have come to in trying to separate my point of view from my political stance is that, for me, that cannot happen. The cliché that *the personal is political* is how my life was and is. There is nothing I can do about it so that is what I have offered.

Working in a highly urbanised area only twenty minutes from the government parliamentary buildings taught me about abject and grinding poverty and about the control of the education process by pakeha teachers and administrators in schools which had mainly Maori and Polynesian rolls and high failure rates. Public Health nursing enabled me to see the children from pre-school to college, and to see bright youngsters become sullen and closed, or struggle to push through. Working in homes put me in touch with sole mothers struggling to educate, feed and clothe their children, and cope with the financial stress of it all.

Working there also showed me the the strength and determination, courage and energy of many of those people to retain their cultures and to make something good out of the colonial and the migrant experiences. I came away with enormous respect for those bound in there, and with cynicism for the systems which bound them.

The establishment of trust, learnt in those homes and communities, was to become a critical factor in my later work on Cultural Safety. This meant divesting myself of the ideas that I had the answers to their needs or that I even understood their questions. I was a privileged stranger and it was necessary for me to understand the rights of people to their full humanity and to learn, as I also had from the experience of working in the Tb ward, that I had power and the proper use of that power should be a negotiated process. My nursing experience to date had taught me that to understand this process, nurses and midiwives needed to understand the influence of attitude as a powerful inhibitor, or initiator of professional interaction. Unfavourable attitudes are easily

recognised by those who have been exposed to their negative effects. Nurses and midwives are highly at risk personally and professionally when they are placed in situations where trust is a negotiable factor. Nurses and midwives needed to recognise this fact and accept that it is the practitioners responsibility, as the power holder, to create an environment which enables people to feel safe in their presence.

My own situation as a nurse from a marginalised insider group meant that I experienced ethical dilemmas of which the health service is unaware. Much of the difficulty lay with the institutional racism which underpins the need to invisibilise the professional activities of border workers, like myself, in cross cultural environments. In order to grow in their ability to care, nurses need to be able to discuss their practice, consult their peers and expert practitioners and to have the confidence that their experience and views will be respected. This is often very difficult for nurses who differ philosophically and politically from their colleagues.

My own experience had been one of comparative intellectual and emotional isolation from the beginning of my education as a nurse. Perhaps as a teacher I could teach from the ideology which I had developed from these experiences and help students to construct a political vision and a wider context from which to practice. Perhaps I could help them to think critically about issues relating to the health and disease of the tangata whenua. And perhaps, from that standpoint, they could expand their vision to their whole practice.

SECTION II

HE HUARAHI HOU

A NEW PATHWAY

He Huarahi Hou

A New Pathway

Section II of the thesis addresses the development and evolution of Cultural Safety, building on the personal and professional story established in Section I. This section traces the transition process and movement forward of the Cultural Safety concept more fully into the public arena.

This initial movement is set primarily within the nursing and midwifery professions. However, I begin by focusing on national issues surrounding Maori identity and ethnicity, formal and informal, in order to explore the historical relationship between the status of Maori health, the Treaty of Waitangi and health services in New Zealand at the time of Cultural Safety's development. The clarification of these issues was necessary to enable me to work effectively in the teaching environment and introduce what was essentially new and revolutionary material to nursing and midwifery students.

A chronological overview to the evolution of Cultural Safety following the immediate period after my initial teaching experiences in 1988 through to 2001 is presented in Chapter Seven and refers to the supplementary material contained in Volume Two. There are two main reasons why I have chosen to present this section of the work as a separate volume. Firstly, my purpose was to convey to the reader some essence of the sheer speed, over this thirteen year period, at which Cultural Safety development has taken place within New Zealand nursing and midwifery professions. Secondly, I have identified four eras in the evolution process of Cultural Safety which build on the private and public narratives which are features in this work showing the increasing movement from the personal to the public, and eventually, political domains.

Each of the eras reflect something of the level of leadership and influence that was necessary in order to move the concept forward, whether that was consulting with Maori, building relationships with the Nursing Council of New Zealand, publishing in

nursing and midwifery journals, informing government committees or taking part in public debate. While some of this work is well known in some circles and to some groups, particularly those I have presented papers to or those who have read the published articles, a lot of the work has not been easily accessible to everyone who might have a use for it. This is a key reason for bringing together a number of papers in a separate volume.

This section concludes with an international perspective, that is a consideration and comparative overview of Cultural Safety and Transcultural Nursing viewed as theories, one arising from an indigenous reality, the other based within a traditional western anthropological approach. This chapter is important in providing a background and perspective on much of the misunderstanding and public reaction to Cultural Safety education in New Zealand which is detailed in the final section of the thesis.

Some excerpts from the interviews have been included in this section as a number of relevant issues concerning concepts of bi-culturalism, multiculturalism and power relationships were part of the interview schedule. Where quotes directly arising from the interviews are inserted, this will be made clear in the text. The speaker will be identified in brackets as an 'interviewee'.

Chapter Five

Towards Cultural Safety

There is ongoing debate surrounding the definition of Maori ethnicity. Having referred, in Chapter One, to some of the complexities involved in obtaining data on students who may enter or exit the nursing and midwifery programmes at differing stages of their emotional identity, it is worthwhile elaborating on the concept of *Maori* used in this work.

Kawa Whakaruruhau: Maori Issues

Definitions of Maori have changed over time. For example, according to the Williams Dictionary (Williams, 1971) the word *Maori* means *normal*, *usual* and *ordinary* (p. 179). 'Maori' denoted ordinary citizens as opposed to non-Maori who entered their environment and were considered different and unusual (Buck, 1950). The New Zealand settler government redefined its meaning by using the word Maori for census purposes from 1858 to describe people as "half caste" Maori/European or more based on the notions of race and blood quantum. This was still in practice in the Maori Affairs Act 1953 (Mako, 1998). The Maori Affairs Amendment Act 1974 responded to Maori concerns that many Maori were not eligible to identify as Maori in relation to the Act and the census, even though they were of Maori descent, being Maori had meaning for them, and they emotionally identified as Maori. Concepts of ethnicity became accepted as more relevant and the first major change was made to the census question on race in 1976 (Reid & Robson, 1998). In 1986 the definition based on ethnicity was adopted followed by a question on self-identification in the 1991 census.

For the purposes of this work, Maori are accepted as people who have descent from a Maori and who may or may not claim that descent, or may be located at any position on the identity gamut. The emotional identity spectrum experienced by people of Maori

descent is acknowledged and supported. Generally the people of Maori ancestry referred to in this study have self-identified as Maori although that identity may change according to social and emotional pressures which they may experience over their lifetimes. Statistics New Zealand (2001) acknowledges that ethnicity is a dynamic concept and that individuals can belong to more than one ethnic group at a time and can move between ethnic groups over time.

The effects of colonisation and the growing awareness through the 1970s and 1980s of the ongoing and long term impact of the colonisation process on Maori health outcomes were a critical impetus for the development of Cultural Safety. As political awareness and activity among Maori during this time began to increase, gatherings of Maori people working in, education, welfare and justice and health were also meeting together, many for the first time, to discuss those areas of concern in relation to Maori.

The attention of health authorities to the state of Maori health had been reinforced by the participants of a hui held at Hoani Waititi Marae Auckland, in March 1984. Primary Maori concerns had formerly been land, education and welfare. Now the attention turned to health. This well attended gathering of Maori health professionals was the first national hui to be held on Maori health and was a focus for a large number of concerns including the need for research, the requirement that Maori should be involved in Maori health service design and delivery, and the need for government to recognise the growing body of evidence that Maori health and disease issues were different from those of the general population.

Durie (1994) states that there were hui throughout the country in the early part of the decade which accepted a model of health incorporating, taha wairua (spiritual health), taha hinengaro (mental health), taha tinana (physical health) and taha whanau (family health), and that this became widely accepted as the preferred Maori definition of health Hui Whakaoranga also recommended that health and education institutions recognise culture as a positive resource. Spiritual and emotional factors as contributors to health and wellbeing were emphasised at the hui. Although Durie admits that the Whare Tapa Wha model is simple, “even simplistic”, it had immediate appeal to Maori and pakeha alike. For example the model was adopted widely by nursing schools and formed the basis for the philosophy of the inaugural curriculum of the Waiariki Polytechnic nursing school at Rotorua which was set up in 1985. A further model appeared during this

period which has enjoyed a level of acceptance, Te Wheke (Pere, 1991), which represents the tentacles of an octopus, each concerned with an aspect of health or illness or community and family.

The Treaty of Waitangi

The formal agreement between Maori hapu and the British Crown took the form of a treaty written in both Maori and English which was signed initially at Waitangi in the Bay of Islands in 1840. Later versions were signed at several other sites around the country (Appendices 3a, 3b, 3c).

Although the first article in Maori ultimately accommodated a very loosely worded transfer of sovereignty, the Treaty of Waitangi made significant guarantees of Crown protection of Maori taonga/treasures while guaranteeing that Maori also retained control over Maori resources in article two. In article three the treaty guaranteed Maori the same rights and privileges as British subjects enjoyed in 1840. In common with all treaties this one was written with the future in mind. Although the treaty was declared a simple nullity in 1877, because it had never been incorporated into New Zealand law by a specific Act of Parliament, it was acknowledged as the founding document of New Zealand in 1992 (Durie, 1994).

Contact with introduced diseases, war and poverty contributed to a dramatic reduction in the Maori population from 1769 to 1890. The Maori population, although inaccurately measured, was clearly in continuous decline. Mason Durie states that the Maori population had dropped by a third in less than a century and quoted a prophecy from 1884 in '*Whaiora'*:

> Just as the Norwegian rat has displaced the Maori rat, as introduced plants have displaced Maori plants so the white man will replace the Maori. (1994, p. 32)

Fortunately this prophecy was not fulfilled but the Maori population remained essentially rurally based until post 1945 when the migration to cities accelerated. As most of the non-Maori population was already urban based there was little real contact between Maori and non-Maori until the mid 1970s when Maori began to recover numbers, and make a critical impact on the social climate of New Zealand.

There has been much debate and speculation over the contemporary relevance of the treaty to health care and the application of the words of the treaty as agreed to in 1840. Debate has also been consistent over the meanings and interpretation of the differing texts in Maori and in English. Fiduciary obligations although unwritten are understood to mean that both parties must act in good faith toward each other.

The practice has emerged of extracting and addressing principles of the treaty rather than to attempting to analyse and understand the exact intention of every word in the English and the Maori texts. Although Durie states that extracting principles and applying them to contemporary health situations has its limitations, the practice has acquired popularity in assisting people to translate the treaty guarantees into possibilities for action (Durie, 1989). There are a range of principles which have been developed over time by different organisations but the ones which have acquired the most currency in daily society are the three which were produced by the Royal Commission on Social Policy (1988). They are the principles of partnership, participation and protection. The ideas behind these principles have been variously interpreted according to the organisation which has employed them.

Graphic evidence of the status of the health of Maori people was recorded in a report to the Minister of Maori Affairs called, *Progress Towards Closing Social And Economic Gaps between Maori and Non-Maori* (Te Puni Kokiri, 2000). Comparison with non-Maori as demonstrated in this report upholds the argument of many Maori that since the Crown took over the management of Maori health and disease status, Maori have been consistently failed by all Crown agencies concerned with health service and delivery to the indigenous people of New Zealand.

Since the Treaty of Waitangi Act 1975 the treaty has grown steadily in the public attention. Pushed largely by Maori urban activism to address the social and economic consequences of legislatively induced poverty (Durie, 1994), the establishment of the Waitangi Tribunal was seen as a significant outlet for Maori frustrations. Publicity given to the succession of cases and the landmark decisions that it made in respect of tribal claims against the Crown, enabled treaty issues to assume an importance which they had not had over the previous 100 years. The treaty became a focus for race relations activity, particularly in respect to property rights. Maori attempts to assert their arguments regarding these matters often caused vituperative comment from all levels of

New Zealand society, ranging from radio talkback to the 1975 Court of Appeal decisions on the role and function of the Waitangi Tribunal.

Political issues in relation to the Treaty of Waitangi or health and economic disparity were unexplored in nursing education and evolving approaches to matters relating to the health of the indigenous people were happening from a "biculturalist or multiculturalist" angle in which the primary emphasis is on ethnicity and exotic cultural difference. All exotic or etic, outside groups of people, came to be included in the multicultural paradigm.

In New Zealand the term *biculturalism* came to represent the relationship between Maori and others, particularly the Crown. This gave rise to a constant argument that other cultures were not being given adequate consideration in any or all contexts in which Maori were contesting for resources or arguing for attention to Maori defined political issues. The impression was given that Maori were activating simply for their own purposes and that other cultures needed patronising and defending. The idea that there were intact groups of people which could be called cultures was considered to be commonsense and normal and was referred to in everyday conversation as though cultures were measurable and easily definable.

Many Maori have identified health as a major issue worthy of a case to be taken before the Waitangi Tribunal. Although such a case has not yet been constructed there is continuous discussion of the possibility of doing so in Maori circles. Maori nurses have been involved in these discussions at an informal level and would certainly be involved in a case against the Crown in respect to Maori health. (Waitangi Tribunal, personal communication, Wellington, 2000). Because the New Zealand public, including most Maori, had so little knowledge of the treaty, its content and its future implications, the response of the public was volatile and usually ad hoc. Loud protest erupted against Maori activism or non-Maori support for Maori activism, on the radio, in the bias of television and newspaper reporting and letters to the Editors. Cartoons which drew on negative Maori stereotypes and other media further enhanced a climate of vitriolic and angry attitudes and behaviour toward Maori attempts to make change.

Terms which applied to the study of issues of Maori health and disease varied at this period but the most commonly employed were: biculturalism, cultural differences,

cultural awareness, and cultural sensitivity. None of these terms addressed the political context in which Maori ill health was happening. The political link between the treaty and its guarantees of equity including the possibility of equal health status with other New Zealanders in article three had not been correlated in the teaching of nurses. The discussion of issues of power and Maori representation in the health service lay in the very near future. It was in this climate that I first encountered classes of nursing students.

Chapter Six

Learning and Teaching: Students as Teachers

Although I had an undergraduate university degree which was unusual for a nurse practitioner or a nursing teacher in 1986, I had no theoretical training in teaching let alone teaching in the delicate area of antiracism or attitude formation and change. I had little formal analysis of the situations around me and no classroom experience. I entered the teaching environment with few tools other than my own nursing education and practice and a deep commitment to help create positive change.

The following year, the Standing Committee on Maori Health (1987) recommended that the Treaty of Waitangi be regarded as a foundation for good health. I was beginning my teaching practice at a very interesting time in New Zealand history. Although my first attempt to include Maori health issues in the curriculum of the Parumoana Polytechnic, a 35-hour paper called 'Intercultural Nursing', was the subject of congratulations in a letter from the Nursing Council of New Zealand, there was no formal agreement between the Council as a professional body set up under statute, and Maori, based on the Treaty of Waitangi.

The idea of a cultural checklist in which heavily stereotyped *cultures* were able to be predicted by nurses leading to insight on the part of the nurse and conformity and compliance on the part of the patient, (Bruni, 1988), was something which I later came to describe as a cultural smorgasbord (Ramsden, 2000). The metaphor was one of "cultural tourism" or "voyeurism" where the nurse stood outside, secure in the culture of nursing, and surveyed the patient from the viewpoint of their interesting exoticism. The interesting exoticism was usually in deficit compared with the culture of nursing and allowed the nurse to be patronising and powerful. There were no grounds for the nurse to consider that change in their own attitude and self knowledge was needed before any trust could be established.

It was also assumed that nurses could speak for the perceived needs of people from other ethnic groups. The popular concept of culture remained ethnicity based while groups of people with clearly defined commonalities, sharing kinship, world views and ways of existing in the world such as religious groups, for example Jehovah's Witnesses, closed religious sects, or the Salvation Army were not seen as exotic cultures. Nor did nurses see themselves as having the right to investigate or provide commentary on groups of people in the way that they felt they could about Maori.

A further philosophical underpinning of the multicultural debate, discussed in the previous chapter, and relevant to the nursing and midwifery education context, arose when Maori tried to assert political status as First Peoples. The disagreement lay in the nursing notion that all people should be nursed equally regardless of their difference from nurses or from each other. This ideology was expressed by the National Action Group in *The Aims and Scope of Nursing* (1988) that saw nurses as being providers of care irrespective of differences such as nationality, culture, creed, colour, sex, political or religious belief or social status. Very similar words are reiterated in the International Council of Nurses Code for Nurses which states:

> The need for nursing is universal. Inherent in nursing is respect for life, dignity, and rights of man (sic). It is unrestricted by considerations of nationality, race, creed, colour, age, sex, politics or social status. (Johnstone & Ecker, 2001, p. 403)

The report which I wrote in 1990, *Kawa Whakaruruhau, Cultural Safety in Nursing Education in Aotearoa* (Ramsden, 1990a), refuted the premise that people could be nursed regardless of all the elements which made them unique in the world. In the introduction I wrote:

> The idea of the nurse ignoring the way in which people measure and define their humanity is unrealistic and inappropriate…People are still prepared to die in order to maintain their cultural, religious and territorial integrity. It is not the place of the nursing service to attempt to deny the vital differences between people however altruistic the rationale may be. (p. 1)

In the graduation speech to the Diploma of Nursing students at Nelson Polytechnic, I wrote that:

> Only one word needs to be altered in order to suitably change the old nursing philosophy to become appropriate for the end of the 20th Century and onward into the 21st. That word is irrespective…Nurses must become respective of the nationality of human beings, the culture of human beings, the age, the sex the political and the religious beliefs of other members of the human race. (Ramsden, 1988)

These statements lay two years into the future. Initially, I too adopted the multiculturalist/ethnic approach. Although I was uncomfortable about it from the beginning of my teaching experience I was not clear about how to analyse or express my diffidence. Fuimaono Karl Puloto Endemann, then Deputy Head of School Palmerston North Polytechnic School of Nursing, commented passionately on multiculturalism in his interview for this project:

> I hate multiculturalism…yes I do…I hate it. Hate to me is a very powerful word. Because what multiculturalism does, it actually demeans people. I always say that for us Pacific Islanders it makes us into the hula girls, and the chop suey and rice kind of sentiment, like that's what we are right across the board…. If we are all the same, how come you are rich and I'm not? (Karl Puloto-Endemann, interviewee)

The ideology of multiculturalism was deeply held by students and were expressed by many of them in a microcosm of New Zealand society. Common statements were:

> "We are all the same in New Zealand."
>
> "What is different about Maoris?"
>
> "Why should they have more than us?"
>
> "We are all one people. I grew up/went to school with Maoris and they were the same as we were."
>
> "Maoris have special privileges that we don't such as scholarships."
>
> "New Zealand is a multicultural society, what about all the other cultures?"

I realised that it was essential to place this kind of discourse into a social context and then somehow teach what I had found to nursing students (Wetherall & Potter, 1992).

From the beginning I tried to introduce an analysis of racism in New Zealand communities and describe its effect on Maori people. I began by describing differences between Polynesian and United Kingdom based cultures indulging myself, in a naive way, in stereotypes of each group. The cultural checklist approach (Figure 3) was satisfying for most students because it gave them something to quantify and to repeat back in assignments. For a short while I found it more convenient to teach from this position but my own life experience imposed itself on the information I was dispensing. It was clear that cultural stereotypes were simplistic and untrue and that the complexity of post colonial cause and effects on New Zealand society must be taught. I came to struggle hard against the checklist mentality and consequently made my own work much harder. Later I became able to use the treaty as a teaching framework but as yet there was no backup from the statuary nursing institution which could help teachers to formulate and uphold such a framework.

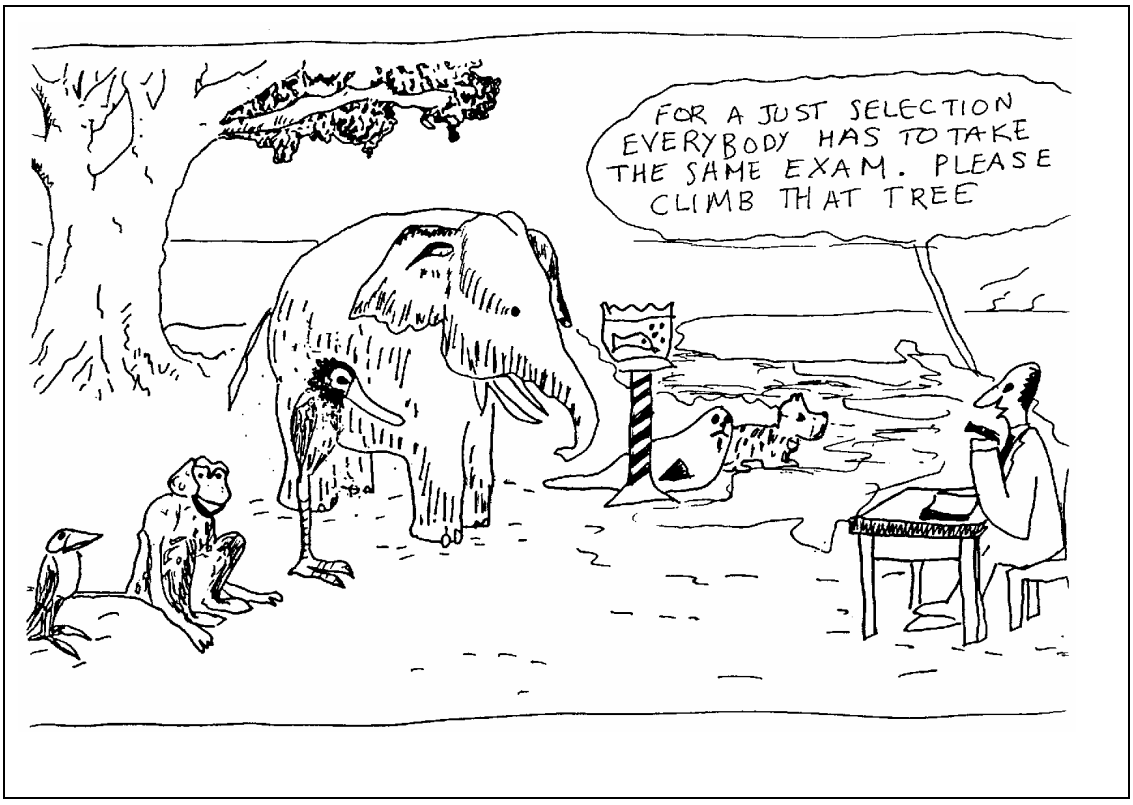


Figure 3
Levelling the playing field?
Source: Unknown

In 1994 the Nursing Council of New Zealand, the statuary regulatory body for nurses and midwives, acknowledged the Treaty of Waitangi in a three-year strategic plan (Nursing Council of New Zealand, 1994). Part of this plan identified the role of the Council in relation to the Treaty of Waitangi as a critical strategic issue. As a Crown agent, the Nursing Council is morally bound to observe the principles of the Treaty of Waitangi as are all Crown agencies although the Treaty of Waitangi does not appear in the Nurses Act 1977.

> The Nursing Council of New Zealand is in effect, an agent of the Crown through its statutory role in the maintenance of standards of education and practice for nurses and midwives. It is empowered by the Nurses Act 1977 to act as such an agent by setting and monitoring standards to ensure safe and competent care for the public of New Zealand. (Papps, 2002, p. 98)

In an environment of assimilation and denial of difference this was the worst place to start teaching. Students were largely from the New Zealand islands and descended from United Kingdom immigrants. They were mostly young female school leavers with little travel or cross cultural experience. The polytechnic was situated in a low socio-economic area. Although the ratio of people from Pacific island communities was much higher in Porirua than other parts of Wellington, anecdotally, intimate interaction between groups was low apart from public activities such as attendance at schools.

These young people had come to be nurses and the work on racism, cultures and difference that I was offering appeared to have little bearing on nursing which was a profession in their view which cared for people regardless of who they were. Students were very clear about expressing their opinions. If they did not see the relevance of what I was teaching they protested loudly, ignored my presentations, spoke during visiting speakers' presentations and eventually boycotted my classes. At one point I had only three students attending class, one was an older Samoan woman, another a scholarship student from the Solomon Islands and the third, a pakeha who had arranged her hair into three stiffly pointed projections dyed bright green. These three students stayed with me all year and I am grateful to them for their gentleness and patience to this day.

*What I did learn from the students' challenges**?***

Like me, the students lacked the capacity to analyse what was happening to them in my classes. They had less knowledge of the Treaty of Waitangi than I did and they were confronted and affronted by my challenges to their lifetime beliefs about race relations in New Zealand. Patti Lather (1991), in discussing the development of emancipatory social theory, is clear that an empirical stance is required which is open ended and grounded in respect to human capacity but also needs to be profoundly sceptical of appearances and *"common sense"* (p. 65).

While I was learning to explain issues in a professional context it was not quick enough to meet the students' immediate educational and emotional needs, and their responses became collective and punitive. They exercised what power they could by refusing to participate in my classes as much as possible and I exercised what power I could by presenting them with information which I thought important for their practice. It was also critical that I did not demonstrate the passion I felt for this topic; although it was permissible for me to show stimulation, excitement and enthusiasm in the teaching of my other subject, surgical nursing.

Systems of education are not neutral (Freire, 1973) and are established to meet a set of agendas. Roy Shuker (1987) argues that the schooling system functions as a state construction to reproduce labour power and the means of production:

> This involves producing a labour force with ideas values and practices which are consistent with, and in acceptance of existing power relations. (p. 21)

There was little question that the students who were entering nursing courses and had been educated in New Zealand (the majority) were fixed in their views on race relations and the locus of power. The power clearly lay with Anglo derived middle to upper middle class members of New Zealand society and not with Maori or other marginalised groups of people.

I learned that unless I could show an effect in the environment of health and disease then teaching the cause, ie land deprivation, social injustice and/or racism, was almost pointless. This was material students had never been exposed to. It was critical that like any other historical facts they made sense to the student and should be presented in the

correct framework of their education. I needed to ask myself, why were they in the course? Then I had to address the facts that I was wishing to teach to the reason for the presence of students, which was to become graduate nurses and to deliver excellent service.

The next part of my developing pedagogy was to relate the facts to nursing practice. Here my nursing practice in the Porirua community stood me in good stead. I was able to illustrate the relationship of history to the people and communities around us and to the disparities and facts of life with which most of the students were more than familiar. It was also possible to link the Treaty of Waitangi breaches to health and social disparity. When I began to draw on practice my classes refilled and I was able to learn as I went along with students. Although we were learning different facts, we were both learning about power, mine to create emancipatory change in students' view of the world and students to create teaching which would match their needs to become nursing professionals. Since I was also working with students in clinical practice it became possible to translate classroom teaching to the hospital or community environments and again back to the classroom. The following three practice examples illustrate particular aspects of this.

Practice Examples

The importance of attitude, recognising and understanding the powerlessness of patients and the power of nurses, and the centrality of open-mindedness and self-awareness, are illustrated in the following practice examples.

Practice Example One: Attitudes matter

> Attitudes matter and when people need a nurse or need health care they are in a vulnerable state, extremely vulnerable, and they need respect and they need to be treated with love and justice. (Isabelle Sherrard, interviewee)

A Maori woman was admitted to a local hospital seriously ill from a rupture of a hydatid cyst in her abdomen. She was deeply unconscious when the student nurse and I came to help with her care in the Intensive Care Unit. We joined the ward round and were present during a full staff meeting around her bed as she lay unconscious her breathing maintained by a respirator. Apart from her present condition the woman did

not look as though she had been healthy or prosperous prior to admission. She was tired looking, had no teeth and was clinically obese, white roots were growing through her hair. Although comment was made only on her obesity it was clear by the attitude that staff did not consider this woman to have been compliant when first diagnosed and that she had presented an extreme surgical risk. There was general conversation about her non-compliance with attendance at clinics and her irresponsible attitude toward her condition. The atmosphere during the discussion between surgeons was that she had brought a great deal of her trouble upon herself by not turning up at clinics and disappearing from the surgeons' supervision until the dramatic rupture of the cyst.

It was clear that the student nurse was listening to the conversation carefully and that she was also absorbing the non-verbal communication that was happening between the lines. We decided to do some investigation into the background of this unfortunate woman. As we went carefully through her notes we discovered that she was a sole caregiver of eight children, some of whom were pre-school grandchildren. She had been trying to keep her family together by working a little piece of land with sheep and share milking, hence the exposure to the possibility of hydatids. The pressures of child rearing, poverty and prioritising for the needs of others had caused her to forgo her trips to town to attend at the hospital. There was one phone call of apology for inability to attend the clinic in the notes.

When the student had put together the background to the situation this woman was in I asked her to present her findings to the class, including the unspoken communication. The student nurse made an excellent and clearly thought out analysis of what she had seen and heard, as well as not heard but had understood and she unknowingly gave me two of the objectives that I later brought to Cultural Safety. They were:

- To educate student nurses and midwives not to blame the victims of historical process for their current plights.
- To educate student nurses and midwives to examine their own realities and the attitudes they bring to each new person they encounter in their practice.

Practice Example Two: Recognising powerlessness and power

A student and I were working together in a busy surgical ward. A young man was admitted from Western Samoa for elective surgery for an inguinal hernia. The young man spoke very hesitant English and preferred to sit quietly cross-legged on his bed waiting for something to happen. The student and I were anxious that there was no interpreter to assist with the preparation for surgery and as the time for his premedication approached it became obvious that nobody had spoken with this young man or helped him with his preparation. He still required a pubic shave, skin preparation and theatre garb. Finally we went to the nurse who was caring for him and asked about his preparation and suggested that an interpreter would be helpful, she told us to find one for him. Finally as the time for theatre approached we found a young Samoan nurse from another ward, negotiated her release from her ward and got to the bed just as the nurse arrived to shave the patient, the nurse with the intramuscular pre-medication hove into view and the theatre trolley arrived. The patient became frustrated as the interpreter tried to explain the procedures and each health worker pushed to complete their tasks. The patient was insulted by the attempts of the female nurse to shave his groin, something unacceptable in his own cultural environment, the staff were also frustrated as time passed.

This confusion had clearly arisen because of a poor initial nursing assessment and resultant inadequate planning on the part of the primary care nurse and the patient did his very best in a foreign setting to cope with the nursing mismanagement that had been visited upon him. Had the patient responded in ways that the staff considered inappropriate, for example by shouting or physically resisting attempts to touch him, the possibility of his being blamed for behaving in ways which were upsetting to staff and ward routines would have been very high. Intervention by the interpreter, who fortunately was a nurse (often non-health professionals are informally involved as interpreters) and could explain what was happening, and the locating of a male nurse to do the shave, saved the situation from being potentially quite disruptive to all concerned. The sheer grace and patience of the young man also made it possible to negotiate his way through the mosaic of dilemmas.

The students analysed this situation and applied the objectives of Cultural Safety to it recognising the powerlessness of the patient and the power of the nurse to create an

environment in which these quandaries need not have developed. Had the nurse made an accurate assessment of the patient's language status at admission most of the confusion could have been avoided. The issue therefore lay with the practice of the nurse rather than the behaviours of the patient.

Practice Example Three: Open-minded, self-aware

At the afternoon shift report the senior nurse giving the overview of the ward commented that a Samoan woman patient had had over twenty visitors who said they were family that morning, most of whom insisted on staying close to the patient. As the nurse gave this information she rolled her eyes, sighed and looked frustrated. She did not say anything pejorative about the patient or the amount of visitors or them being in the way of nursing cares being carried out, but it was clear that this was what she was thinking. Each time she mentioned the patient she non-verbally expressed impatience and gave the impression that the afternoon staff were in for a trying time.

This dilemma is a particularly good one for student group discussion because it highlights the rapid socialisation of student nurses. Most students by year two of their degree programme in my experience, agree with the nurse conveying the non-verbal messages relating to "inappropriately" sized family groups and other visitors upsetting ward routines and other patients. It takes an exceptional student to detect the underlying racism relating to the definition of family, and to see that the nurses on the previous shift should have negotiated their way through this situation with the large kinship group of the patient and should not have left this situation to become the legacy of the afternoon staff. There can be a range of solutions depending on the circumstances all of which can lead to successful negotiation and mutually beneficial outcomes. From this type of situation the final two objectives of Cultural Safety were drawn:

- To educate student nurses and midwives to be open minded and flexible in their attitudes toward people who are different from themselves, to whom they offer and deliver service.
- To produce a workforce of well educated, self aware registered nurses and midwives who are culturally safe to practice, as defined by the people they serve.

The issues highlighted by these practice situations and the teaching which was evolving from them produced dilemmas of their own. Questions arose not only in relation to how such material should be taught but who should teach it, how it should be assessed, even where and when it should be taught. Because cross cultural issues in the New Zealand context were perceived to be between Maori and non-Maori, most practice exemplars and test questions were based in this primary New Zealand relationship. Culture was uncompromisingly seen as ethnicity and it remained difficult to present the diversity of notions of culture which my anthropological training had given me. It was frustrating to see stereotyping questions used which were pejorative, patronising, treated Maori as exotic and did not relate to the ill health or otherwise of Maori people. Above all, they did not test nursing or midwifery practice. As highly diverse, colonised and urbanised people with mostly inter ritual contact with pakeha, there was little that Maori had to show apart from the postcard and tourist imagery. This is what appeared to be built upon when teaching and testing nursing assessments.

> In some ways I think it was easier for pakeha institutions to dump Cultural Safety on a Maori or a Maori Department and then it could be, as so many Maori things are, marginalised. That, in the first few years of the programme, was my main fear about how it was developing. I don't particularly want nurses to know how to sing waiata, I want them to treat my mother properly if she's unwell. (Moana Jackson, interviewee)

The newly established Maori Studies Departments in polytechnics were called in to provide Maori teachers who were non-nurses, to assist in this process. This served to enhance the Maori Studies view of Maori health and to entrench it in the systems of teaching nurses and midwives. Maori Studies teachers were not teaching nursing and midiwfery because it was not possible for them to do so. In some schools, students were being taught to recite prayers in Maori and being tested on their capacity to remember the prayers, and in others to sing Maori songs and perform dances. Unfortunately remnants of this period still persist in some Schools of nursing and midwifery.

The political and economic realities of life for many Maori people became subsumed by romantic and sentimentalised colonial constructs (Bell, 1992). There was further debate over the place of teaching Maori issues and for several years it was thought useful to take students to traditional Maori locations to learn about *"the habits and the customs of the natives."* (Ramsden & Spoonley, 1994, p. 163). This was comfortably in line with

Transcultural Nursing theory (Leininger, 1991) and is discussed in more detail in Chapter Eight. Although the Nursing Council of New Zealand was clear that this practice, if followed at all, should relate to nursing and midwifery educational aims, it remained popular as a group familiarisation process and an enjoyable class outing (Nursing Council of New Zealand, 1996).

For some groups the outings were not so enjoyable as politicised Maori began to challenge their audiences in a range of ways. My experience taught me that contentious issues such as race relations in New Zealand should not be raised in the first year of any nursing diploma, or later degree programme, for a range of very cogent reasons. A level of trust had not evolved within the class group by early in the first year (sometimes in the first week) when students were often taken out to marae for the 'Maori experience'. Another reason was that Maori students were placed in very emotionally vulnerable situations when they had often not defined their own identities. Students usually did not possess the social or educational building blocks on which to base such information in relation to nursing. By the second year, students had settled as a group and had some clinical experience to compare to classroom theory. As I began to learn the pedagogy which the students helped to teach me, and was more able to integrate practice exemplars having acquired some educational theory, I found my classes remained well attended.

Appointment to the Department of Education

Late in 1987 I was approached by the Department of Education to consider a secondment to research the health needs of young Maori trainees on government pre-employment schemes. This meant relocation to downtown Wellington and entry into education and research politics. At this time I was also appointed to the Education Committee of the Nursing Council of New Zealand, the first Maori appointment to this significant and powerful committee or to any committee on the Council. Nursing and midwifery education was the obvious place to start the work which became known as Cultural Safety and the juxtaposition of the appointment to the Education Committee and the opportunity to gain a national overview and national influence through the Departmental secondment, were extremely fortuitous.

On completion of the research project and the production of the educational video and poster package that emerged from it, I was further employed by the Department of Education to set up and facilitate a hui which was to be concerned with the recruitment and retention of Maori students in nursing courses.

At this period the Department of Education had a position called Senior Education Officer, Nursing, filled by Ms Janet Davidson (who was interviewed for this project), which had responsibility for the overall educational co-ordination of the fifteen polytechnics providing nursing courses. Such was the concern of the Department of Education to respond to the principles of the Treaty of Waitangi and to get Maori health issues successfully integrated into nursing education, that the position offered to me was especially created. The position was called Education Officer, Nursing and Maori Health, and was one of several which were involved with Maori issues in the tertiary sector.

Looking back it is possible to see that my time in the Department of Education provided an amazing opportunity to translate my prior experience, concerns and emerging insights as a teacher to conceptual and practical strategies for nursing education at a national level. It also provided opportunity to bring together issues of Maori health and the role and place of nurses within healthcare to make a critical difference.

My role was to help co-ordinate curriculum development and course content in all the polytechnics at a national level. This involved a series of visits over the next two years and resulted in the production of *A Model for Negotiated and Equal Partnership* (Ramsden, 1989a) (presented in Figure 4), which was accepted by all polytechnics and implemented regionally according to their own community settings. Relationships between local iwi, and nursing schools were critical to the model. A most innovative response was the relationship that the Otago Polytechnic Department of Nursing developed with Ngai Tahu, the local tangata whenua, where the School of Nursing and Ngai Tahu co-own the Cultural Safety curriculum to this day.

In the years following the writing and introduction of the model, discussions with educators teaching in polytechnics at that time have shown me that they regarded it as revolutionising for their thinking and for their practice. It provided a structure and

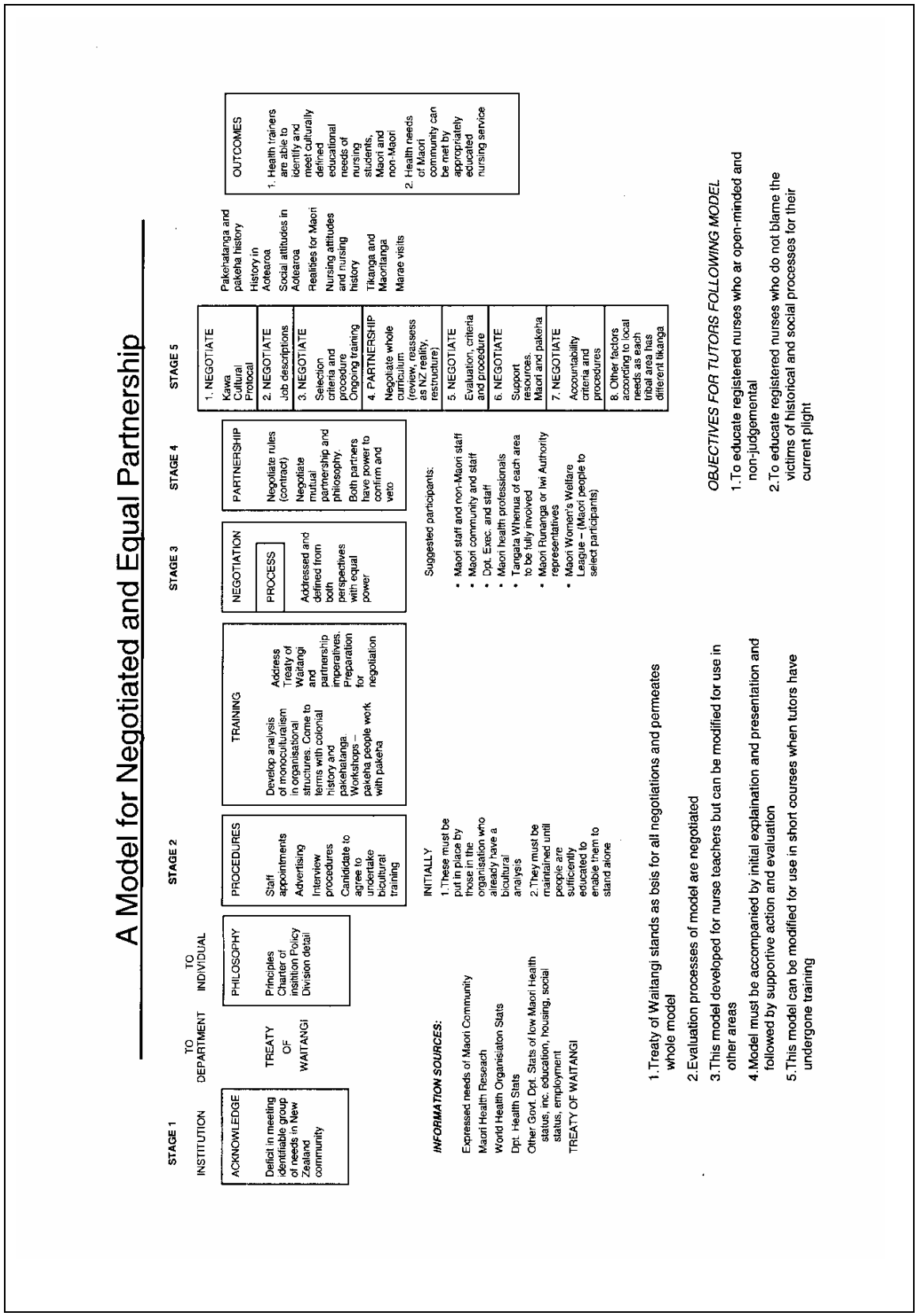


Figure 4
A Model for Negotiated and Equal Partnership

process for moving forward with this aspect of education. It also provided a basis for arguments for obtaining resources.

A number of nurse educators have shared with me that the Model came at a time when they were seeking alternative strategies in nursing education, as they recognised the importance of addressing these issues. However, in some places these educators were lone voices.

The Hui Waimanawa

The second critical impetus for the development of Cultural Safety, also associated with my role at this time, was a national hui, the Hui Waimanawa. This hui which I was commissioned to run in 1988 was significant in several ways. First, the budget allowed me to take the gathering to my home area so that I could be supported in the work by my grandparents and other family who came and sat with me for the week. My grandfather named the gathering, Hui Waimanawa, in recognition of the tears which had been shed over the years of colonisation and to recognise the importance of the hui being able to happen.

Second, since the gathering was concerned with the experience of Maori students, I invited Maori students to take part in the hui which had over a hundred participants. Third, the participation of Maori students produced the term '*Cultural Safety*.'

Fourth, the report of the hui and the *Model For Negotiated and Equal Partnership* (Ramsden, 1989b) became critical turning points in the implementation of Cultural Safety into nursing education because they were accepted as national documents from the Department of Education and were reinforced by assistance from the Education Officer, Nursing and Maori Health.

Origin of the Term *Cultural Safety*

A first year student from Te Arawa studying nursing at Christchurch Polytechnic was at the Hui Waimanawa. Although shy because of the status of other participants she had been listening carefully to the talk and to the language being used. Finally she rose to her feet and said that legal safety, ethical safety, safe practice/clinical base and a safe

knowledge base were all very well to expect from graduate nurses "*but what about Cultural Safety?*" This young woman was overwhelmed by her own courage. Sitting in the hui, I picked up what she said and with her permission from that time adopted the term *Cultural Safety* to refer to the work which has since emerged from the hui.

Acceptance by the Nursing Council of New Zealand and the schools offering nursing and midwifery education of the two documents *A Model For Negotiated and Equal Partnership* (Ramsden, 1989a), and *Kawa Whakaruruhau: Cultural Safety in Nursing Education in Aotearoa* (Ramsden, 1990a), legitimated the term *Cultural Safety* and admitted it to the nursing and midwifery lexicon. Linda Wilson, Head of School, Occupational Therapy, Otago Polytechnic, and I (personal communication, Dunedin, 1993) identified expected educational outcomes of a culturally safe graduate health professional presented in Figure 5.

All graduates	→	*develop the skills of critical analysis*
All graduates	→	*recognise where things are wrong*
Two thirds of graduates	→	*recognise the opportunities to create change and see where to intervene*
One third of graduates	→	*contribute to change*
Outstanding graduates	→	*initiate change*

Figure 5
Outcomes of a culturally safe health professional

This is not a measure of any group of students at any time but simply a model to which students and teachers may aspire. It does not require concrete prescription but rather creates a set of aims which students and teachers can see as achievable alongside their own rhythm and pace of development. It does not stipulate that students will have reached a prescribed level of achievement by a given time but acknowledges the rate at

which each student works and it also agrees that such learning may take place over a total lifetime, that learning does not need to confined to a three year programme.

Moving into a teaching environment and having direct contact with students from the very beginning of their training gave me further insight into both my own and their learning needs about emanicaptory change and ways in which this information could be approached and used meaningfully within nursing and midwifery.

To some extent, the key concepts of Cultural Safety education were already in place prior to my moving into teaching. However, there had been no education framework on which to "hang" the concepts, learnt as a practitioner, which could be relevant to those students in a classroom who were without a practice base. The two components of theory and practice needed to be brought together for me as a teacher, and from that position I could bring the same information and analysis to students as they moved through their training and were exposed to practice situations.

The key objectives of Cultural Safety education arose directly from these practice/classroom encounters:

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

These objectives formed the basis for the early Cultural Safety documents I produced which are discussed in the following chapter. They have remained, to this day, the fundamental cornerstones on which Cutural Safety education is based.

Chapter Seven

The Evolution of Cultural Safety

The intention of this chapter is to showcase the extent and depth of work which has gone into the development of the Cultural Safety concept. A chronological approach is used to examine the evolution of Cultural Safety as an indigenous New Zealand nursing and midwifery educational and service experience between 1988-2001. The chapter refers directly to the supplementary material contained in Volume Two, which includes a number of my own published and unpublished documents including speeches, presentations, papers and submissions.

I have identified four eras in the evolution process of Cultural Safety which build on the private and public narratives which are features in this work. The previous chapters in this section have highlighted some of the background and impetus to the internal development of the concept and the movement towards a focus involving working relationships with Maori and non-Maori people who use nursing service, students, teachers and institutions, and practitioners of nursing and midwifery. This chapter highlights not only the written work produced but also draws attention to the range of the audience, both national and international, that Cultural Safety was attempting to address. It is from within this audience that some of the key players were chosen to take part as interviewees for this project and their contribution is presented in depth in Chapter Nine.

Following on directly from the origin and context for the naming of *Cultural Safety* at Hui Waimanawa earlier in 1988, the first era explores some important influences in relationship to my early thinking and the conceptualisation of Cultural Safety up to the year 1991. Key documents from that period, produced while I was working in the Department of Education are referred to (Volume Two, *Section 1*), building on those primary objectives of Cultural Safety which were identified in the previous chapter.

The second era relates to the years 1992-1994 which I have termed a period of refinement/embedding for Cultural Safety. Of critical importance for the work produced then was the role of the Nursing Council of New Zealand and the introduction of Cultural Safety into the state examinations for nurses and midwives. This era also coincided with a major change in the New Zealand health system. The impact of the health reforms on the provision and delivery of services during this time was highly significant. Such changes provided opportunities for Cultural Safety to move beyond nursing and make/re-establish wider links with various government ministries concerned with health, education and Maori development policy formation. The latter part of this era also saw the beginning of the movement of Cultural Safety into the public domain and the powerful influence of the media on the public's understanding and perceptions of the concept (Volume Two, *Section II*).

The third era in the evolution of Cultural Safety covers the period between 1995-1998 (Volume Two, *Section III)*, a time during which there was considerable documented political and public commentary in New Zealand regarding the place of Cultural Safety within nursing and midwifery education. This era was dominated by the threat of a Parliamentary Select Committee investigation into the teaching of Cultural Safety. The production of a second set of Nursing Council guidelines for the Cultural Safety component in nursing and midwifery education in 1996 were important because of the broadened focus on social areas which appear to have lessened the impact of Cultural Safety in relation to Maori health issues. The significance of this is explored further in the final era of the evolution process of Cultural Safety.

This last period from 1999-2001 (Volume Two, *Section IV)* reviews Cultural Safety as a contemporary concept and highlights ongoing issues resulting from the public and political impact of Cultural Safety in the early nineties. The definition of Cultural Safety at a range of levels is critical and fundamental to the survival of the concept. This is examined in more depth in Chapter Ten of this thesis. However, an initial exploration of the re-definement process is presented in this final era in the evolution of Cultural Safety.

Early Thinking/Conceptualisation 1988-1991

The body of work produced in the early part of Cultural Safety's evolution process was primarily concerned with attempting to identify a clear path by which health services might more effectively address the poor health status of Maori people and provide sufficient background knowledge to enable a considered analysis of the historical, political, social and economic situations that were continuing to impact on the health of Maori people. Nurses and midwives were key people in enabling this to happen because of the sheer size of the workforce and the extent of their coverage and access to people over the whole of New Zealand.

Recognising that there was another educational component needed in the training of nurses and midwives, meant reviewing the philosophy and ideology of the nursing service here which had emerged from a particular time and place in Victorian England under the skill and influence of Florence Nightingale. I proposed that nursing and midwifery services, soon to enter a new century, needed to provide care *respective* rather than *irrespective* of all of those factors which maintain our integrity as members of the human race (Ramsden, 1988). A nursing service able to recognise and respect human difference would go a long way toward addressing problems in health service delivery to Maori. This has remained an unchanged cornerstone in Cultural Safety education and the work produced in this period built on that foundation through both public presentation forums (Ramsden, 1989b) and in nursing/midwifery specific forums through written documents and papers submitted for publication (Ramsden, 1989a, 1990a, 1990c, 1990d, 1990e).

One of the central areas needing to be addressed was the role of the Treaty of Waitangi as a tool for negotiating the relationship between Maori and the Crown. In terms of the nursing and midwifery professions, the treaty defined the relationship of the Crown as provider of education resources for nurses and midwives and their subsequent employment on registration. As was previously mentioned in Chapter Six, comprehensive education with regard to the treaty was not part of the State school system and students coming into training institutions did not have the educational building blocks on which to base Treaty of Waitangi information in relation to nursing and midwifery.

A Model for Negotiated and Equal Partnership (Ramsden, 1989a) was a key document produced during this period, suggesting a process by which nursing and midwifery educators could approach the idea of incorporating bicultural values into their courses. The model required an understanding of the treaty and its implications for power and resource sharing which could be translated into positive action through such mechanisms as employment of staff and ongoing in-service training using suitably qualified people/organisations. As was noted in the previous chapter, relationships between local iwi and nursing schools were critical to the model and it is through the establishment of these relationships that the negotiation and partnership process of the model could be truly integrated. The follow-up publication, *Kawa Whakaruruhau: Cultural Safety in Nursing Education* (Ramsden, 1990a) documented feedback from the public consultation process undertaken during the early development phase of Cultural Safety. At this stage, the concept of Cultural Safety involved consideration of two interrelated issues:

- The safety of Maori people training and practising as nurses.
- The safety of Maori receiving care and treatment as turoro (clients).

By this time, I had recognised that a rapid response to the educational needs of student nurses and midwives examining this area of theory and practice development for the first time, was required. In conjunction with that, recommendations and guidelines for teaching along with assessment processes were also needed. The establishment of Komiti Maori in every training institution providing nursing and midwifery education was seen as necessary to successfully facilitate the implementation of Cultural Safety on a national basis and guidelines for the procedures and functions of these committees were developed (Ramsden, 1991).

The previous three foundation documents (Ramsden 1989a, 1990a, 1991) were pivotal in focussing the work required for the beginning of the second period of the evolution of Cultural Safety. At the end of 1991, the Nursing Council of New Zealand ruled that the State registration examinations for all nurses and midwives would include a 20% section on Cultural Safety to be introduced for the first time in 1992.

Refinement/Embeddedness 1992-1994

One of the key tasks for the early part of this period was working with the Nursing Council of New Zealand to develop a policy document to assist nursing and midwifery teachers to introduce Cultural Safety into the education curricula for students (Nursing Council of New Zealand, 1992; Ramsden, 1992a). An emphasis on the broader meaning of *'culture'* was much more apparent, with a shift away from a Maori studies approach (more synonymous with *'ethnicity'*) in the teaching of Cultural Safety. This needed to be very clear in terms of the criteria for assessment of students throughout their training, as well as in the preparation and marking criteria for the Cultural Safety component in the state examinations.

Cultural Safety was being introduced into the nursing and midwifery education curricula at the same time as major changes were underway in the provision and delivery of health services in New Zealand. This was an opportunity to reflect those changes and link Cultural Safety with wider policy development, beyond that of nursing, and thus make use of the opportunities for funding available in the new health environment (Ramsden, 1992b, 1993a). This was crucial for the development of the concept because committed funding was needed in order for nursing and midwifery educators to come together to continue work on standardising the criteria for Cultural Safety education, monitoring and assessment in teaching institutions. However, ongoing funding for the development of these processes was never fully addressed and continues to be a major issue affecting Cultural Safety's viability to this day. This was one of the key issues raised in my submission during the Select Committee Inquiry into Cultural Safety and is discussed later in this chapter (Ramsden, 1995f).

At the same time, more input at a public level to enable community involvement in the development and refinement of Cultural Safety was needed. This was achieved to some extent with the successful funding application for one proposal using a consultation process to identify the meaning of culturally safe and acceptable health care for Maori providers and consumers of health services (Ramsden, 1993a). It was consultation processes such as these that were also very important in terms of demonstrating early examples of work on intellectual property rights which lay the foundation for developing a process of ownership of the Cultural Safety curriculum between the Crown (represented by the teaching institution) and iwi (Ramsden, 1993b).

The momentum surrounding the development and refinement of Cultural Safety was growing throughout this period and I was asked to speak or make a written contribution to a range of forums, nationally and internationally, explaining the concept (Ramsden, 1993b, 1993c). The United Nations identified 1993 as the Year of the Indigenous Peoples and so there was the opportunity for various audiences to consider what this actually meant for Maori and to link Cultural Safety with wider aspirations and contexts common to other indigenous peoples including notions of citizenship and sovereignty issues (Ramsden, 1993d, 1994a; Ramsden & Spoonley, 1994). Later papers would develop this argument further, in discussing the commonality between the experience of colonisation amongst indigenous peoples, which has led to forms of cultural poverty and very real economic poverty (Ramsden, 1995e). Another issue for Maori was the need to define our relationship with tangata Pasifica, both as peoples living side by side within Aotearoa, and as part of the wider Pacific community. There were possibilities for combining collectively as Pacific peoples to define strategies for change which needed further exploration (Ramsden, 1994b).

In terms of the New Zealand audience, there remained a substantial amount of work to be done regarding the general public and nursing and midwifery students' lack of knowledge and understanding regarding the Treaty of Waitangi, given that the treaty was central to Cultural Safety education. The need for good information was no more apparent than in the media response to the Anna Penn case which arose in the latter part of 1993. The Anna Penn case related to the issue of assessment in Cultural Safety in nursing education. Many newspaper and radio reports recast the central issues of racial disadvantage and racism into arguments concerning "political correctness" fuelling public fear and prejudice of a Maori take over of nursing and midwifery education and practice (Ramsden, 1993e; Ramsden & Spoonley, 1994).

The negative repercussions from the media coverage of that case continued well into 1994 and reinforced for me the urgent need for a comprehensive education approach to the Treaty of Waitangi which would facilitate opportunities for skilled analyses and an informed debate.

In my discussion paper prepared for the New Zealand Nurses Organisation Code of Ethics review (Ramsden, 1994c), I identified ethics as being culturally defined and that New Zealand nursing notions of ethics were based on the social structure, morals, and

philosophies of the dominant United Kingdom derived peoples who had settled here. In considering ethics in the New Zealand context, recognition of the ethno specific pakeha education of nurses was necessary if other groups (who differ from ethnic pakeha) were to have full representation and involvement in the process of review, debate, definition and agreement on what ethics meant. The implications of this was that the Treaty of Waitangi should be considered as the primary issue for New Zealand nursing and midwifery.

In relation to the general public there were a range of issues concerning the state education system and the romantic mythology taught in schools regarding Maori and the colonial settlement of New Zealand which have and continue to persist (Ramsden, 1994b, 1994d). Alongside this, noticeably at the secondary school level, there were consistent reports of students, including significant numbers of Maori, failing in classes and in national examinations. A central issue here is that of professional responsibility, but this has seldom been raised. If the education system were to move away from a deficit theory towards processes of accountability and regular audit where performance indicators were built into the contracts of school principals and other education managers, what would be the outcome? I proposed that where specific groups of people were being failed by a service, and such failure can be clearly measured and demonstrated, then contracts should include a requirement to eliminate failure in service delivery by detailing an improvement in teaching skills which meet, in this instance, the specific needs of Maori students (Ramsden, 1994d).

Many of these same issues continued to be a focus for much of my work into the third era of the evolution of Cultural Safety. What was to be most noticeable during this time was the movement of Cultural Safety from a public debate into the political arena. As a result of that political involvement there was a galvanising of support for Cultural Safety education from within the nursing and midwifery professions.

Political Turbulence/Public Commentary 1995-1998

As has already been highlighted, a large part of the work I was involved in related to developing and strengthening the quality and comprehensiveness of the information available regarding the Treaty of Waitangi. Initially this was necessary in order to provide sufficient background and context to the arguments for why Cultural Safety

education was needed in nursing and midwifery in response to the disparities seen in Maori health status. This has already been discussed and debated in the previous eras of Cultural Safety's evolution. The need to present and build on that information, for both local and international audiences, emphasising Cultural Safety as a quality issue in health care, was ongoing (Ramsden, 1996; Papps & Ramsden 1996).

There were many threads to the treaty work which have wide implications at a range of levels. For example, in a population-based system of electing governments, groups of people who have fewer numbers have little likelihood of controlling their futures (Ramsden, 1995b). This is an extension of the work discussed earlier regarding the definition of ethics in nursing based on who has the power to define and how that shapes the way in which society views itself and those people in it. A treaty-based argument would support the position of Maori as a treaty partner with the Crown and therefore place Maori in charge of determining and defining Maori concerns, irrespective of population numbers.

Similarly, on that basis, professional appointments to the Nursing Council of New Zealand should have a Maori nurse and Maori midwife representative with suitable criteria established (Ramsden, 1995c). They should occupy a peer role with other professional Council members, rather than serving as kaumatua. The process of appointment would need to be established; in particular what place does the Crown have in appointing its treaty partner representatives to statutory bodies?

The threat of an inquiry into Cultural Safety by the Government's Education and Science Select Committee was addressed in my submission to the Selection Committee in August 1995 (Ramsden, 1995f). I stressed that New Zealand is not a multicultural society in terms of the access of "other" cultures to power. Other cultures are permitted little more than ethnic food and entertainment displays. There is no real representation by their groups in the decision-making processes of their communities or the country, and they are unable to effect real change for themselves.

The limitations of the terms of reference for the Committee were very evident. Most obviously, they appeared to be based on the subjective experience of students who were not in a position to comment authoritatively on nursing and midwifery practice and were learning material that most had never before been exposed to in the ethno specific

education system which dominates in this country. The other limitations to the terms of reference included no provision for consumers of the service to comment on possible changes in service delivery to them and no provision for assessing whether education outcomes and objectives of Cultural Safety courses were being met.

The recommendations I made to the Select Committee focussed on the need for establishing sufficient support and education mechanisms nationally to be available for Cultural Safety teaching. This would cover such necessities as funding to set up national standards for content and delivery of Cultural Safety teaching and development of a pedagogy for peer review to be funded by the education institutions as Crown organisations, minimum qualification requirements for those teaching Cultural Safety on entry to teaching, formal ongoing education and a minimum practice period before being employed as a Cultural Safety teacher. Recommendations concerning the provision for further education for those Maori tutors originally employed by ethnicity rather than qualifications, and ensuring Cultural Safety be maintained within Nursing and Midwifery departments, rather than Maori Studies departments, was heavily emphasised.

Throughout this period of the media coverage and following the Select Committee hearings, I continued to write and present information to the public and to the nursing and midwifery professions about why Cultural Safety was critical and the impetus behind the development of the concept (Ramsden, 1995d, 1996, 1997). The need to keep my professional colleagues informed was particularly important over this period in terms of recognising the strength that nursing and midwifery had shown in support of Cultural Safety education (Ramsden, 1995g).

The negative media coverage and threat of the enquiry throughout this era in Cultural Safety's evolution did have repercussions however, as there had been in the earlier 1992-1994 period. A second set of guidelines for Cultural Safety were produced by the Nursing Council of New Zealand (1996) following the independent review undertaken by Spoonley and Murchie (1995). While the guidelines (Nursing Council of New Zealand, 1996) included my essay examining the relationship between the development of Cultural Safety and the Treaty of Waitangi, reinforced the position of the treaty as a negotiating tool (Ramsden, 1996), it was clearly evident that a less provocative political stance was being taken. Compared with the earlier 1992 guidelines (Nursing Council of

New Zealand 1992), the overall impact of Cultural Safety had been subsumed into the broad and non-specific area of social issues. Alongside that, the position of the Treaty of Waitangi, as central to Cultural Safety education, was significantly diminished.

This was something of a flagship signalling what was to follow in the next era of Cultural Safety's evolution. The need to examine the contemporary position of Cultural Safety within nursing and midwifery curricula and how the concept was being re-defined to meet educational rather than service needs remained a serious focus for the work presented during the 1999-2001 period.

Contemporary Cultural Safety/Re-Definement 1999-2001

In a paper delivered to the New Zealand Nurses Organisation conference in 1999 (Ramsden, 1999), I emphasized the important role of research in building professionalism in nursing. Research is political, and we must ask the question "who will benefit from the research?" All research involves basic assumptions about the reasons for individual behaviours, what is an acceptable research approach, where it is appropriate to publish results, and so on. While these assumptions are often unstated and taken for granted, they strongly influence what is actually studied and the way research is conducted. There is therefore a need for culturally safe research, just as there is a need for culturally safe nursing practice. In particular, Maori models of health need to apply to reality just as any other model should. The four taha – whanau, tinana, hinengaro and wairua - lately renamed Te Whare Tapa Wha (Durie, 1994), are not an ancient whakatauki. The model is derived from a nursing construct designed in the mid-1980s at Waiariki Polytechnic to assist in healing the division between biomedicine and an integrated approach to human care. It was fine for its time, but must now be reviewed. The analysis of Maori health models should move on to consider such matters as taha poor education, taha unemployment, taha racism and taha powerlessness.

In Nursing Praxis in New Zealand (Ramsden, 2000) I gave a personal overview of the history of the development Cultural Safety, and its redefinition to meet educational needs rather than service needs. In this paper I discussed, more fully, the importance of "trust" as a key concept of Cultural Safety, and the importance of establishing the "trust moment" between the nurse and the patient.

Many of these issues were raised in a special issue of Kai Tiaki Nursing New Zealand produced in February 2001 (New Zealand Nurses Organisation). Coincidentally, as I prepared the editorial for that issue (Ramsden, 2001a), the 2001 edition of Potter and Perry's *Fundamentals of Nursing* (2001) arrived on my desk. It had a section on Cultural Safety alongside the section on Transcultural Nursing. The analysis was more politically astute than previous editions, but frustratingly, the usual assumptions about Cultural Safety were made. Firstly, that culture and ethnicity are synonymous. Secondly, that Cultural Safety is about something confusingly called biculturalism and students learning Maori language and customs, and thirdly, that nurses can predict culturally-based behaviour, and have the right to control the practice environment accordingly.

Later in that year, I was able to more fully address some of these issues when presenting to the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) conference in Melbourne (Ramsden, 2001c), urging these nurses to identify and value the leadership and skills available within their communities and to seek the influential positions on Hospital Boards and University Councils as is their right as First Peoples. Involvement in this type of activity had been important for me throughout the evolution of Cultural Safety. My memberships and appointments to a number of Boards and organisations included: the Health Sponsorship Council, the National Heart Foundation of New Zealand, Te Hotu Manawa Maori, Council member of Lincoln University, member of both the Ethics and Maori Committees of the Health Research Council of New Zealand, Executive member of the Asthma Foundation of New Zealand, founding member of the Maori History Association of Aotearoa, member of the Medical Association of New Zealand as representative for the New Zealand Family Planning Association and appointment as New Zealand representative to the International Bioethics Board, to name but a few. All of these positions enabled me contact with a range of different groups and organisations and gave me skills in negotiation, mediation and advocacy which I could bring to the Cultural Safety work. Similarly, they were opportunities for exposure of these groups to an informed analysis regarding the position of the Treaty of Waitangi in relation to their organisations and the processes required for establishing, within their groups, a negotiating, meaningful partnership with the tangata whenua. The lobbying and need for constant promotion of both Cultural

Safety and Maori issues has been a necessary and critical thread to the Cultural Safety journey throughout these past thirteen years.

An important development in the Cultural Safety journey internationally had occurred at the International Council of Nurses (ICN) meeting in Harare, Zimbabwe, in 1995 and work from that time was continuing into this last period of Cultural Safety's evolution. At a meeting of the Council of National representatives, a resolution had been proposed by New Zealand, as a Member Association, that the ICN develop guidelines to encourage Cultural Safety in nursing education and practice (New Zealand Nurses Organisation, 1995). This coincided with 1995 as the start of the United Nations (UN) Decade for the world's indigenous peoples in the development of policies, strategies, planning and service delivery to improve their health status. The resolution was unanimously adopted (attached as Appendix 5). Further work, throughout 1998-2000, has been ongoing in terms of ICN guidelines detailing development processes for assessment, evaluation and resource allocation in line with the UN development of a charter of indigenous peoples rights.

The evolution of Cultural Safety education has been marked by a very rapid and at times, extremely political process, for all those concerned in its development. Each of the eras reflect something of the level of leadership and influence that was necessary in order to move the concept forward, whether that was consulting with Maori, building relationships with the Nursing Council of New Zealand, publishing in nursing and midwifery journals, informing government committees or taking part in public debate. This chapter has highlighted how Cultural Safety even over its relatively short history to date, has been redefined, from the time of the writing of the initial key documents, through to its acceptance into the curricula by the Nursing Council of New Zealand, and following the Select Committee process.

In many ways, there is a need to return to the same questions that were posed when Cultural Safety was first introduced into the nursing and midwifery curricula including "*How is Cultural Safety defined*?" "*What are the processes for assessment of theoretical and clinical Cultural Safety*?" "*How does the patient say that students are culturally safe*?" These fundamental questions which formed the basis for the key documents

produced early on in Cultural Safety's evolution (Ramsden, 1989a, 1990a) remain the yardstick by which much of the contemporary re-definement of Cultural Safety needs to be measured.

Part of this steady undercurrent of re-definition has been as a result of the confusion between Cultural Safety education and Transcultural Nursing. The differences underpinning these two theories and the reasons why Transcultural Nursing, in current colonial New Zealand society, should be constantly examined and debated, are presented in the following chapter.

Chapter Eight

Cultural Safety and Transcultural Nursing

> For me the exciting thing about Cultural Safety is, if colonisation was about civilised England creating a "primitive other" whom they could dispossess, what Cultural Safety tries to do is make the pakeha the other. That's why it's so difficult for many pakeha, they are so used to being "it", and everything else is different. (Moana Jackson, interviewee)

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.

Prior to the development of Cultural Safety, the concept of Transcultural care had been widely accepted as an approach to nursing people from other cultural groups. In the traditional western anthropological sense this theory is based on the idea that the culture of nursing represents the norm and that the people who use the service are exotic. Transculturalism states that such cultures need to be learned and understood in order to permit predictions of the health of individuals, groups and cultures (Leininger, 1991). This activity is called ethno nursing and is based in the notion of ethnicity as the major driver of culture relating to anthropological concepts which were current in the 1950s when Leininger did her fieldwork in Papua New Guinea and first began publishing her theories of ethno nursing (Leininger, 1970). Interestingly, ethno nursing does not require the nurse to learn the language of the patient. This transgresses the basic premise in participant observation on which ethno nursing is based.

The most obvious differences between Cultural Safety and Transcultural Nursing lie in the anthropological and sociological definitions of culture and their interface with the related concept of ethnicity. A number of terms will be used in this chapter which are relevant to both approaches and recognise the respective philosophical and consequently practice related differences, which underpin these two theories. I have identified some of key concepts which are summarised in Table 1.

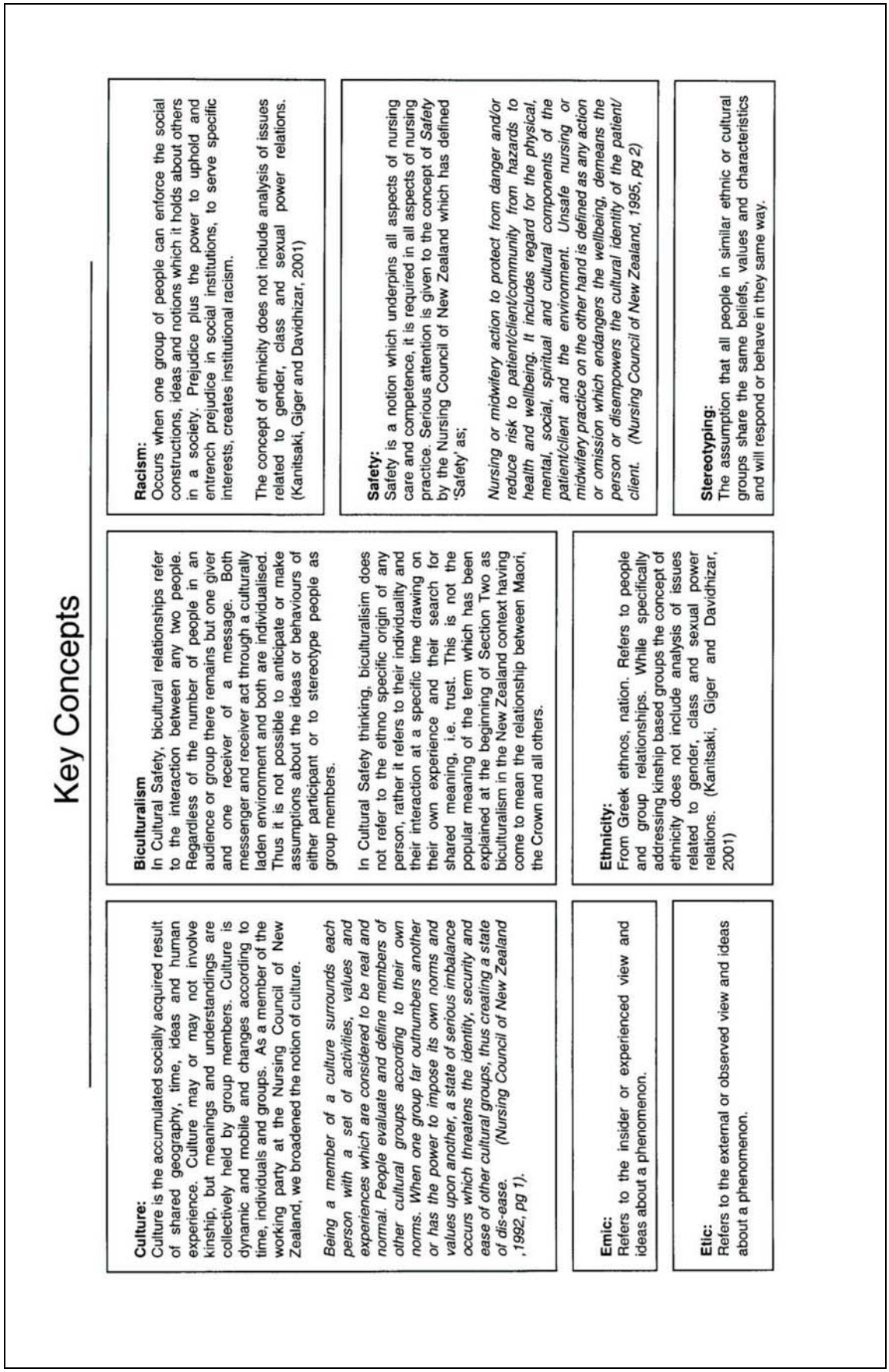
Comparisons and Contrasts

Cultural Safety has been developed from within Maori cultural reality. Maori people no longer accept that our world is a perspective on the reality of any one else. We have our own whole, viable, legitimate reality. It operates in different ways for different Maori but it is one of the realities in this country, not a perspective (Ramsden, 1990a).

Cultural Safety began with the Maori response to difficulties experienced in interaction with the western based nursing service. It does not accept that the culture of nursing is normal to patients. It assumes that the nurse is exotic to the patient, and that only the person experiencing service can say whether it is fully effective and will be approached again. Cultural Safety gives the power to the patient or families to define the quality of service on subjective as well as clinical levels. It 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).

Cultural Safety is concerned with the transfer of power from service providers to health care consumers, addressing issues of power imbalance (Cooney, 1994). The importance of this, in terms of the need to examine dominant power structures and how they impact on health, both within and between groups, has been recognised by a number of commentators (Bruni, 1988; Jiwani 2000; Kearns, 1997; Walker, 1995). While Transcultural Nursing theory identifies the existence of monoculturalism, it does not give nurses strategies for challenging it at a political level, rather they learn to work within this power structure to provide culture-specific care to individuals and groups at the practice level (Cooney, 1994).

Table 1
Key Concepts in Cultural Safety



History shows that through a process of colonisation Maori have been victims of oppression and racism and today their poor health figures represent the outcomes of 160 years of monocultural domination (Pomare & de Boer, 1988). Cultural Safety developed from the experience of colonisation and recognises that the social, historical, political and economic diversity of a culture impacts on their contemporary health experience. Thus, structural influences, which have a significant impact on health status, cannot be ignored. Bruni (1988) states that:

> Any programme aimed at altering health status must address structural factors. Furthermore, attitudes, beliefs and expectations must also be considered within this context. (p. 30)

Bruni elaborates further on the need to move beyond descriptions of variables to the application of a critical framework that can meaningfully address change:

> In order to explain the health-related attitudes and behaviours of various peoples, an historical perspective that addresses processes of change is vital. Indeed without a critical framework, explanation is not possible and the identification, amelioration or resolution of a problem an impossibility. Furthermore, 'descriptive' understanding is at best interesting, at worst misleading and futile. (p. 26)

Information or even skill in traditional Maori ethnographic detail will not enable nursing or midwifery students to give effective and safe service to many of the urbanised casualties that comprise the Maori population. Psychiatric service, paediatric or antenatal service in highly urbanised areas may be completely untouched by nursing and midwifery knowledge of greetings in Maori or marae protocol. Furthermore, nurses and midwives possession of knowledge of traditional Maori activities and language skills encourages the employment of deficit perceptions of Maori, which are already internalised by many Maori and non-Maori alike.

Ethno nursing as used within the Transcultural Nursing programmes has developed from cultural anthropology and takes on an observational approach to other cultures (Cooney, 1994; Smith, 1997). While care remains focussed on the "cultural" activities of the patient, there remains the tendency to promote a stereotypical view of culture over time thus making it difficult to respond to individual diversity (Ramsden, 2001).

Bruni (1988) agrees that this can lead to a static approach to culture where groups of people come to hold an unchanging and uniform set of beliefs:

> The problem of stereotyping cultures is compounded by the assumption that the country of origin of a person (or his/her parents) identifies the most significant dimension of his/her experience. (p. 29)

Cultural knowledge belongs to the culture and as such, cultural identity and traditions should remain with the culture. Teaching nurses to be experts in Maori culture leads to further disempowerment of Maori, given that there are significant numbers who have been deprived of knowledge of their own identity and traditions (Coup, 1996). Ethnographic information is only one facet of many Maori health issues, albeit very significant. The question could be asked, how does Transcultural Nursing theory educate nurses to give service to culturally dislocated adolescents with perhaps a serious self destructive urge? This age group comprises a significant percentage of the current Maori population who are highly at risk of self-harming behaviours and suicide (Te Puni Kokiri, 2000). Cultural Safety is based in attitude change. If nurse and midwife practitioners hold safe attitudes, they will be able to work with the continuum of Maori people, from traditional practitioners of the culture to those who have been denied any information about Maoritanga.

Those who do not identify as Maori but are identified as such by the dominant culture comprise a further group. Maoriness encompasses a very wide range of experiences, responses and realities (Nursing Council of New Zealand, 1992).

> Cultural Safety enables the provision of care which respects a person's cultural values and preserves their well being regardful of differences. There needs to be a shift from both the philosophy of cultural sensitivity and providing care regardless of culture, towards one of Cultural Safety which is mindful of, or has regard for, the person's culture. (Coup, 1996, p. 7).

Cultural Safety is viewed as a partnership between client and nurse/midwife based on the *Negotiated and Equal Partnership Model* (Cooney, 1994; Coup, 1996). This model has four identified stages which looks at a process for addressing attitudinal change. The first stage involves finding out what you have, the second stage is to dismantle it, the third stage is to put something else in its place and lastly, the fourth stage is

translating the changes into action. The nursing skill lies in enabling people to say how service can be adapted and to negotiate compromise (Ramsden, 1997).

All interactions are by definition bi-cultural as they essentially occur between two people, the nurse/midwife and the client (Coup, 1996). However, bi-cultural in this instance again, is referring to *culture* in its broadest sense rather than being focussed on ethnicity. One of the people interviewed for this project discussed his understanding of bi-cultural when applied to Cultural Safety.

> I suppose one way of trying to understand better that binary through Cultural Safety is to recognise that any situation is bi-cultural on one level. Yes, we live in a society that to some extent is a bi-cultural society; but let's not try to deal with the macro issue all the time and especially in one on one clinical interactions, let's recognise that even if I was a nurse or a doctor dealing with a fellow Pakeha patient that had many of the same characteristics as me, hypothetically, born in England, middle class, middle aged male; that would still be a bi-cultural situation because for better or for worse I've been socialised into being a health care professional. So I guess one of the key metaphorical spin offs for me in terms of thinking through Cultural Safety is this idea that bi-culturalism is not just something that operates on a macro level in our society that, [in] any sort of didactic situation you have two parts to a dynamic which can be bicultural because of issues of class, gender, professional identity. (Robin Kearns, interviewee)

From its inception, Transcultural Nursing has existed within a multicultural context, focussed on race and ethnicity (Leininger, 1978). It has assumed that nurses and the culture of nurses are normal and commonsensical. In talking about the need for Transcultural Nursing, Andrews states:

> Given the multicultural composition of the United States and the projected increase in the number of culturally diverse individuals and groups in the future, it is apparent that there is an increasing need for nurses to focus on the cultural beliefs and practices of clients. (Andrews as cited in Cooney, 1994, p. 9)

Cultural Safety is based on the premise that the term 'culture' is used in its broadest sense to apply to any person or group of people who may differ from the nurse/midwife because of socio-economic status, age, gender, sexual orientation, ethnic origin, migrant/refugee status, religious belief or disability (Ramsden, 1997). Transcultural Nursing is based on the premise that the term 'culture' refers to ethnicity. Patterns of

learned behaviours and values are shared among members of a designated group and are usually transmitted to others of their group through time (Leininger, 1985). Transcultural Nursing was established to enable nurses to study people from different cultures using humanistic and scientific methods (Leininger, 1978).

Cultural Safety is a requirement for Nursing and Midwifery registration in New Zealand. Successful passing of the State Examinations for nursing and midwifery registration is evidence of Cultural Safety competence (Coup, 1996). Certification is awarded by the Transcultural Nursing Society, to nurses who have educational preparation in Transcultural Nursing or the equivalent. In examining the fundamental differences between Cultural Safety and Transcultural Nursing I have used the approach set out in Table 2 which was first discussed with my colleague Kathie Irwin (personal communication, Wellington, 1997) and has been presented at many seminars since that time which views Cultural Safety and Transcultural Nursing in terms of "Life Chances" and "Life Styles".

The Redefinition of Cultural Safety

The redefinition of Cultural Safety into an idealized mixture of Transcultural Nursing and naïve often romantic reconstructions, based in versions of Maori Studies, has persisted in some Schools of Nursing. Although I have been clear that Cultural Safety and Transcultural Nursing are fundamentally different, there is a steady undercurrent of redefinition of Cultural Safety analysis away from the concerns of structural and multifaceted social inequality, to the culturally descriptive nature of Transcultural Nursing in New Zealand nursing education. Such terms as 'cultural competence' requiring 'cultural supervision' implying that culturally unsupervised nurses will be incompetent and therefore dangerous, have been used to describe nursing practice by an Associate Minister of Health at a nursing graduation ceremony in New Zealand (Turia**,** 2001). None of these terms have been defined or explained but they have their roots in the tenets of Transcultural and ethnonursing.

Table 2
Cultural Safety and Transcultural Nursing

Life chances rather than life styles

Transcultural Nursing (Traditional Western)	**Cultural Safety (Indigenous)**
Assumes that nurses and the culture of nursing are normal	Assumes that nurses and the and the culture of nursing is exotic to people
Retains the power to define norms	Gives the power of definition to the person served
Assumes that by studying "culture" checklist mentality and reinforces stereotypes by not exploring social, historical, economic, class and occupational diversity	Concerned with human diversity
Focus external on patient, retains power	Focus internal on nurse or midwife, exchanges power, negotiated

Notes: A key part of Cultural Safety is that it emphasises life chances rather than life styles

An underlying premise of Transcultural Nursing is the idea of cultural difference, that a homogenous group of people who are nurses encounter patients who are culturally different, exotic and *other*, but are also homogeneous, possessing a body of finite cultural content, customs and traditions based on kinship. Transcultural Nursing also suggests that by studying the customs of *other* or exotic cultures, nurses will gain insight into their worlds. The power to define norms is retained by the nurse.

Elaine Papps (2002) asks the question:

> Is Cultural Safety, then the same as the notion of Transcultural Nursing . . . or the same as cultural sensitivity . . . or the same as cultural competence . . . or the same as culturally competent nursing*?* (p. 101)

Papps suggests that it is not, and others have agreed with her conclusion (Cooney, 1994; Coup, 1996; Papps & Ramsden, 1996; Ramsden, 1995). However, Leininger (1997) maintains that Cultural Safety is an integral part of the Theory of Culture Care to provide culturally congruent care. Although Leininger argues that issues in relation to social inequality are an integral part of the Theory of Culture Care, they are not explicit nor easily determined and defined within any of the literature. This issue has similarly been identified in Bruni (1988), Swendson and Windsor (1996), and Coup's (1996) work. Papps (2002) believes that understanding how Cultural Safety is different from other concepts requires an understanding of the term. She has suggested that the term *Critical Social Theory* may have been more understandable to most people than the term *Cultural Safety*.

The process towards achieving Cultural Safety in nursing and midwifery practice can be seen as a step-wise progression from cultural awareness through to cultural sensitivity and on to Cultural Safety. However, the terms cultural awareness and cultural sensitivity are not interchangeable with Cultural Safety. These are separate concepts.

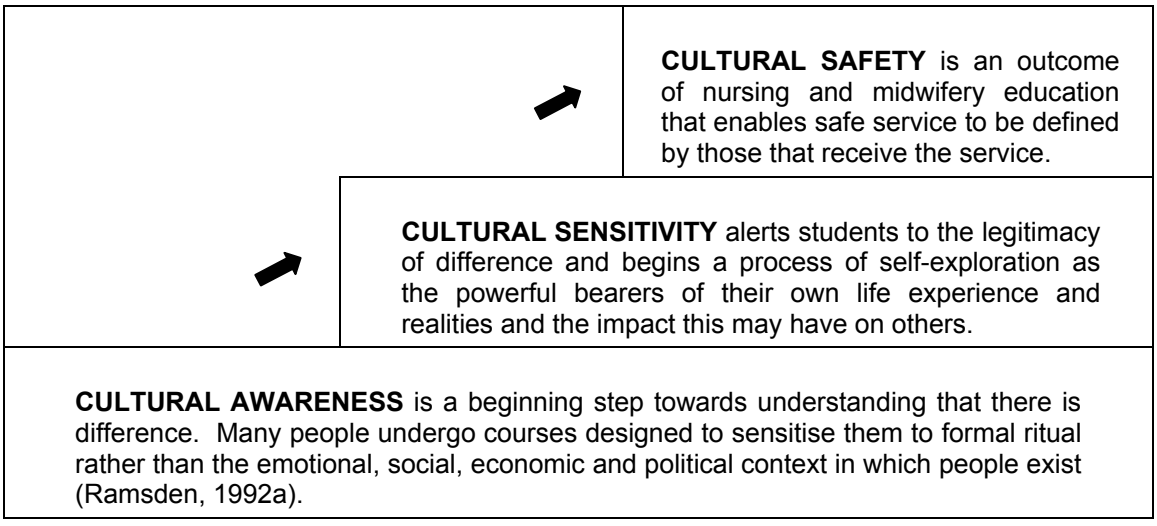


Figure 6
The process toward achieving Cultural Safety in nursing and midwifery practice

It is clear that Cultural Safety does not place an emphasis on sensitivity or an awareness of other cultures. Cultural sensitivity and Transcultural Nursing are both concerned with having knowledge about ethnic diversity. This seems to be the basis of misinterpretation of the concept of Cultural Safety. The term '*culture*' is read as '*ethnicity*'. But the skill for nurses does not lie in knowing the customs or even the health related beliefs of ethno-specific groups. The step before that lies in the professional acquisition of trust.

Its emphasis is to place an obligation on the nurses to provide care within the framework of recognising and respecting the difference of any individual. Rather than the nurse determining what is culturally safe, it is consumers or patients who decide whether they feel safe with the care that has been given, that trust has been established, and that difference between the patient, the nurse and the institutions which underpin them, can then be identified and negotiated (Ramsden, 1997).

Difference is always seen as legitimate and is always seen as negotiable between nurse and patient. Cultural Safety within nursing therefore addresses power relationships between providers and recipients of care (Kearns, 1997). One of the interviewees, Fuimaono Karl Puloto-Endemann, clearly articulates this issue;

> I knew that as nurses [we] were very powerful people. I mean people say "oh but we don't have the power," but that's a load of rubbish because we have incredible power. They strip people down to absolute nakedness . . . literally, totally and expose them. I just think that Cultural Safety is a mechanism to monitor you because at the end of the day we have to become part and parcel of the culture of that institution we work in and we take on the persona of that culture. I would say that I've been in a very powerful position, particularly in the psychiatric area and in that situation I was a very dominant person, when the palangi becomes in effect, a minority, we actually swap roles. And when you see palangi in that situation, it's when you leave that institution you know intrinsically what their experience is because you experience it outside of that world.
>
> (Karl Puloto-Endemann, interviewee)

Transcultural Nursing suggests that curricula need to contain ethno-specific knowledge about a variety of cultural groups in order to help nurses or nursing students to work effectively with patients or clients of other cultures. The risk in this is that all differences can become stereotyped. This is precisely what Cultural Safety seeks to avoid. Transcultural Nursing in this respect can be seen as the antithesis of Cultural

Safety teaching (Papps, 2002). Some key features of Cultural Safety and Transcultural Nursing are summarized in Table 3.

Table 3
Key Features of Cultural Safety and Transcultural Nursing

KEY FEATURES OF
CULTURAL SAFETY AND TRANSCULTURAL NURSING

CULTURAL SAFETY	TRANSCULTURAL NURSING
Emic, indigenous cultural reality	Etic, outsider cultural perspective
Concerned with the transfer of power and establishment of trust.	Seeks to maintain power
Developed from experience of colonisation	Ethno nursing developed from cultural anthropology
Cultural knowledge belongs to the culture	Cultural knowledge can be acquired and managed by the nurse
Culturally safe care	Culturally congruent care
Provides care regardful of individual differences. Sees patient as individual who may share information about difference if trust can be established.	Provides care regardless of individual differences. Sees patient primarily as group member.
Negotiated and Equal Partnership Model	Patient and nurse are co-participants
Interactions are bicultural	Nurses are multicultural
'Culture' is applied in its broadest sense	'Culture' refers to ethnicity
A requirement for nursing and midwifery registration in New Zealand	Certificate of competence in the United States

An example of culturally safe practice may be seen in the action of a self-aware nurse who recognises homophobia in their own personality and chooses not to work in the area of HIV/AIDS where chances of encountering homosexual people are higher than in some other areas of nursing employment. The nurse acknowledges that the effect of his or her homophobia on the recipient of care may be unsafe and detrimental to care and that it would take a great deal longer to establish trust in this context. This example could be applied to a wide range of situations.

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

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

A major issue in relation to Cultural Safety has been its name. As indicated earlier in this chapter, the definition of Cultural Safety refers to culture in its broadest sense. But the original definition was unacceptable to those who viewed the ‘truth' about Cultural Safety in terms of ethnicity, and perceived it in relation to the multicultural nature of New Zealand society even while, in terms of the management of power and resources, New Zealand has been a monocultural society since it established self government under the New Zealand Constitution Act in 1852. Thus, the use of the term ‘culture’ constantly linked Cultural Safety to the discourse of multiculturalism.

The entry of Cultural Safety into nursing and midwifery education in New Zealand has been rapid and has also been refined over time. This is not unusual in any

developmental process of a theory which is based in emancipatory change and requires careful positioning, and in most cases, challenge to an existing *status quo*. What has been difficult for Cultural Safety is the lack of educational building blocks in place for many of the students entering nursing and midwifery on which to move forward such a concept. This has not only been problematic in the professions but also, within the perceptions of the public in understanding Cultural Safety.

The concept of Transcultural Nursing in current colonial New Zealand society should be constantly examined and debated. The traditional western anthropological stance of observation of *other* and the exploration of difference as a point of access to the lives of others assumes that people want their lives to be observed, predicted and responded to at the level of the exotic. My own academic training, experience as a member of several marginalised groups in New Zealand, interaction with the health service as a consumer, as well as in practice and teaching, tells me this is not so.

Cultural Safety in nursing education is doing two separate but interrelated things. Firstly it aims to identify attitudes that may either consciously or unconsciously exist towards cultural/social differences in the provision of nursing care. Secondly it attempts to transform those attitudes by tracing them to their origins and enabling students to see their effects on practice through a framework of practice related reflection and action. Cultural Safety always seeks to locate its action in the belief systems and behaviours of the caregiver rather than the patient.

Cultural Safety is about power relationships in all nursing and midwifery service delivery. As was my own experience, it is also about power relationships between teachers and students of differing cultures. It invesitgates setting up systems which enable the less powerful to genuinely monitor the attitudes and services of the powerful to comment with safety, and ulitmately, to create useful and positive change, which can only be of benefit to nursing, and to all the people whom nurses and midwives serve.

The final section of this work moves Cultural Safety into the public arena focussing on the narratives of those people interviewed for this project.

SECTION III

HE WHAKAWHANUITANGA

THE PUBLIC NARRATIVE

He Whakawhanuitanga

The Public Narrative

Section III comprises one chapter presenting the public narrative of Cultural Safety using a chronological approach similar to that used in Chapter Seven which traced the evolution of Cultural Safety. In the previous sections of this work, both my personal and professional/public journey with Cultural Safety has been highlighted. The focus of this section now turns the work wholly outward, to the personal and professional/public journeys of those who have been involved in their own Cultural Safety journeys and who, at the same time, have contributed to my understanding and to the development and maintenance of the concept since its beginnings in 1988 through to the current issues for consideration in 2001.

The people interviewed were all known to me. They were key individuals in different aspects of the development of Cultural Safety and were chosen as potential interviewees because of their particular role or position. Twenty-one of the twenty-nine interviewees were registered nurses. Several were involved in the development of Cultural Safety through their positions as nurse educators, either as lecturers or as Heads of Schools of Nursing. Some of these nurses had significant responsibilities in developing curricula and implementing Cultural Safety within nursing education programmes. Other nurses held key professional roles with nursing organisations, such as the New Zealand Nurses Organisation, were members or employees of nursing's statutory body, the Nursing Council of New Zealand, or held influential positions in the Ministry of Health. One nurse had changed her field of employment to the Department of Education and played a significant part in the development of Cultural Safety through her position there. The other eight individuals were interviewed because of a particular perspective or insight they could offer, perhaps through their work in Treaty of Waitangi and anti-racism analysis and education, or through working with Maori realities in different aspects of society such as health and social services. One was a Member of Parliament.

While a chronological approach is used in presenting the voices of the interviewees, specific issues also form a focus to reflect the various stages through which Cultural Safety has moved and the activities and reactions of those people, the interviewees, who were involved in that movement. Thus, some of the time periods overlap in consideration of the multiple key issues that were occurring over various time periods, and because of the multiple roles that some of the interviewees have had in the Cultural Safety process. For example, some people who had input at the developmental stage of Cultural Safety when it was being introduced into the nursing and midwifery curricula, would also represent nursing and midwifery leadership, to argue the case for Cultural Safety during the time of the Education and Science Select Committee hearings. Others have been influential in contributing to the shape and form of the original ideas that underpin Cultural Safety and have continued throughout, to be mentors for me, in terms of their analysis and skills in critique.

The interviews took place between June 1997 and May 1998. A total of twenty-four interviews were conducted, some as individual interviews and others as group interviews of up to three participants. The decision to have group interviews was based on the positions held by interviewees during a particular period. For example, participants who were involved in some capacity with the Nursing Council of New Zealand at the time of Cultural Safety being intorduced and discussed within the Council were interviewed collectively. An open-ended interview style was used with twenty core questions asked of every participant (interview schedule is attached as Appendix 4). The questions related to four key areas concerning the development, teaching, practice and public reaction to Cultural Safety.

Chapter Nine

The Response to Cultural Safety

The response to Cultural Safety has been wide ranging and has involved a number of people with varying personal, educational and professional backgrounds and perspectives. This chapter will present their narratives in relation to five broad areas which have been important in terms of the development, teaching, practice implementation and the public and political understanding surrounding Cultural Safety. These are:

- Cultural safety in the wider context
- The appropriateness of Cultural Safety for nursing and midwifery
- The response from within nursing and midwifery education institutions
- 1990-1997, the Nursing Council of New Zealand, the media response and the Select Committee hearings
- Practice implications and the continuing evolution of Cultural Safety

Cultural Safety in the Wider Context

One of the key people who was pivotal to my thinking and who, I believe, has facilitated the great movement and change of ideas and the regrowth of our people's confidence about political issues is Moana Jackson. Moana was present from the very early development days of Cultural Safety. He saw it as a means for considering issues of power and recognised that Cultural Safety had the potential to make links with wider Maori aspirations for sovereignty.

Moana is of Ngati Porou and Ngati Kahungunu descent. He is lawyer and is currently Tumuaki of Te Hau Tikanga, the Maori Law Commission.

> The key to Cultural Safety for me is its part of making our people strong again and protecting our people where ever they are. And in inventing a concept of Cultural Safety I think you've given our people a tool and although I didn't know much at the time of it's nursing ramifications, I could see it's value as a ... if you like, a cementing tool, in the development of our people, and that's the effect it had on me … It had to develop in a particular context in nursing therefore it had all sorts of professional and nursing consequences. But it also had a much wider ramification that our people could use the idea of being culturally safe as part of their reclaiming of our sovereignty, of our rights and so on ... because for me, you can't claim rights unless you're safe in who you are and you can't express those rights unless you're safe and then have the power to do so. (Moana Jackson, interviewee)

Moana was very clear in expressing his belief that Cultural Safety was part of a wider movement within Maoridom and that the work should be viewed together with other Maori processes which have been underway both in the distant past and more recently in the last twenty years.

> I don't see the development of Cultural Safety in isolation, I won't use the word holistic but I see it as part of the intellectual process that our people are going through, for want of a jargon term, the de-colonisation that our people are going through. And so the work that people like, Linda and Graham Smith are doing in developing a Maori pedagogy, in education, the work that Kathie Irwin's done ... I think there are different levels in Maori academic life where similar ideas are being developed and to me they are all different and address different areas of academic disciplines but they are also all inter-related. But beyond the university or wherever, they are also inter-related to the work I think our people are doing on the ground and if you talk to say, a little marae based group that are trying to set up a health clinic or something, they will not use the jargon of "Cultural Safety" or they won't even use the jargon of "sovereignty" probably, but that is actually what they are trying to do. So I see it as an initiator and a forerunner of other ideas which have been developed but I see it as part of one of the exciting changes that's been taking place. The only difficulty I see with some of the intellectual development is that it gets frozen in academia and academics read about it and debate it but it actually doesn't get out to our people and one of the strengths of Cultural Safety is by its very nature, it got out to our people. (Moana Jackson, interviewee)

I asked Moana to talk more about what he thought the strengths of the concept, Cultural Safety, were.

> First, its strength is to challenge students to analyse where they've come from. I don't think we should under-estimate that in a New Zealand educational system because there is one thing that education lacks in this country, it is the teaching of an ability to be critical, the colonizing mentality doesn't encourage criticism, it encourages conformity. But what Cultural Safety as an academic idea does, is that it re-invents or reclaims the need to critically analyse things, and I think that's most important and its greatest strength in a general academic sense.
>
> In a more specific sense of nursing education, we as a people are not going to be able to remedy the unwellness of our people in six months or a year because its the consequence of a hundred and fifty-seven years of dispossession. And so it's crucial that we have people working in that area who are actually going to help our people be well. And so, I think its strength is that it, it helps provide that in nursing education in a specific area. But then its broadest strength I think, is what we've been talking about a lot and that is, that is a political idea and in the end remedying the ills of our people is a political and a constitutional issue, not in terms of the Beehive and Parliament, but in terms of changing the mindset of our people about our power and our powerlessness and so on.
> (Moana Jackson, interviewee)

The teaching of colonial history and its impact on the indigenous people has been considered an important part of Cultural Safety pedagogy in line with understanding the whole context in which a person exists which includes the history, the political environment, the social environment, the economic environment and all the variables that influence those things. I asked Moana to comment on this and the role of the Treaty of Waitangi in Cultural Safety.

> ... In a general New Zealand sense, to teach de-colonisation you have to teach history, you have to teach the ideas and philosophies of dispossession. And in nursing, as part of that culture, there is a need for it as well. So to have a de-colonised nurse requires the teaching of all the things that Cultural Safety tries to do.
>
> … I actually see that the treaty has been recaptured and redefined and as Atareta said, tino rangatiratanga has been redefined because the treaty has been redefined and if the treaty is to be part of Cultural Safety, then it has to be seen for what it is, that is a colonizing text. It was, in the eyes of the colonizers, a tool to facilitate our dispossession. Now that's not how it was seen by our tipuna and I think both sides need to be seen and understood and again, if you're to have a culturally safe nurse they need to understand both sides. But

> what happens is, because of the redefinition that's taken place, if two sides are taught, it's the Crown side and the Crown version of the Maori side so they're still getting the treaty as a colonising text. They're not getting the treaty as a reaffirmation of Maori rights, but the treaty as a statement which reaffirms the colonial world view. So if the teaching of the treaty is as a colonising text, then it has no part in Cultural Safety. If it is seen as a colonizing text in the eyes of the Crown but as an affirmation of our independence, in the eyes of our people, then it has to be part of the history and the background that Cultural Safety seeks to address. I get increasingly disheartened when I hear our people talk about our rights as if they began on the 6th February 1840, as if prior to that we were right-less. As though we didn't have a process that defined who we were, what our rights were, what our obligations were and so on. ... But the treaty is not the reason for Cultural Safety, colonisation is the reason for Cultural Safety and therefore the treaty is part of the colonisation story. If there'd been no treaty, our rights would still be there and what I think is important to do is to place it firmly in that context. (Moana Jackson, interviewee)

Atareta Poananga was interviewed at the same time as Moana. Atareta is of Ngati Porou, Rangitane, Ngati Kauwhata and Te Whanau Apanui affiliation. She has worked in Foreign Affairs as a diplomat and is also trained as a lawyer. I recognized that both Moana and Atareta had understood the concept of Cultural Safety from the beginning. From my own experience in talking about and then teaching the concept, I knew this to be unusual among both Maori and non-Maori. I asked Atareta to consider what it was in her own life, that had informed her thinking and what had motivated her to be the person she was who could recognise this kind of concept.

> Well, how I can really relate to it is because I think you can have an idea of what oppression is, in a general sense, but never experience it or feel it. And I've only really come to understand meanings of terms like colonialism, decolonisation, Cultural Safety because I've been through the fire myself. And I've seen the pain (of) other Maori, in general and individually, who've suffered the same way. So that's why I came to see the power of it, the importance and the mana of pursuing Cultural Safety because it's part of that whole process, removing ourselves, getting out of that pain that we're in every day of our lives, to a position where we are in charge of our own destiny.
> (Atareta Poananga, interviewee)

Early pakeha influence on Cultural Safety ideas was in how to establish a process by which Cultural Safety education could be introduced into institutions educating nurses

and midwives. Pakeha had begun to question their own sense of identity and place within New Zealand and during the 1980s there was a move within government departments to sponsor training workshops on anti-racism, biculturalism and treaty awareness. Annie Collins worked as a trainer for anti-racism workshops and completed a training video on institutional racism in 1987. She talked about some of the personal changes that were occurring for her throughout the 80s.

> It would have started around about, way back in '82 or so when I began to be trained by pakeha people on anti-racism workshops and training … At the time I was working with a Maori film director and because of what I was working on [it] was prodding my conscience and moving me out [of] the sort of cultural training which I had been brought up in. I was looking for some way to be of use, to be of help and I was focussing on Maori at the time, whereas the people in new perspectives, Ray and Mitzi Nairn, whom I was staying with at the time, re-focussed me towards pakeha. They said, "you don't concentrate on the people who are at the end of the problem, you concentrate on the people who are causing the problem." And that was pakeha. And that was a point at which I realized that I had to change my focus. (Annie Collins, interviewee)

Annie recalled the context of change occurring in New Zealand during the 1970s and 1980s and the parallel influence of increasing social and political activity among Maori.

> We were working in the second decade of really increased pressure from Maori groups. Nga Tamatoa back in '72, had already done a great deal of work. Then, Te Matakite o Aotearoa, the Maori land march, put a great deal of pressure on and of course coming out of that was the Waitangi Tribunal being set up. And all those, those two decades, the '70s and the '80s were a huge change period for our society. And for pakeha, once the Springbok Tour happened in '81 which was a watershed of pakeha having dealt to them the sort of...actions that were being dealt out to Maori quite often via the police … Also, the other huge factor for pakeha around '81 was that we had to begin examining ourselves and to examine ourselves we had to take apart ourselves, we had to ask the question, "who are we, what does our culture do?" You know, most people were asking, "do we have a culture" and then of course the answer gradually became "yes, of course we have a culture, how the hell does it work, this is how it works, this is what's operating here. " So the whole business of pakeha identity was happening in the '80s.
> (Annie Collins, interviewee)

At the time when I first met Annie during the 1980s, I was aware that she had been working as part of a group which ran workshops on anti-racism training for government departments around the country. I contacted her in 1988 to talk about the idea of including key elements from her work into a nursing education curriculum. Our discussion from that meeting laid the basis for the development of the *Model for Negotiated and Equal Partnership* (Ramsden, 1989a), a foundation document for Cultural Safety.

> There were about 3 or 4 specific stages to it. The first one was to examine what you were in dealing with attitudinal change. Your first stage was to find out what you had, the second stage was to dismantle it and the third stage was to put something else in its place. And of course we added a fourth stage which was how do you use it, where do you go from here ... translating it into action. ... There were elements that needed to come in which were specific to nursing. And there were also things which I think you as Maori set in place ... Power was a huge part of it ... where it is accessed and how it is accessed and what were the critical places within an institution that you had to pinpoint in order to know that you would have change. (Annie Collins, interviewee)

Annie also spent a lot of time working with Hospital Boards and Heads of Departments and running workshops for nurses which she found very challenging. I asked her about her impressions of nurses attending the workshops.

> I have to say that nurses were tough. Nurses were about the toughest of any of the groups that we worked with. They were power holders par excellence . . .And cynical with it. And, you know, I try to be sort of fair and say, well you're in an industry or a profession in which the power has been grabbed and held by male doctors and you've had to carve out whatever position or decision-making position you have been able to get and you've had to hold on to it. But somewhere along the line, that doesn't quite add up because in fact, the higher that those nurses got in hierarchies within hospitals or whatever, the stronger power-holders they still were. I thought when I went into my first nurses lot that here would be these women who would be caring, helpful really aware of the sort of stresses that dis-empowered people have in society and that wasn't the case at all. And in many ways I was horrified, I still am, I still remember... that very clearly, that is probably my clearest recollection of workshop participants. And it was overlaid with the language of caring and the language of being put down, by doctors. (Annie Collins, interviewee)

One person who saw the potential of Cultural Safety in his area of work, was Robin Kearns. He is of Scottish and English descent and identifies as a pakeha New Zealander. He is a senior lecturer in Geography at the University of Auckland. I asked Robin about the impact that Cultural Safety had on him and why.

> It made me sort of just prick up my ears metaphorically, to begin with and think about the ways in which the health profession, more specifically yours, nursing and midwifery; held the potential to be reoriented towards a more inclusive form of practice and a more inclusive philosophy that could underlie that practice so I was excited in principle I would say. And then a next level for me was a level of excitement as I was able to sort of digest the ideas and apply them to my own field and that signalled to me the possibility that these ideas didn't have to be ring fenced within nursing and midwifery.
> (Robin Kearns, interviewee)

One of the important areas that Robin talked about was the training and learning environments which accepted and encouraged a view of the world in terms of binary constructs. I was interested in Robin's views regarding binary constructs between Maori and pakeha at a macro level. The extension of this idea in relation to bi-cultural interactions at a micro-level between the person and nurse/midwife in Cultural Safety teaching was discussed in the previous chapter.

> Maori/Pakeha is a binary construct in which one cannot be adequately understood without reference to the other in the New Zealand context. I think one of the challenges is to understand the dynamics and to acknowledge that on one level the construct of Maori/Pakeha has an empirical reality and yet on another, it's fiction, because within the two halves or parts of that binary opposition, there are unpredictable degrees of diversity. Maori in a unitary sense as one sort of homogenous group, is a myth which has been conveniently and politically deployed in the face of colonialism, so too the idea of Pakeha has been created through reference to Maori. This colonial construct also does not permit the human diversity which the word Pakeha has come to represent.
> (Robin Kearns, interviewee)

I first met Robert Consedine in the 1980s while he was involved in Project Waitangi and since then we have run treaty workshops together on a number of occasions. He had some involvement with liberation movements in other countries during the 1960s and then followed that up with work for International Aid. I asked Robert about the range of

responses he encountered in workshops when people are exposed to the concepts of Cultural Safety.

> I think it challenges two fundamental ideas apart from being afraid of something they don't understand. One is the outcome of assimilation. That a huge number of Pakeha people, their starting entry point into all of this is the belief that Maori are just the same as us and it challenges that idea. And that idea is very deep in people- this idea that what are they going on about-they're just the same as us. A kidney is a kidney is a kidney. And so that would be the primary thing actually because once they get over that idea people become open to expanding their understanding of it. But that idealism is deep.
> (Robert Consedine, interviewee)

Robert described a fear among people of exposure to 'difference' which would demonstrate that there was another group of people who had to be dealt with, sometimes in different ways – with particular respect to Maori/pakeha relations in Cultural Safety. There was a sense of 'takeover' by another group which made people feel threatened and afraid.

> There's a huge fear of, and lack of respect for difference. And I think it comes out of our history. Assimilation was about sameness and what Cultural Safety and the treaty debate does, is it turns people's traditional worldview upside down literally. I think in [the] Pakeha world we have yet, even after 10 years of thinking about it, [to be] aware of the enormity of the transformation that has to take place in the Pakeha world with this whole debate, which includes Cultural Safety. It is enormous and people come to it thinking they need to learn what's in the treaty, which is that much, but, in fact, the transformation that has to happen amongst Pakeha is monumental. It goes right to the roots of who we are. (Robert Consedine, interviewee)

One of the nurses interviewed was Elaine Papps. Elaine completed her nursing training in 1969. She worked in paediatrics and theatre before becoming involved in nursing education as a tutor at Nelson Polytechnic and later, at Otago Polytechnic. She was Chairperson of the Nursing Council of New Zealand between 1990-1996. Elaine recognised Cultural Safety as having parallels with Critical Social Theory.

> I see Cultural Safety as being critical social theory and to me, it's quite clear that it fits within those parameters. It's really no different from teaching people or being aware of what the socio-political [and/or] economic issues are in society [and] realising what

> impact they have on people. Why people feel the way they do about certain things because of the lack of information, bits of history that are omitted. And doing something about it that comes from the person. So it's linked with Critical Social Theory and it's linked with critical pedagogues of critical teaching processes. (Elaine Papps, interviewee)

Elaine discussed Critical Social Theory in relation to perceptions held of nurses and nursing and why Cultural Safety education was so challenging in this respect.

> I think there is the resistance that comes about because of Critical Social Theory and also I think because people see that nurses and perhaps to a lesser extent, midwives, should not be involved in this particular process. And that's to do with nurses being, the images of stereotypes of nurses, they are doers, they're not thinkers, they don't make these changes to social structures or don't get involved in politics. They do as they're told basically and I think that Critical Social Theory is really threatening to people who think that things might emerge and people might get knowledge about social, political and economical structures and then that would be making them far too powerful.
> (Elaine Papps, interviewee)

The Appropriateness of Cultural Safety for Nursing and Midwifery

It is not a coincidence that nursing and midwifery has responded as solidly as it has to the ideas of Cultural Safety. Nurses comprise 70% of the health workforce in New Zealand and are by far the largest group of health professionals. Nursing and midwifery is inevitably involved in the Cultural Safety process because the roles of nurses and midwives in all areas of society often involve front line work with people suffering from the outcomes of poverty. The realities of barriers to service are norms for nurses and midwives, particularly those who work in communities outside secondary care and are able to equate the feelings of cultural risk which many people express, with missed opportunities in service delivery. I asked a number of the interviewees who were nurses and midwives what impact the concept of Cultural Safety had had on them and why.

> To me it was wonderful because it suddenly ... it was almost like saying, “bingo!” Because it’s a belief that I always had but this time now, I knew it was going to involve a lot of people. See, a lot of us were trying for a long time, trying to teach people but at the end of the day, they were only going to learn about another culture from their perspective. There was no way that people were going to change because it was just nice to know. It

was never going to be an impact that was going to make any difference. They were going to just treat everybody the same. You know, every time I hear people say, “oh but we’re all the same” and the ramification of that is that it doesn’t respect the individual person. It doesn’t respect you as a person, or your age, your sexual orientation, your gender, your culture, it doesn’t respect it. And I find it very difficult because as a Samoan nurse I used to find that that was a total impossibility. (Karl Puloto-Endemann, interviewee)

It was about ... it was about treating everybody's knowledge as valuable as anyone else's. It was just so simple, that no one knowledge is greater than any other.
(Kere Pomare, interviewee)

It’s about empowerment of people and people’s individual rights of freedom and their reality is as valid as the next person’s reality and human rights in fact. It’s fundamental, as that is what comes up for me really. (Ketana Saxon, interviewee)

I'm unable to move beyond my initial understanding of the concept which is respect for other people's values and beliefs and not be disrespectful or unsafe so, to me it's about respect. That's how I see the concept however I can see that an association with the concept of culture is seen as ethnicity because most people associate the notion of culture with race or ethnicity and not in its broader context. (Elaine Papps, interviewee)

It was like a light going on and thinking, "how could I have been a practitioner and a teacher without recognising this fundamental, a fundamental right of people to be treated with safety." We talked a lot about safety issues in nursing and Cultural Safety was a dimension that just hit like the, you know, proverbial flagship really.
(Janet Davidson, interviewee)

[Cultural Safety] had a large impact because it started to make sense of placing nursing and midwifery practice in this country. It started recognising that we weren't working in isolation and although we were reading a lot and a lot of that information was coming to us as nurses and midwives in practice at that time was from the States, there wasn't a lot that said, “where are we at in this country?” And so when we started reading the work of Cultural Safety, it meant more than just the words. It actually meant, this is nursing in this country, this is what we're here for, this is the work we're doing and this explains it, in our language; it makes sense. . . I think it's about the theory of nursing and midwifery in New Zealand. (Wendy Bunker, interviewee)

During the course of interviewing people for this project we realised that one of the commonalities coming out in people who had fought and supported the Cultural Safety experience was that many of them had something just a bit different in their lives that enabled them to recognise the concept. This was commented on by Atareta Poananga earlier in this chapter. Similarly, Gillian Grew and Janet Davidson shared some of their personal lives with us relating what had brought them to nursing and why Cultural Safety made sense to them. Gillian was born in the United Kingdom and spent her formative years in Hong Kong. She was the Chief Nurse in the Ministry of Health from 1993-1997.

> I'm not sure why, whether it was because of my bi-cultural background but I tend to think it is not only did I have the language but all my peers were from a different cultural group and ethnic group from myself and even from a different social group so that I was very early on exposed to very different ways that people lived and as a young formative child I had to try and make some sense of all of that and I couldn't obviously initially as a very young child, understand why we had a big apartment for example and some of my friends (the whole family) lived in one room. So it was probably quite good for me as a person to be exposed to all those differences which is why, when I started nursing, I felt really bad about what we were doing to people. I understood the reason that you collected sick people and you put them into a place where all the professionals could manage them, but it tended to feel incredibly alien to me because it didn't seem dignified, it didn't seem kind, you know, all those sorts of things and I felt very uncomfortable about that as a nurse. That here we were bringing people who were sick, unwell, frightened, taking them away from their comfort zone really, you know their family and support and stick them into a hospital and isolate them from everybody then you make rules about who can't come and visit except in these times and it all seemed incredibly cruel to do that, and I couldn't believe, even as a young woman, that that would make it easy for people to get well again. (Gillian Grew, interviewee)

Janet Davidson is a Registered Nurse who trained at Napier Hospital in 1959. In 1981 Janet became the first nurse to work in the Department of Education as Education Officer (Nursing), responsible for the transfer of nursing education from hospitals to polytechnics.

> I think as a woman, I knew what it was like to be discriminated against, as a lesbian woman I knew what it was like to be discriminated against so I think coming from a very

> much a minority culture which was those days was fairly positive however...It gave me an understanding of what it was like to be overlooked, not accepted, a part of a group that wasn't valued and issues that I had experienced were very similar to issues that I, I understand exist for Maori, "you're not good enough, you're a second class citizen, you're not educated enough", whatever it happens to be. And I think as a minority person I felt that pain, of other people. (Janet Davidson, interviewee)

The Response from Within Nursing and Midwifery Education Institutions

Cultural Safety became a requirement for nursing and midwifery education courses in 1992. At that time, on its introduction into nursing education institutions, the Nursing Council of New Zealand provided a national shape for Cultural Safety in terms of the policy and guidelines for polytechnics in curricula development and assessment (Nursing Council of New Zealand, 1992). The polytechnic nursing departments responded rapidly to the need for change and incorporation of Cultural Safety into their programmes and nursing teachers worked hard to fulfil that and generally achieved this in a variety of ways

Working in the area of new liberal material, some of which was still being researched (as all knowledge always is), creating ways to assess learning outcomes and translating that into a teaching style which challenges without distressing students, as well as relating this to health and disease outcomes, is a highly skilled task.

> We get three years to teach to show a young person with very fixed views a different way of thinking, and I mean if you have ever lived which I am sure you may have, with a teenager around 17, 18, I'm not blaming students because I of course don't know their life, but they do know what is right and it's unfortunate that you are trying to point out there might be another way. Now you have got a whole classroom of them sitting there and looking at you, and you respect that, but you've got three years or so, whatever you do and how you do it at the beginning it is just so critical because that's what they will take on board and react to. (Judy Kilpatrick, interviewee)

Ketana Saxon reiterated Judy's comments when recalling her time as a nursing student. In her first year of nursing training in 1993 she was the local representative for the student unit of the New Zealand Nurses Organisation (NZNO) and went on to become the studnent unit spokesperson.

> That's the nature of it, it's about your own growth and change and attitude development. So the very nature of it is challenging and people who are opening that can of worms need to have the skill to facilitate it. I think that was one of the things that came through most loudly in the feedback that I got from being in the Student Unit, that it's a wonderful concept and its value for nursing is enormous, but if people don't have the skill to put it across the way it's meant and actually guide people through their process of understanding that people can actually go backwards instead of forwards because people just react and then close down and then that's it, "I don't want to know anymore about it!" So I think that's a crucial point, I really do think the way it's put across is the key.
> (Ketana Saxon, interviewee)

Teachers require a sound knowledge of New Zealand history to be able to place the health and illness issues in this society in their neocolonial framework and establish the cause and effect relationship for students. This is inordinately skilled work and cannot be achieved overnight. Lou Te Hine Pouri Simmonds is of Ngati Raukawa and Ngati Huri descent. She is a Registered Comprehensive nurse and has most recently worked as a nursing tutor at Northland Polytechnic. Lou recalls the initial introduction of Cultural Safety into the institution where she now works as a lecturer compared with her experiences in the same institution five years before as a student.

> But the actual concept of Cultural Safety now - I think if it could have been introduced and understood I think in a way that I am looking at it now it would have been I mean just this wonderful thing that it would have sat really nicely beside all the other theorists that have talked about nursing and been really comfortable for students to look at. But the pain and the struggle that it has actually been through has still I think having an effect on people about whether they want to take it on board or not. But for us, the fact that we've actually gone from comprehensive to a degree course has helped the concept of Cultural Safety, because it's been able to fit in so beautifully in Social Science and alongside Critical Social Theory and Sociology which is where it was always really meant to be because for our people that's what was supposed to have happened, that it was supposed to have sat there but I think our people at the time were so passionate with it and what they thought it mean. (Lou Simmonds, interviewee)

The Kawa Whakaruruhau report (Ramsden, 1990a) had strongly recommended that teachers of Cultural Safety be able to meet regularly to peer review teaching practice, compare experience, build on successful teaching styles and outcomes and discard those

which were not useful. Government reforms and the restructuring of departments, notably the Department of Education, occurred at the same time the theory and application of Cultural Safety in nursing and midwifery education and practice was being developed. Along with many other initiatives, Cultural Safety was no longer able to be funded or nationally co-ordinated. Thus, opportunities to meet and develop a national process, and to set national standards from the beginning could not be developed.

This has had important implications for how Cultural Safety education has been and continues to be taught within some institutions. The most recent Guidelines for Cultural Safety Nursing and Midwifery education (Nursing Council of New Zealand, 1996), have sought to redress this to some extent although it remains the ultimate responsibility of individual nursing/midwifery education programmes. One of the main dangers is that Cultural Safety is re-defined and becomes confused with Transcultural Nursing. Both Elaine Papps and Mereana Roberts had seen this happening.

> I go back to the understanding of the two separate words. There's 'cultural' or 'culture' and 'safety', and there's a huge misunderstanding about that even amongst my colleagues, my peers that I work with. And I think again, that may alter as they move through the in-training courses that have been suggested in the guidelines that all lecturers within our department must move through … I think there is a lot of misunderstanding still, I don't say that amongst our students. I think our students are the least of our problems. I think our professions [nursing and midwifery] are still struggling to understand the concept and prefer to drift into Transcultural Nursing because they find some sort of, I don't know what it is, international thing, it's also American. That seems to be where they get a lot of information from so they feel a lot of comfort with [a] Transcultural perspective as opposed to what was born out of our place.
> (Mereana Roberts, interviewee)

> I think one of the threats is this notion of "Transcultural Nursing" that keeps creeping into the language and the lack of recognition that we're really talking about something quite different. The strength of Cultural Safety is that it's not about Transcultural Nursing at all. It's about something completely different and much more relevant to nursing.
> (Elaine Papps, interviewee)

Kere Pomare can vividly recall her reaction to Cultural Safety teaching, as a Maori woman and midwifery student, in 1992, the first year of the concept being a requirement for nursing and midwifery education courses. Kere is of Ngati Toa, Te Atiawa, Rongomai-wahine and Rongowhakaata descent. She trained as a nurse at Wellington Polytechnic in 1986-88. She later returned to the Polytechnic to undertake midwifery training.

> When I went to do midwifery, things had changed a lot. Cultural Safety was part of the programme, which it hadn't been when I was there before. You often felt on the spot you know and I didn't like it. It didn't like it at all. The Cultural Safety classes or whatever they were, I wouldn't go to them just because I felt so bad being in them and Lis didn't go either I don't think. But then you get criticised, how come she doesn't have to do it ... that type of thing. You just felt so uncomfortable ... you just felt so uncomfortable.
> (Kere Pomare, interviewee)

Because Maori had articulated Cultural Safety, the response within nursing education was often interpreted as teaching traditional Maori custom and ritual. Maori, who were unqualified to teach students or to teach nursing and midwifery, were often brought into courses where they could not fulfil student expectations in relation to practice. Later Maori nurses and midwives without teaching or formal qualifications or new graduates without practice credibility were also employed to teach students. Amongst other things, this approach within teaching perpetuated naïve and often romantic reconstructions of Maori leading to the creation of a stereotype of Maori people which invited students and graduates to nurse stereotypically. The evolution of the Maori stereotype is not necessarily the fault of teachers, although maintaining it can be.

> I remember the tutor talking about Maori people's body language and I remember sitting there thinking, you know, I started to get all twitchy myself because I was sitting right at the front of the room and thinking, "they're all looking at me, they're all looking at me" or it was about, “sometimes a Maori might say, “nah”, and it really means ...” It was just really, really bad stereotypes. I felt distinctly uncomfortable in it and then we were taught lots of stereotypes too about what Maori women wanted in childbirth.. This was all taught by Maori ... it was a Maori tutor that taught Cultural Safety. (Kere Pomare, interviewee)

Not only was there a danger in encouraging nursing and midwifery students to practice in a culturally unsafe manner, there was also the issue of cultural knowledge being

inappropriately taught and used in situations which would further disempower the recipients of care.

> The other thing was that we were getting all this knowledge like, "how Maori women want to birth, what they want to do with their placenta..." And then you get people taking this knowledge they're given and practicing it and we did a research assignment at Ngati Toa about antenatal needs for the women down there, and one of the things that came up was...one woman, quote..."a midwife offered me the placenta in a plastic bag, I just about jumped off the bed! I've never seen...no one ever asked me...I didn't know what to do with it." And so we had this...people reaching tertiary level education, pakeha, getting the knowledge when Maori people haven't and are still way behind because it's been taken off us years ago. And Maori people aren't making it into tertiary institutions so that's how unsafe it is...you see a placenta dangling at you in a plastic bag and you wonder what the hell it is! (Kere Pomare, interviewee)

It might be argued that people appointed in this manner to teach Cultural Safety were set up to fail because the institution did not define its academic requirements and continued to employ people by ethnicity rather than skills. This would be in contravention of the requirements for teachers in other areas of nursing and midwifery education. It was recognised that teachers of Cultural Safety needed to have nursing qualifications and significant relevant, postgraduate practice experience as well as an undergraduate degree with a strong social science content. This was later to became a requirement outlined in the Nursing Council Guidelines (1996). Mereana Roberts sees this as critical.

> A lot of the Cultural Safety issues that we work with as nurses and midwives, I think are more safely dealt with by people who have worked in the profession or who know the philosophical base of the professions, both nursing and midwifery. . . The information or teaching to our nursing and midwifery students can only come from people like ourselves who have worked in our profession. Because its about making tangible links with students between what they're learning and hearing from us as kaiako and putting it into a tangible space for them to say "I can work with this in practice." And that comes from our ability to share our stories, not only as Maori nurses and midwives but as Maori nurses and midwives who have worked in practice with our people and with lots of other people, so we can share our experiences. (Mereana Roberts, interviewee)

The Nursing Council of New Zealand, the Media Response and the Select Committee Hearings 1990–1997

The Nursing Council of New Zealand 1990-1995

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. In 1990, in a move that was progressive for its time, the Council required all Schools of Nursing to address their commitment to the Treaty of Waitangi relationship and to explain its expression in their school. In this way, focus on the treaty was required to be translated into action enabling local responses within Schools of Nursing.

Allison Chappell was the Chairperson of the Nursing Council at that time and recalls the beginnings of the background discussion to that move. Allison became a member of the Nursing Council of New Zealand in 1984 and was the Chairperson from 1987-1990. During this time she was appointed Principal Nurse at Hutt Hospital in Wellington and later became the Surgical Services Manager.

> In 1989 the Council had its first planning day to look at what its real goals were and at that time we established one of the goals. We wanted a goal to do with the treaty. I remember there was a lot of discussion about what it ought to be and we used the words "principles" and somebody then came back that it wasn't right to talk about the principles of the treaty. So that's where we debated, that's the start I think, how could the Council really reflect the Treaty of Waitangi in its activities. (Allison Chappell, interviewee)

The Treaty of Waitangi is the key to the application of Cultural Safety in the New Zealand context. Karen Guilliland was a member of the Nursing Council of New Zealand in 1991 at the time of Cultural Safety first being introduced and discussed within the Council. Karen registered as a General and Obstretrics nurse in the late 1960s and then went on to work as a midwife until the end of the 1970s. She was the Director of the New Zealand College of Midwives at the time of her interview for this project.

> From my perspective as a Council member appointed to protect the public safety, we were coming from the education of the public, the immersion of Cultural Safety into the health system and in that sense I think Cultural Safety was completely huge. It was huge

> in comparison to what else was happening in nursing ... I do think it's about being the right people in the right place at the right time and ... I think that Irihapeti, as an articulate visionary, enabled those Nursing Council people to feel that they were doing the public justice and that was quite separate to being about nursing education and midwifery education. ...It was interesting being on Council at the time because it felt like something historical was happening.
>
> Cultural Safety was profound that it got introduced into nursing. My experience on Nursing Council was that it felt like a dangerous thing to be doing. It felt like this was a very radical thing to do and that you were going to be criticised, you had to have a rationale for it. I didn't feel like that about physics, anatomy, nursing knowledge ... that was the difference. At Nursing Council, when we were sitting around the Nursing Council table there had to be some lobbying done behind the scenes and that there was a sense that something profound was going to happen. I mean that's what it felt like for me. I mean there was this determination for rightness ... And it was not to do with nursing or midwifery you see. I reckon it was to do with Maori/pakeha.
> (Karen Guilliland, interviewee)

Elaine Papps also recalls the discussion regarding Cultural Safety which took place prior to the resolution being passed making it part of nursing and midwifery education within the Council.

> Well, at the outset it had a lot of impact at Council meetings in terms of lengthy discussions that went on when it was first introduced and that was probably about 1991 and there was a resolution passed that it was to become part of nursing education and part of the state final examination and there was a lot of discussion and debate and disagreement and concern. And the resolution was passed and I guess at the time I really didn't know that the whole notion of Cultural Safety would eventually have, what I can only describe as, a profound personal and professional effect on me because of my role as the Chairperson of the Nursing Council. . . So, for me, initially the introduction of the concept was something that I thought was appropriate at the time in nursing education. Had I known that it would be, was to have such an impact in the future, I may well have thought differently about it. (Elaine Papps, interviewee)

Cultural Safety was seen as one of the outcomes required of each applicant for registration as a nurse or midwife. Patricia French is a Registered Comprehensive nurse. A major component to her involvement with Cultural Safety was in developing the

relevant questions for inclusion in the State examinations. Consistent with the national trend at the time, any information relating to Maori which had been included in previous State exams, had been presented in its most narrow of anthropological forms and definitions. This had a subsequent impact on the introduction of the Cultural Safety questions into the examinations.

> I remember the '88 State exams and having to be very careful about how you worded the questions and at that stage we were still inclined to say "Linda, who's 57, a Maori, blah, blah, blah" and we had to say "who identified as a Maori" so that we could get back the stature between the person who was living or identifying with that culture as opposed to somebody being labelled. So that was a big step forward, putting that into the exam in a meaningful way, and then of course it was all about Maori at that stage, not about any other cultures. I remember the answers and the markers coming in and setting the criteria and so on and that where people failed to meet the criteria was when they didn't know tikanga Maori and they didn't say things like "this woman would be whakama" and stuff like this. I just think what an enormous leap we've made since those days and it's no wonder there's been so much difficulty within education in the early 90's with those sorts of concepts (for) teaching in the Cultural Safety situation when that was the objective for State exams. But, we didn't know any better, we were developing, we've moved along ... haven't we moved along! (Patricia French, interviewee)

Rather than the questions being based in nursing and midwifery interactions which related to power and powerlessness, the early questions in the State Final Examinations were more concerned with rituals such as removing shoes at front doors, which did not relate to nursing or midwifery outcomes. The questions were gradually changed to become more integrated with service delivery in nursing and midwifery.

The Media Debates 1993-1994

At the point when Cultural Safety was still seeking to establish itself within nursing and midwifery education curricula, there was a minor media explosion regarding a nursing student attending Christchurch Polytechnic in 1993 who failed the "Culture and Society" component of her programme. This incident was to become known as the "Anna Penn" case. Figure 7 (Parts A, B and C) presents headlines and Figure 8 (Parts A and B) presents samples of 'Letters to the Editor'. Together they illustrate some of the

media and public perception and reaction to Cultural Safety during the time of the case coming to national attention.

Cultural Safety became the focus of a second media frenzy in 1994. This incident involved a nursing lecturer at Waikato Polytechnic, whose teaching contract was not renewed due a range of issues including his outspoken opposition to having been described as "culturally unsafe" by colleagues. Nursing Council of New Zealand staff and others in their roles as Heads of Departments of Nursing around the country expressed their dissatisfaction at the manner and quality of the media reporting regarding Cultural Safety.

Figure 7 Part A
The Media Debates

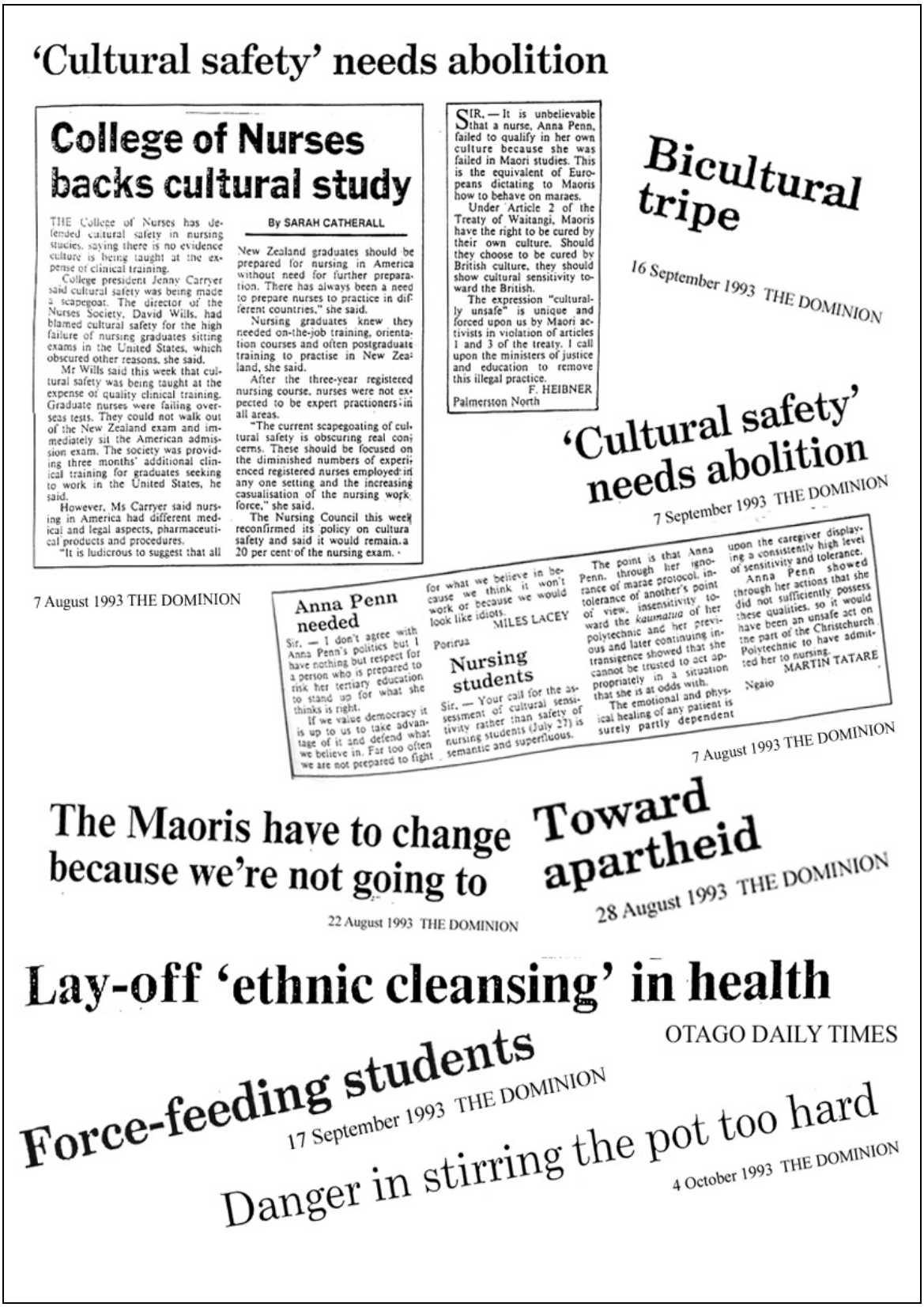


Figure 7 Part B
The Media Debates

Figure 7 Part C
The Media Debates

Sir,—What a depressing message would-be nurses are getting from the Anna Penn affair: subscribe to current politically correct orthodoxy or forget about a career in nursing. Despite her documented ability and suitability (references from hospitals here and abroad, using terms such as "quiet confidence", "completely reliable", "helping to motivate and support the client" (July 21), she is presented to us by the polytechnic as someone displaying "such flaws in judgment and behaviour" as to be unwelcome as a nursing student. Just who is telling the truth? How many overseas-trained nurses are currently employed in this country? Before such employment, have they been required to obtain the vital culture and society qualification? If not, surely their continued employment is quite unsafe. If they, and New Zealand-trained nurses from the pre-culture and society period, are to continue in service without the qualification, surely it disproves the necessity for the qualification in the first place? Were I sick, I may not enjoy being cared for by the formidable Ms Penn, but I would feel that I am in safe, competent hands.—Yours, etc.,

R. L. CLOUGH.
July 21, 1993.

Sir,—The issue at Christchurch Polytechnic is not about free speech. Free speech is central to the learning style of the nursing course. It is actually encouraged at the hui, as long as someone else is not already speaking, and it does not include insulting behaviour, such as heckling, booing, white-power salutes. What the issue is really about is that nurses are more than technicians and to promote health they must show respect and caring. Anyone who has suffered the opposite experience with health professionals knows the stress (ill health) this causes. Good intentions are essential, but not enough. Nurses need to understand their own and other cultural beliefs in order to know how to convey respect and caring in differing cultural contexts. Pakeha culture has its own rules about how and when to speak. It is not approved of to call out in a court room or during a church service. The nursing students also visited the Jewish synagogue. Any student who interrupted a service, especially with anti-semitic slogans or gestures, would also be regarded as failing to demonstrate respect for others.—Yours, etc.

MARGOT HAMBLETT
(Former tutor, treaty

Sir,—I have been following the recent controversy involving Anna Penn and the Christchurch Polytechnic with great interest. I recently left university and was planning on doing some courses at the polytechnic to further augment my education. I note with much alarm, however, what happens to polytechnic students who dare to question what is taught and who disagree with the polytechnic's views on racial issues. For the past five years, at both Canterbury and Lincoln Universities, I was led to believe that to challenge and question what is taught is healthy. It fosters good debate and helps fee-paying students satisfy themselves that what is taught is factual and relevant. Most, after all, want an education, not indoctrination! Unfortunately, it appears that the Christchurch Polytechnic is not a sufficiently mature institution to withstand critical comment. Needless to say, I have opted to continue my education in a university environment.—Yours, etc.,

JAMES M. CLARK.
July 22, 1993.

Sir,—I have watched the debate about "cultural safety" and nurse training, but feel that what is missing is not what the Nursing Council and polytechnics want to teach, but what employers expect. I have been involved in the employment of health professionals for nearly two decades, yet I have grave anxieties about the real level of skills that the course teaches. As an employer, I would not put a new polytechnic graduate in a position of having to make all but the most basic decisions regarding patient care. I find that levels of knowledge and competence to practise are seriously limited and that one would expect to "carry" a graduate for at least a year before one could consider him or her competent to practise. That so few new graduates find employment at all is possibly due to the fact that most employers share my doubts. Perhaps the Nursing Council and the polytechnics should concentrate less on teaching the esoteric and more on teaching clinical practice so that on graduation nurses can function safely in clinical areas.—Yours, etc.,

(Dr) G. A. WALMISLEY,
National director,
Richmond Fellowship
New Zealand.
July 24, 1993.

Polytechnic course

Sir,—In reply to Bev Clark (July 17), Ms Penn was naturally stung by revelation in the "Holmes" interview of what should have been treated as private and confidential. In the context, Maori interest in genealogy is irrelevant. As to marae distortion of the printing press incident, very charitably treated in Ms Head's article (July 30), Ms Penn obviously knew the true tit-for-tat story and was outraged by the fabrication that was put across. Her carefully framed raising of the "tat", or stealing by Maoris of pakeha printing presses, was deemed offensive; the retaliatory stealing by pakehas, was the grievance. What biased selectivity! If figurative language was the (albeit inappropriate) intent, later vouching for its literal truth was inexcusable. Ms Penn simply pursues her values of truth and justice. Is there no accountability on the marae?—Yours, etc.,

JOY JOHNSTON.
July 22, 1993.

Sir,—Nursing is a vocation; the needs of the patient are paramount. Skin colouring or race never caused former nurses to make distinctions. When nurses were tutored in hospital, the treatment of Maoris never arose. Anna Penn must have encountered a greater diversity of races in England, where she received an excellent reference. To raise ill-feeling among the young people by recounting old grievances is wrong. To disagree with a lecturer on doubtful historical statements, when the principal subject is nursing, is to risk failure. This is iniquitous. Uneducated, but racially acceptable students could do great medical damage. An educated, questioning nurse could detect when something was seriously wrong, for she is no robot.—Yours, etc.,

V. H. ANDERSON.
July 21, 1993.

Sir,—Does it not seem just a little bit farcical when throughout the three-year comprehensive nursing course the nursing students are told that to exhibit any form of judgmental behaviour would result in disciplinary action and the possibility of being deemed not a "fit and proper person", yet at the end of the day the potential nurses' future comes down to just one person's judgment?—Yours, etc.,

D. ROWLAND.
July 22, 1993.

28 July 1993 CHRISTCHURCH PRESS

Figure 8 Part A
Letters to Editor, Christchurch Press

17 July 1993 (ctd)

Letters to the editor

Polytechnic course

Sir,—We are concerned that what is essentially a personal grievance between a former student and the department of nursing has resulted in a widespread perception that the diploma of nursing course produces "mediocre" nurses more concerned with being "politically correct" than with achieving a high level of practical competence. As students we believe that the course provides good theoretical knowledge and practical skills and also an appreciation of the importance of the holistic approach to nursing. We are confident that the course prepares us well for the State examination. We value the expertise, integrity and commitment of most of the tutors and also the frequent opportunities we have to evaluate course content, clinical placements and tutor effectiveness. Some of us have had difficulty in accepting opinions and values expressed by various tutors, but we recognise that tolerance is an essential attribute in nursing. The course requires a high level of commitment and we aim to achieve a high level of nursing care, not merely "compliance" with the philosophies of the department.—Yours, etc.,

KIM BASHER,
WENDY GRACE,
SALLY STOCKWIN,
CATHERINE KONINGS,
LYNN BARCLAY,
TRACEY HEWITT,
KATRINA RADFORD,
DENAE GLASSEY,
LYNETTE McLENAGHAN,
NOELINE ARANGA,
LISA PORTER,
JILLIAN JONES,
NEIL BEAUCHAMP.

July 16, 1993.

Sir,—I am neither pro-white nor anti-Maori. I am multicultural in my views, but I object to the treatment meted out to Ms Penn. It is not easy to reconcile the sincere beliefs of a race struggling for survival today with the changing ideas of a new age of young people unafraid of voicing their doubts. Doubting, if accompanied by thoughtfulness, is a healthy step forward. Maori culture today is not suffering at the hands of people who ask sincere questions about it; instead, it suffers because so many sit and never ask questions, never thinking deeply about the precepts but meekly accepting, and soon forgetting, what they are told. There is no teaching more likely to promote falsehood than the idea that something is so sacrosanct that it must not be questioned. We do this not because we know, but because we are trained to accept. We develop a sense of loyalty to a teacher without the discretion to judge as to the truth of the teaching. We hesitate to think for ourselves. I admire Ms Penn for questioning and thinking for herself.—Yours, etc.,

D. D. NATION.
July 15, 1993.

Sir,—I am personally saddened by the misinformed front-page article in "The Press" on July 10. In four short lines it has publicly tried to negate every examination that I have sat in the past three years because, simply, I am Maori. Have all the hours I have spent shut away from my husband and children studying been a farce? I have apparently passed my examinations by foul rather than fair means. I am a member of the Nursing Students' Whanau. I have never been given or offered questions to examinations; neither has any of my colleagues. This article only continues to perpetuate the myth that I, as a Maori, constantly need to be "carried" by others to achieve. Not true. I, too, have achieved marks of 92 per cent, and these in the sciences field of nursing. To end on a positive note: "Tini whetu e iti pokeno" (a multitude of stars, a small dark cloud).—Yours, etc.,

A. FINLAY,
Third-year comprehensive nursing student.
July 14, 1993.

Sir,—To the black and white of it all: the hui, the gathering together; whether a forum for discussion and lively debate, perhaps even heated exchange, or a joyous assembly in common celebrations (yes, this too is occasion for hui); the heart and the mind had a voice here. Certainly there is kawa (a certain etiquette to be observed), as there is to a greater or lesser degree in all of our social interactions, of whatever culture; yet kawa applies to everyone gathered. It is not, nor should it ever be, selective. In the context of the marae, of the hui, kawa extends to the formalities of welcome, of ritual greetings, of whaikorero (oratory). Kawa does not say: "This is what I think and you will remain silent." Kawa says: "If your words offend me, I will reply. If your words attack me, I must reply." It also says: "If you speak as I feel, I will give you support." Kawa does not say "Accept what I tell you. I am right and you are wrong." That is for your own heart to decide.—Yours, etc.,

BENJAMIN BROWN
(Tainui).
July 15, 1993.

Sir,—In August 1992 my partner died suddenly of a medical condition. Unfortunately, he died in hospital — not an easy place to grieve or for our friends and whanau to come and be with him. Thankfully, though, the nursing staff at Christchurch Hospital were brilliant. They were caring and sensitive — sensitive to the culture, practices and protocol of the Maori, for which I and many others are extremely grateful. I believe Maori input into nursing training at the polytechnic is essential, particularly given the shocking imbalance in Maori health statistics. I hope nursing students will come to see the yearly hui and other Maori components of the course as a unique and vital part of their training, not as something to be feared or criticised long before the event. In my experience, the cultural sensitivity of the nursing staff enabled them to deliver a high level of quality care and professionalism which would otherwise have been unobtainable.—Yours, etc.,

MARY O'DONOGHUE.
July 14, 1993.

Sir,—I am disappointed and dismayed by the treatment of a nursing student, Anna Penn. I feel she has been treated unfairly. Ms Penn came across to me as an eloquent, sensible and empathetic person who would keep her head in a crisis — definitely attributes needed by a nurse; and I know, because I am a nurse.—Yours, etc.,

(Miss) ADRIENNE
BENN-HOYLE.
July 14, 1993.

Sir,—I was concerned to read the articles and letters today about the polytechnic nursing course. It occurred to me that there is another group disadvantaged by the present system, namely the able Maori and Polynesian students whose qualifications will now be regarded with suspicion. How must they feel now that this situation has come to light? Far from benefiting these students, their elders involved are denying their capabilities and displaying a lack of confidence in their ability to complete the course without extra help. These methods are robbing such students of self-respect and the satisfaction of a job well done.—Yours, etc.,

J. M. MURROW.
July 14, 1993.

Sir,—On "Holmes", Anna Penn showed why she is not yet ready to pass the cultural component of her nursing studies. However, as an inquiring and intelligent student, she should be able to develop the required skills, but it may take some time. Perhaps the polytechnic's peer tutoring system may help her to this end. Her statement that the kaumatua should not have referred to her father was incorrect, both culturally and educationally. Genealogy, or whakapapa, is important in Maori culture. To say to a Maori that a genealogical reference is irrelevant indicates either ignorance or arrogance. It is imposing one's cultural value on another or restricting the free exchange of information. Educationally, it is unsound also. Effective education incorporates the student's background. It was to Anna's credit that she gave the kaumatua her relevant background. She shows good insight into the reasons for her difficulty with this part of her studies. Perhaps she cannot yet see that she needs to progress further to be where she would like to be.—Yours, etc.,

BEV CLARK.
July 15, 1993.

Sir,—Your excellent editorial and the article by Dr David Novitz brought to the light an insidious trend. I have had similar treatment from a Government department, and also from another polytechnic, where the social workers' course put most energy into instilling political correctness and victim consciousness. My fumbling attempts to resist these were certainly met with the "bullying, moral blackmail, and stifling of argument" that you describe. I chose to abandon the course. Anna Penn has shown greater perception and more courage. I am delighted to see the issue aired and debated and to see from your readers' letter that the malaise is not widely accepted, as I had feared it might be. You state that "In truth, they are 'oppressed' simply because they say so and have come to believe it". How true! How unacceptable! In talking with the unemployed, with feminists, and other "victims", I have found this to be the single most threatening statement that can be made. We can help those who feel disempowered by supporting their strengths, not their helplessness.—Yours, etc.,

HUGH KLEIN.
July 15, 1993.

Sir,—One of the most surprising aspects of the polytechnic nursing fiasco is that it has gone on until now, unchecked by public disclosure. This might be explained by the pressure to which students daring to dissent have been subjected. Ms Penn and "The Press" are entitled to our gratitude for bringing it into the open. Hopefully, what has been disclosed will bring an end to this perversion of education. Ms Penn is right. An internal inquiry is unlikely to be satisfactory, having regard to existing attitudes apparent in the polytechnic. Instead, there should be a public inquiry to assess the fitness of the polytechnic to have responsibility for training our nurses. Incidentally, Ms Penn seems to be exactly the sort of person we need in the nursing profession.—Yours, etc.,

J. MARSHALL.
June 15, 1993.

Sir,—The day of Anna Penn has been a long time coming, but was as inevitable as the eclipse of the sun, when two cultures contest the veracity of their upbringings. Dr Novitz (July 14) must allow for curricula pre-emption. Nor is this a course for staff nurses; its purpose is to educate and determine suitability for practice. It appears Ms Penn did not meet curricula requirements and whether she has the tolerances needed for public practice is a matter for the examiners. This is a niche problem rather than one of racial incompatibility. Her partial pass would count and her talents would be of value to the health industry, which has alternative training schemes. If Ms Penn cannot agree with the polytechnic's rigid failure premise, she has recourse to the Race Relations Office.—Yours, etc.,

TE OKORO JOSEPH RUNGA.
July 15, 1993.

Sir,—When I require hospital care, one of my concerns is for the medical treatment I am given. My other concern is for the care I receive from the hospital staff. I have an expectation that my doctors and nurses are qualified professionals, but their subject marks are of no significance to me, and neither is the fact that they may have required extra coaching to achieve their qualification. What is important to me, as I lie ill, vulnerable and worried, is the manner in which my doctors and nurses relate to me; their empathy, their respect for me, the uniqueness that is me, and the particular needs that are mine. These skills are personal qualities which I see as essential in people selected to train in the caring professions — qualities to be enriched and developed through the learning opportunities afforded by cultural input into training.—Yours, etc.,

A. HEREWINI.
July 15, 1993.

Sir,—So, Mr Hercus is having an internal investigation concerning the recent allegations about the nursing department. Does he really think polytechnic students are so stupid that they will have any confidence in the outcomes of his internal inquiry? Come on, an independent inquiry is needed.—Yours, etc.,

J. K. WILLIAMSON.
July 15, 1993.

CHRISTCHURCH PRESS

Figure 8 Part B
Letters to the Editor, Christchurch Press

Colleen Singleton trained as a Registered General and Obstetric Nurse in 1965. In 1995 she became the Chief Executive of the Nursing Council of New Zealand and held that position up until 1998.

> The media debate had to be a milestone (for Cultural Safety) and why? Because of ignorance really, ignorance on the part of the media, ignorance of the population generally and the difficulty for the Council in trying in any way, or other nurses who wanted to be part of that, to explain what Cultural Safety was. We were not able to get that message across. (Colleen Singleton, interviewee)

Alison Dixon is a nurse and Head of Department for Nursing and Midwifery at the Otago Polytechnic. She has had a pivotal role in developing a relationship between the Department and the Ngai Tahu Trust Board.

> Well I find it interesting that they are only interested to know if they can sell newspapers and like when Paul Holmes asked us about what was in our exam questions and we faxed them off and he didn't use them because he couldn't make a case because they married up with the curriculum and the outcomes of those papers. They weren't what the media was saying it was all about, but he didn't report that. (Alison Dixon, interviewee)

Fuimaono Karl Puloto-Endemann trained as a mental health nurse at Carrington Hospital and later did his general and obstetric training at Auckland Hospital and National Women's Hospital. Karl was a lecturer and Associate Head of Nursing Studies Department at Manawatu Polytechnic for fourteen years.

> Because the media is intrinsically part of the dominant culture and we have to be very, very clear about that. That is part of their control, is the media. And yeah, I think one of the most powerful things here is education of the media, the use and the values of the media reflects that of the dominant culture, quite clearly to me … it doesn't reflect that of us. (Karl Puloto-Endemann, interviewee)

Robert Consedine reiterated the thoughts of the other interviewees regarding the media reaction to Cultural Safety.

> I think the media focuses on conflict and loves conflict and will always be there when there's conflict but because of that I think that it presents every dialogue about everything as a conflict where there are essentially winners and losers and I think that's where they

> leave people all the time. There's an "Assignment" programme on tomorrow night on land and I can guarantee that the focus will be on the conflict. There is no focus in media on the benefits to everyone, on the commonality from this because that doesn't sell. The second thing is that the media is incredibly racist. It has always been racist. It doesn't understand it's racist because racism is about the use of power and power is the fundamental ingredient for the promotion of racism. And a lot of it's unconscious in the sense that if you challenge them, they have no idea what they're doing.
> (Robert Consedine, interviewee)

One of the most criticised features of Cultural Safety was its actual name, which Elaine Papps identifies as having been associated with the more narrow definition of 'culture' in the public's view, rather than the meaning as it should be applied. The term *Cultural Safety* is consistent with normal nursing language. It has been firmly retained because the word, safety, is subjective. It gives the power to the user of the service to say whether or not they feel safe. Although she supports the retention of the term, Papps speculates on the possibility of a different term for the process of teaching the components of Cultural Safety.

> I think it would have been easier because I think that more people would have been able to relate to it in terms of broadness of the concept of Critical Social Theory, what it is and not ... Because, people associated Cultural Safety, it had racist overtones, it might have been less problematic had it been introduced as Critical Social Theory because people would not have seen it as, as being associated with ethnicity, which in New Zealand means Maori. However because the political agenda was named I think that's what makes it very special, because it is about Maori health, and so naming the political agenda despite all the blood and guts that's been spilled along the way, it's [been] worth it.
> (Elaine Papps, interviewee)

Media coverage at the time highlighted a raw nerve in New Zealand society. There were still deeply held prejudices against Maori throughout New Zealand society and the media handling of Cultural Safety in this context irresponsibly exploited Maori involvement in the evolution of Cultural Safety.

> The media will always be a powerful weapon against us but we need to try and work with that rather then get sucked into the tar, like I believe the public are when they're exposed to things. The media managed to tell people that we are pumping out nurses that were

> going to be wearing puipui's and tattoos and stuff. So we've had to be really strong too and help turn that around. (Lou Simmonds, interviewee)

When nurses tried to bring in other issues, the print and radio media kept taking it back to a Maori issue. It seemed to me, that part of this was underpinned by a deep fear in the New Zealand psyche of a Maori takeover of a trusted group such as nurses and there seem to be some issue round that for people, because they were not interested in the rest of Cultural Safety.

Judy Kilpatrick trained as a nurse at Christchurch Hospital. She has been the Chairperson of the Nursing Council of New Zealand since 1996 and that position at the time of her interview. Judy reiterates the point that an in-depth and balanced perspective on Cultural Safety was never a feature of the media reports.

> I mean in the paper today its still popping up that the only focus is Maori. Now in some ways I understand it because I got to know that I am culturally safe by having going through experiences and relating it to Maori and I suppose that is threatening. Because by the mere fact that all that media attention went onto Maori the media took it to be able to have a chance to Maori bash, or if they want to be nice about it to push a Maori course so that whole focus did become Maori, and Cultural Safety is much greater than that.
> (Judy Kilpatrick, interviewee)

> This whole thing of Cultural Safety is fascinating; there have only been three complaints. We had one which was around the assessment of the student as an internal issue and one might argue that wasn't the assessment process (that) was inappropriate. We had one around the staff management and you will never know the full story but it was a staff and management issue, and we had one that was very convenient for a political party. Now given you have got 1500 students or even more because that is what you get out a year so you have about over 3000 students and you have had three complaints, what an amazing amount of attention. I mean I should be so lucky that over something that is really important I should get that much attention . . . so your perspective's gone to hell.
> (Judy Kilpatrick, interviewee)

The Select Committee Hearings 1995-1996

The public response to Cultural Safety fuelled by the media reporting between 1993-1994 heralded a political response in 1995 with the involvement of nursing and the

Nursing Council of New Zealand in a potential Parliamentary Select Committee investigation into the teaching of Cultural Safety in nursing and midwifery education. Isabelle Sherrard was a member of the Nursing Council of New Zealand from 1990 to 1996. She trained as a nurse at Christchurch Hospital and worked in the medical-surgical areas and in Intensive Care before beginning a career in nursing education at UNITEC.

> My opinion about the review is that it was driven by the politicians and it was misplaced and there was a large hidden agenda or perhaps more than one. It was difficult to find out exactly what happened to trigger the extent of the uproar in my view. Even being on the Nursing Council, I was somewhat amazed and bewildered about what had led to what we were seeing and there was a lot of confusion. (Isabelle Sherrard, interviewee)

This opinion was not shared by everyone at the time. Gillian Grew, as the Chief Nursing Advisor to the Government, expressed the opinion that the Council had not acted quickly enough.

> I had actually warned the Council. This did not pop out of the woodwork suddenly, it was something that was grumbling along. We had ample warning, as you remember Kathryn O'Regan contacted me and said she was very concerned about Cultural Safety and she had got these letters from people about it. I went over and spoke to her and suggested that it would be useful for her to talk with you. So you went over and we talked about the concept of Cultural Safety and she was quite comfortable with the whole notion wasn't she? And I remember going to the Council and telling them all that this is something that is critical to the Council and you have the responsibility for making sure that Cultural Safety goes into the nursing curriculum and is taught in such a way that it is OK, it was actually the teaching of it that was an issue and we needed to do something about it. (Gillian Grew, interviewee)

While the inquiry did not eventuate, nurses appeared before the Select Committee on Education and Science on three occasions. Gillian's role within government was crucial in explaining the realities of nursing education, practice and Cultural Safety to politicians.

> I was very actively involved in it in the early days as you know, and I actively promoted the concept all the time and when Cultural Safety became a parliamentary issue I talked quite frankly to Ministers about it, my understanding of Cultural Safety and what it meant

> and all the Ministers that I spoke to had no difficulty with what I was saying. (Gillian Grew, interviewee)

The following statement was made by myself to Gillian during her interview and has been included here.

> The extraordinary thing was that those involved in the work were never consulted and that was the Ministry of Health, Te Kete Hauora, who had absolutely no idea of the concept, and got it confused with Maori Studies. They didn't understand nursing, or midwifery and then somehow advised Ministers against it and clouded the whole issue when they should have been advised by you and should have checked it out with the people who designed the concept. It isn't about Maori, it starts with our people and the core of it is the New Zealand experience with the Treaty and so on, but from there we do broaden it. As long as we keep the core Treaty work, it doesn't need a Maori mandate.

Gillian agreed and followed with this assessment of the situation.

> So putting it in simple terms, nobody I spoke to had any difficulty about it, except interestingly enough Maori people within the public service. And I found that quite extraordinary, but I was supporting it to Ministers and I had sitting alongside of me Maori who were saying there is no mandate for this; this is not a concept that is useful to Maori. It did place me in a very awkward position, you see I don't see Cultural Safety as Maori, I see it as much broader than that. So while we did use the bicultural heritage that we have got in this country as a starting point to try and explain the notion, it became all muddied and people starting saying Cultural Safety is about being the Treaty of Waitangi, Maori you know, and there are elements of all that in it, but it actually clouded the issue in my view. (Gillian Grew, interviewee)

Kathryn Wilson felt there were wider political agendas which drew Cultural Safety into the position of a convenient scapegoat. Kathryn did her nursing training at Greenlane Hospital and Rotorua Hospital. She was a tutor at Waiariki Polytechnic in the 1980s and later became Head of Nursing in 1987. She later took up the position of Nursing Advisor at Rotorua Hospital and completed her Masters degree in 1993. She was the Education Officer for the Nursing Council of New Zealand at the time of her interview for this project.

> There was the political move to get nursing education on a framework which was really strongly resisted because nursing is a profession, and the medical people, the physiotherapists, no other professional group even entertained the idea of going onto NZQA framework but nursing was really being targeted, so I think that maybe Cultural Safety became a scapegoat and people's emotions and biases were fed and played on and used really. I didn't think the problems were any worse maybe than what is happening now with mental health nursing in the curriculum . . . but it didn't achieve the same kind of hysteria amongst the population as Cultural Safety did. (Kathryn Wilson, interviewee)

Margaret Austin agrees that politics played a large part in the Cultural Safety debate from the point of view of people attempting to make the most political gain possible from the situation. She was a member of and subsequently chaired the Education and Science Select Committee and was also Shadow Minister for Education in the National Government at the time of the Select Committee hearings in 1995 and 1996.

> Politics did enter into it because as you will recall at that time it was the beginning of Doug Graham's initiatives to get the resolution of the claims, the Treaty claims on track, and I think I would like to place on record my total admiration for what he has been able to achieve even though I was not around the cabinet table and only on the periphery of listening to some of the national MP's. He must have had a diabolical time getting those issues, not only on the table, but in a state where they could become public and proceed. Because if there was one thing that emerged right at the beginning with the Cultural Safety issue started to appear every week on the Select Committee agenda, it was that really, this was an excuse to draw into the open an issue which some people in politics thought they could score political points from. (Margaret Austin, interviewee)

The original Chair of the Select Committee adopted a patronising attitude toward the nurses. Other members were overtly aggressive in their questioning and appeared to be relating their questions more to the media people than to considering the answers from nurses.

> I regard the whole process now as having been less than professional, because if there are things which people on a Select Committee have to do, it is first and foremost to keep and open mind and not to be making judgements in the absence of evidence. And if you regard the Select Committee process as presentation of a submission which involves you in listening, and also in reading, it then requires you to ask questions to elicit understandings and meanings and after that to go into consideration so that all that has

> been said by a wide range of people emerges with some sort of consensus of viewpoint, or, some ideas are accepted and others are rejected because there hasn't been sufficient evidence to support them and once you have considered through that process with an open mind you will actually arrive at good decisions and good recommendations. But the agendas were such that people were not going into a Select Committee hearing with other than a fixed view of what they wanted to hear and the line of questioning was not to elicit understandings but rather, to force the person or persons who were making the submissions into or conceding that the questioner's point of view was in fact more correct than theirs. . . And that was very, very clear as you well know in the way in which questions were put around the Select Committee table, they bristled with both politics and prejudice. (Margaret Austin, interviewee)

It was clear that some members of the Committee were intent on taking advantage of public racism and showed clearly that they had little knowledge of nursing education. One of the things that appeared to strike the media and some of the members of the Committee was the fact that we were teaching the colonial history of the country.

> Well, I think if I said it once, I said it probably two or three times at each Select Committee hearing. That the whole development was in its infancy and you had to allow it to evolve and of course there would be mistakes made alone the way, but again, it follows directly on from what we just said about thinking critically and you can't do that without a background of knowledge and understanding. And we are never going to challenge any section of our society to think critically about the way in which this country was settled over seven or eight centuries, not just the last two, unless we begin to teach rather methodically our own history, and our own history is very much based on the "we" group and the "we" group has effectively excluded anybody who wasn't Anglo-Saxon. You see, it's thinking critically, thinking independently, but you can't do that unless you have got a background of knowledge and you can't have a background of knowledge unless you've read. (Margaret Austin)

Margaret brought her experience as a teacher and a scientist to the Select Comittee hearings and focussed on the real issues, the primary one being that of the teaching of Cultural Safety. She recognised the pedagogy and its application and saw the meaning and intent of the term, *Cultural Safety*, and defended it from her later position as Chair of the Committee.

> Things were not going well and I was asked to Chair the meeting almost at the end of hearing submissions and we were able that day to manoeuvre the consideration to the point where, as the report which I just revised or re-looked at, was able to suspend the Inquiry on the grounds that the Nursing Council would come back to us inside a year with a re-vamped curriculum, an indication of the way in which it was going to be assessed and evaluated and a guarantee that there would be some evidence of implementation across all of the institutions. And so we then waited for that to come through. I think that was probably a very good outcome, to put the initiative back with the Nursing Council. It meant that we did not have to consider or come to grips with the term Cultural Safety which was a real sticking point around the Select Committee table ... I suppose if I had any criticism of what we were hearing at the Select Committee, it would be that those who were charged with working with prospective nurses in some of the institutions hadn't established that trust. They didn't understand the nature of the teaching/learning environment and had used their authority in the assumption that it would be accepted, and of course it never is ... I feel very, very strongly that it doesn't matter what aspect of the curriculum it is that you are wanting to introduce, it has to be done in a way which will determine its success and not its failure. One of my catch phrases is that teaching has to be a research informed profession. And you cannot have a research informed profession unless your people are steeped in background knowledge in the latest research findings and are then able to apply those research findings to the way in which they approach motivating learning. Because again, another important part of my work at the moment, is trying to get across the message that the teacher is the facilitator of learning no matter at what level, and it is the nature of the learning which is going on and you can't challenge and motivate learning unless you have got this background of knowledge yourself in order to be able to design programmes which will in fact lead to learning outcomes. (Margaret Austin, interviewee)

The Nursing Council of New Zealand Response 1995-1997

As Chief Executive Officer of the Nursing Council, Colleen Singleton was required to report back on the recommendations made by the Select Committee in 1996. She acknowledged that there were a number of issues that needed to be addressed including those of governance within the Council.

> The Minister [of Health] came and met with the Council [in 1995] and she gave the Council the message that there were problems with the Council. Not just Cultural Safety, I think we need to be honest that there were other problems as well, probably highlighted

> by the Cultural Safety debate, and that they needed to get their act together … remember there was a whole lot of debate going on about whether we should have a review of nursing education so there were other issues apart from Cultural Safety. So the Council was brought into light, changing the way it operated and getting its governance together. And that was a very clear message the Council took on and certainly did a lot of work on its governance, which included the way it deals with issues such as Cultural Safety. After the debate and the preparation of the draft guidelines, the Nursing Council arranged a meeting on the 1st of May 1996 in Wellington at which nurses and midwives were invited to attend and members of the public. The Minister, Minister Shipley spoke with the people there and she said very clearly that nursing and midwifery were ahead of their time in dealing with this issue which we're calling Cultural Safety ... One of the important things that happened at that May meeting was that nursing and midwifery leadership who were present made a decision about Cultural Safety when we asked about the baselines. Their response was, "we won't change the bases in the Treaty of Waitangi and we won't change the name" and I thought that was an important milestone.
> (Colleen Singleton, interviewee)

Elaine Papps also reiterates the importance of having kept the name.

> Well I suppose, reflecting back on all the events that have happened, one thing I would say is that the name has been, despite the most incredible pressure, has been retained. And to me, that is part of its very essence. That it was something that should never be changed because it wasn't ours to change, it was something that came from a group of Maori nurses and students who gave it as a gift, I suppose, and so the good thing is that is there still as it was intended, irrespective of all the attempts to sanitise it and de-politicise it. It exists and it's never been buried, as a lot of people I think would want to have it buried and say, it's a very negative thing to have in nursing but that goes back to people misunderstanding the concept. (Elaine Papps, interviewee)

As part of the reporting back process to the Select Committee, the Nursing Council of New Zealand conducted a review into the teaching of Cultural Safety in nursing and midwifery education (Murchie & Spoonley, 1995). Ketana Saxon, as Chairperson of the NZNO Student Unit during the Select Committee hearings was asked to speak on behalf of students.

> Stories were coming in from different tech's (about the) enormous diversity in terms of people's opinion, understandings (and) reactions. It was quite stressful at the time being

> a chairperson, being asked to speak for what was the student view of Cultural Safety. Amongst that group in the student unit they were all much in favour of Cultural Safety. But they are also bringing reports from their polytechs of students who weren't and [they] tried to be quite fair about that, that it wasn't all rosy everywhere, there were problems and there was a lot of grief in the classrooms. (Ketana Saxon, interviewee)

The New Zealand Nurses Organisation ran a major survey of its members opinions on Cultural Safety. Ketana collated responses for the Student Unit from students all over New Zealand.

> When the Nursing Council was doing their review, we designed some sort of questionnaire, I think, or we just got all the student reps to ask as many students as possible to write a paragraph. What was their experience of the Cultural Safety component? I got bundles and bundles of these comments. Mind boggling reading! I have to say that the majority were positive …a minority were just out and out negative. There were a lot who were positive but they were unhappy with their experience of the teaching approach. There were probably more who were either positive in general or were positive but, "if this and this hadn't happened we would have felt better," and then I would say the minority were just out and out anti. (Ketana Saxon, interviewee)

Elaine Papps concludes that an important outcome from the Select Committee hearings for the Nursing Council was the production of a second set of Cultural Safety Guidelines (Nursing Council of New Zealand, 1996).

> Well one of the good things I think the Nursing Council has done, although philosophically I disagree with the notion of "competence" or "competency", there is a list of competencies for comprehensive nursing students and under the Cultural Safety competency is a very clear view of what the expectations are in practice for nurses going out to be safe and competent to practice. (Elaine Papps, interviewee)

The 1997 report from the Select Committee on Education and Science to the House of Representatives following a briefing from the Nursing Council of New Zealand on the incomplete inquiry into Cultural Safety is attached as Appendix 6.

Practice Implications and the Continuing Evolution of Cultural Safety

It is our responsibility as appropriately educated nurses and midwives to acquire insight and analysis into ourselves as members of human groups who develop powerful human behaviours and practices. The culmination of this educational process should enable the most vulnerable our society to say that nurses are safe to be around. The definition of safety should rest with the people who use our service. Karl Puloto-Endemann, Kere Pomare, Janet Davidson and Lou Simmonds are all experienced practitioners. They share their experiences of Cultural Safety in practice.

> People say, 'what is Cultural Safety?' And I say, Cultural Safety is when you enter a health service that's developed by somebody else of another culture, without losing your own self in the process. You know, by using your own process so that if you are Maori you don't be a Maori, if you're a woman, you don't lose it in a male, if you're a Pacific Islander, you don't lose it because you're going with pakeha. The other group that's picked it up very well is the gay and lesbians. So if you are a gay man or lesbian woman, you go through a hospital system and you are a gay man or lesbian before, during and afterwards. They understand that. So the premise is quite simple. And you and I know the practice is harder. (Karl Puloto-Endemann, interviewee)

> Don't assume anything. Don't assume anything and work with what you've got. And sometimes that does mean humbling yourself, it does. It's a funny word, humble, but it's so true, you know, because you do have to when you see a set of rules that just aren't yours. And then it'll work, knowledge is nothing without humility. It doesn't matter how much you've learnt, how much you know in terms of education or if there are ideas which you think would be worthwhile for this person to know or whatever, it's nothing if they're not listening to you, if you're not treating them like a decent human being and so it's got to start with that or nothing else matters. And there are rights and responsibilities and all those things that you still carry on board with your nurse-client relationship.
> (Kere Pomare, interviewee)

> You cannot take a group of humanity and say "they're the same." I mean which is most recent experience in health service, we've had a number of Maori families, were all different from each other. Some have large whanau that we endeavoured to accommodate as much as we can. Some are living very in my experience caring for Maori people in the hospice, much in the Western model, with, with nuclear families etc... You cannot say a Maori person coming through has got these needs and this one's got these needs because

> that's not true, the diversity is exciting. I personally am a great believer in people's diversity, celebrating diversity, not knocking it. And checking out what's appropriate. Who people relate to most, who people want with them when things are being discussed, who are the important 'others' in their lives. And you can't make assumptions for any group. (Janet Davidson, interviewee)

> Those areas can only be identified by the people that we have the relationship with in our practice and so I might care for you today and you give me like kind of a full understanding of what your needs are and I deal with that. But I might by the same token, nurse another Maori woman who will actually have maybe the same condition but she will have totally different needs and they may be needs that come from Maori tradition that she was talking about and I would then be dealing to that. But I don't see that I could actually school myself up and say that's what I would be giving, that's what I would need to know to care for you. What that woman asked for and what you asked for are two different things even though you come from the same culture and as a nurse, I need to be really aware of that. Cultural Safety is defined by those people that are receiving this service not by those delivering it and that is just so powerful, that has been so powerful for me. (Lou Simmonds, interviewee)

Cultural Safety should be the experience of all recipients of nursing care. It is about protecting people from nurses, from our cultures as health professionals, our attitudes, our power and how we manage these things whether unintentionally or otherwise. Sometimes this does not happen.

Robyn Pope has spent most of her adult life working in the social services field. At the time of being interviewed for this project, Robyn worked for the Wesley Wellington Mission as the Community Services Manager. She has two children. Robyn spoke of her understanding of Cultural Safety in theory and her experiences as a consumer when one of her children was admitted to hospital.

> It really interested me. I'm not from a nursing background and I've had no contact with hospitals ever up until this last year. But I just thought it was fantastic finally that people are recognised for who they are rather than what's wrong with them and to me that wasn't specific to any culture. And that's how I read it [Cultural Safety] immediately. I thought "yay" people are going to be treated for who they are.

> It's that recognition that it's [Cultural Safety] for everyone. I need to feel culturally safe but that doesn't mean asking if I want to take my placenta home. It doesn't mean me having to leap into this other culture. And that's what they did, "do you want your placenta?" It's like I'm not Maori, thank you, no, but that's fine. I think it's recognising that it cuts across cultures, that it is important for everyone to be valued and [to have] their individual needs. It's individualising hospital care which was going to be really interesting, and none of them did it individually. It was as though they were technicians rather than human carers, no one seemed to get through to me, it was a though we were all in roles, I was the "mum' role. As long as we all stayed in role everything was okay because they had the power and I was conforming to their requirements, not them to mine. They were all really nice people, all of them professionals, no one was out there to really upset me deliberately or hurt me or anything but I would not got back to [the] children's ward if I could help it. (Robyn Pope, interviewee)

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

Mereana Roberts is of Te Aupouri, Ngati Kuri and Pakeha descent. She currently works as a lecturer in Cultural Safety at Otago Polytechnic. Mereana talked about her approaches to teaching Cultural Safety to students in order to facilitate the link to nursing and midwifery practice.

> Indicators which I see are attitudinal change in students who I guess are more able to cope with diversity amongst their clients, who are able to talk to the diversity of their clients, their clients needs, whether it be a cultural/ethno-specific need or whether it be a religious need or a spiritual need or whatever. They're not just talking about physical issues in relation to their clients, they're actually starting to accommodate other perspectives of their clients … Quite often students have spoken to me about recognising, having worked through the paper that I teach in, the impact when they get into clinical, of the power relationships that exist between them as the professional and the other person

> as the client. They start to make some links about what that experience is like. (Mereana Roberts, interviewee)

Cultural Safety is a lifetime experience and the basic education programmes can only provide the beginning tools for the growth and development of attitude and behaviour change.

> In the programme that I teach on there is quite a heavy emphasis on those particular issues of comment and working with issues like power relationships, looking at racism, institutional, mono-culturalism, those sorts of concepts are talked about not only from a theory base but what does that mean in practical terms. Go back out into the clinical area, look for or discuss ways or observe what those particular areas do in relation to the concept. Can you see them operating at a local level within the particular clinical setting you're in. So I guess that depends on whether or not the person who was delivering the information to the students actually makes that an important part of their content, and how it's related to the students, is it always just kept to the theory or is it something they can actually move across into practice. (Mereana Roberts, interviewee)

> I don't find it stressful to teach Cultural Safety, I find it very easy. It's about basic communication and you say to students, what would you do if you had to go and take someone's, perhaps not a physical recording, but if you had to go and ask them how they liked to get out of bed. You go and say to them, how do you get out of bed, there's no difference between asking them those sorts of questions as to asking them anything in relation to what their Cultural Safety needs are as well. It's about finding your communication patterns and establishing a rapport with your client or whanau, what is it that you need to have happen for you to be okay while you're in this place, in this environment. It's simple and they light up and go "oh!" And instead of saying can we have a checklist you say what's the easiest answer? And it's great, they ask the person if it's okay, do you mind if I wash you hair, can I do this? Just the same way that we ask permission for anything, just add it in to your mix of skills, that you need to ask people, that's a very empowering thing to do, give them the choice.
> (Mereana Roberts, interviewee)

The move from student nurse/midwife to registered nurse/midwife is a significant step. The pressure of a busy work environment coupled with the new responsibilities and expectations placed on a graduate means that sometimes the gap between theory and practice can seem particularly acute. I asked Ketana Saxon about her recent experience

in moving from student to graduate nurse in a hospital ward situation and the experience of implementing Cultural Safety in the practice environment.

> But in terms of just me and my colleague from the ward and day to day practice I think that the biggest obstacle to taking the time to nurse in that way, being alongside people and respecting their realities and those things which is what we wanted to practice and is the essence of Cultural Safety...sometimes the environment and the stress and the lack of resources and lack of time and the lack of experience just were enormous obstacles to doing all of that. And many of us were despairing about the gap between how we wanted to practice and the environment. (Ketana Saxon, interviewee)

In 1992, Western Bay Health started to look at its Clinical Career Pathways (CCP) which initially involved a working party of nurse and midwife representatives from within their organisation who came together to define what they considered to be the domains of nursing and midwifery. Wendy Bunker was a member of that working party. Wendy is a registered nurse and midwife who trained in Britain and initially practiced there before returning to New Zealand to work as a midwife. Wendy has been very involved in the establishment of the CCP at Western Bay Health in Tauranga, which includes assessing practicing nurses and midwives in Cultural Safety.

> Now none of us are theorists, none of us had academic backgrounds so we started from very practical aspects. And we really developed our philosophies of nursing through our domains and we were quite clear on one of the domains at that stage we called it cultural competency (and that) we must have that link in our commitment written into our career pathway. We've learnt a lot along the way but that's what started that off. As we worked through, we recognised that we had to explain this to staff and as we worked writing our document, it come around for the nurses contract. And that stage, we were moving to a local CHE contract. Our management and our Human Resources Manager believed it was really important that this be part of any negotiation. So at the end of 1994, our Career Pathway was entered into our nurses contract which meant, that people had to be assessed on Cultural Safety in order to get their Level 7 and their pay rise. Nurses were all fearful. I mean it was pretty scary. It was at this time of course that all the media things were coming out. And it was pretty scary stuff. We were really afraid, what's going to happen if the media finds out at Western Bay Health we're assessing the nurses and midwives in practice, in Cultural Safety ... But I think too we were committed, we were absolutely committed that this was the right thing to do. (Wendy Bunker, interviewee)

I asked Wendy to talk about assessing attitude and behaviour and how that assessment is done and whether there were any particular problems encountered in implementing Cultural Safety.

> Well, mostly it's through [an] interview process, but we ask all nurses and midwives to write stories, to write exemplars about their interactions with the patients. And we talk about it being a journey. We became very clear early on that we weren't assessing people's knowledge of another person's culture. We couldn't do that. But we could assess people's knowledge of their own culture. And we could assess attitude and behaviour ... once nurses learned that it was actually about practice then they started feeling OK about it.
>
> I think the biggest problems were, with believing that it was Maori studies. And, when we started off on our journey we were confused and we thought we had to get the tick boxes out to say, "if we do all these things we'll be culturally safe." Once we realised that that's not what it's about, that it's actually about attitudes and behaviours it became easier. And so I think that part of the journey that people have to go through [is] to recognise that it's not about handing out the lists or the books to say read this, go on this course, and you will be culturally safe. Once people move past that and start understanding that it's a broader concept, then they can move. (Wendy Bunker, interviewee)

Many of the Maori nurses, having been through the colonial education system as well as the one provided for the education of nurses, felt very seriously disadvantaged when faced with the prospect of being part of a nursing service designed to give Maori people the choice of being nursed by Maori. For many, ethnicity and culture did not match and a level of distress was experienced by most of the Maori nurses employed at Western Bay Health. There were very few who felt competent to nurse in the unknown environment called kaupapa Maori.

> Te Puna Hauora were very visionary . . . they really wanted to have a service for their people which met the needs of their people. They recognised that no matter how good mainstream nurses became, there would always be a gap. So, we started, exploring a complementary nursing service and about a year ago we began. We started with one ward, having a group of nurses, well, each ward has a number of groups and teams of nurses that look after groups of patients. And one medical ward set up a group of Maori nurses to care for Maori patients. And that's now a year on further the kaupapa nursing team's grown, we now have 18 in mental health. We have a beginner practitioner

> programme and rotate through and we have the teams in the medical ward. So we now say where do we go from here? The problem is we don't have enough Maori nurses. (Wendy Bunker, interviewee)

Thus, in this situation there were Maori nurses coming into their identity, choosing to work in the kaupapa section of the nursing service and also being at the beginning of their clinical practice. They are dealing with a whole lot of issues that may not be the same for other people, getting support from their colleagues in the clinical skills as they give that added value to Maori patients.

By having the courage and energy to go about incorporating Cultural Safety into its CCP and Clinical Domains of practice, Western Bay Health nursing/midwifery leadership combined with Te Puna Hauora vision and courage provided a model of the Treaty of Waitangi partnership principle. Janice Kuka is the Manager of Te Puna Hauora at Western Bay Health. Janice is from Tauranga, of Ngati Ranginui and Ngai Terangi iwi. She has worked as a social worker at Tauranga Hospital and was instrumental in setting up Te Puna Hauora, designing and helping to implement the Maori nursing service for Western Bay Health.

> Cultural Safety! We needed Cultural Safety but initially it didn't have any impact, just 'til … I would say just recently over the last say three years that it's made a huge impact, not only on our unit but also I think it's effectively turned the whole place on it's head so, in those three years ... I don't know how long Cultural Safety has been around but for us it's been a short period of about three years from the introduction at a formal level to today. It's had a major impact on us where the organisation now uses the model … the whole hospital, so I think it's had a major, major impact. (Janice Kuka, interviewee)

The kaupapa Maori beds provided Maori patients with the opportunity to choose to be nursed by Maori nurses for two of the daily shifts. The end of the first year data collected by the wards with kaupapa beds showed that approximately fifty per cent of patients who identified as Maori selected to be nursed by the kaupapa teams. Others elected for the general beds although some changed their minds and shifted to kaupapa beds. Those nurses who worked with the people in the kaupapa beds reported that there was little difference in their clinical practice other than more time was spent communicating with patient and family and that kaupapa nurses would stay behind

when shifts changed to help with complex cares or would come in from off duty time to assist, particularly when kinship was shared.

This section was approached through the experience of the interviewees who have all been part of the Cultural Safety journey at various times, and for some, in the guise of multiple and differing roles. All of them have been critical in Cultural Safety's development and continuation and what is clearly apparent from their responses is that they recognised the importance of the work and have been steadily active in explaining and at times, defending the concept, from within their own public and private arenas.

There were some consistent themes arising from the interviews. A number of people, working directly and indirectly in nursing and midwifery education, confirmed that an analytical framework relating to nursing theory and practice, in which the process of colonisation is set, can be applied. This subject was not be avoided in the curriculum, and could be taught professionally and with full explanation to students as to its relevance to nursing and midwifery practice. This was supported by Maori interviewees, who saw Cultural Safety as part of a wider movement within Maoridom which should be viewed together with other Maori developmental processes which were also happening. The role of the Treaty of Waitangi was central in teaching Cultural Safety as part of the colonial history of New Zealand but, as Moana Jackson pointed out, the treaty was not the reason for Cultural Safety, colonisation was the reason for Cultural Safety. In order to be able to do this, teachers required a sound knowldege of New Zealand history to be able to place the health and illness issues in this society in a neocolonial framework.

Cultural Safety enabled nursing and midwifery practitioners to locate themselves in a unique New Zealand practice environment. All of the nurses and midwives interviewed with substantial practice experience had seen examples of the use of power and understood the potential impact of that power on clients they worked with. Creating ways to understand and assess the importance of that power relationship as a learning outcome for students and translating that into a teaching style relating to health and disease outcomes was an important component identified by interviewees working in the education institutions.

Another consistent thread throughout the interviews was that of the recognition of difference. Many of the interviewees understood something of the unique situation of their own personal life experiences which had enabled them to readily understand the basic premise of Cultural Safety. For some like Gillian Grew, it was growing up as part of a different ethnic group from all her peers. For Janet Davidson, it was the experience of being part of a marginalised group, as a lesbian woman, which had an important impact on her life. For Atareta Poananga, it was understanding the meaning of oppression and seeing the potential of Cultural Safety to facilitate moving through that.

The Cultural Safety work has introduced an original dimension into nursing which New Zealand can offer the world. It is frontier work and there is no long established pattern as yet. As the interviewees have remarked on throughout this chapter, we are all learning as we go, often painfully. But out of our mutual pain there has been real growth and real learning and we are developing something which speaks of the real identities of this country. The exposure of nursing and midwifery and Cultural Safety to public and political scrutiny meant a steep learning curve for many of the interviewees and brought to light some of the fears held deeply within the New Zealand psyche.

The interviewees voices represent an important set of insights, analysis, concerns and vision in carrying the kaupapa of Cultural Safety. A number of interviewees raised issues in this section which have implications for the future of Cultural Safety including the redefinition on Cultural Safety, who should teach Cultural Safety, gaps in the general education of the public and the prevailing ideology of multiculturalism. These issues are considered and expanded on in the following discussion chapter.

Chapter Ten

The Future of Cultural Safety

> What do you see as the greatest threat to Cultural Safety? (Irihapeti Ramsden)
>
> The biggest threat that I noticed all the way along was the deliberate misinformation, misinterpretation. And I do believe it was deliberate a lot of the time. And I think the media could look to answer for that. But I think the same threats to Cultural Safety is [sic] a general threat to nursing and nursing education, I mean just the stuff I was saying about the environment and making it impossible to practice the concept and then the education environment**, it's a very big threat to Cultural Safety if it isn't taken up in an accurate form of what it is meant to be. It will just sort of evolve into something else, if it isn't kept to some form** [my emphasis] that is taking it where it is really supposed to go. (Ketana Saxon, interviewee)

In the previous chapters I have told the private narrative and the public narrative of Cultural Safety. In fact, Cultural Safety as a theory and in practice may well be in jeopardy. In this chapter I will discuss the likely direction of this ongoing process and debate outlining several issues which represent a challenge to the future viability of Cultural Safety in nursing and midwifery education.

Redefinition

The term Cultural Safety

Throughout this work I have given upper case letters to the term Cultural Safety. This is firstly to emphasise it as a process which has a real place in nursing and midwifery education and secondly because Transcultural Nursing, which in many ways is its opposite, has assumed upper case letters with reference to that process of nursing education. The term itself has been a recurring issue. Many people and organisations

have sought to change it. The history of redefinition of the Cultural Safety ideas has always been associated with attempts to change the term Cultural Safety to a more popular one such as cultural sensitivity, awareness, competence or appropriateness, thus shifting the emphasis from the nursing specific lexicon related to safety in education and practice, to a more easily managed term and plexus of ideas which has its roots in transculturalism or multiculturalism and appears to be more generic. The transcultural approach is simply easier than the self-reflection, transformation and powerful action and reaction which Cultural Safety requires.

The use of such generic terminology reduces the power of the concept of 'safety'. It removes the original intention to take responsibility for teaching and nursing practice on the part of the practitioner from the language first, of the indigenous people who selected it, and secondly, from the nursing support which it initially received. Finally it has the effect of de-politicising and trivialising the whole meaning and content of Cultural Safety as an analysis of nursing behaviour based in nurses powerful interactions with patients and patients powerless interactions with nurses.

> The term Cultural Safety … was a real sticking point around the Select Committee table, and in fact it would be fair to say that it was only Tau and myself who had any glimmer of understanding of the nature of the term and its relationships with other terms that were used in nursing jargon and curriculum. (Margaret Austin, interviewee)

Colleen Singleton, discussed the term, Cultural Safety, in her interview:

> … it was almost as though for some members of parliament, that if we actually changed the name everything would be OK. And that was just such a superficial and shallow look at what was going on because it would not have actually changed the philosophy, the teaching or any of those things, but politically it would have become more acceptable to talk about cultural awareness or whatever term they deemed acceptable. And I think a milestone in there was the way we stuck out and said "you don't tell other professions what language they should use." We have our own language and we should be entitled to use it. (Colleen Singleton, interviewee)

In his interview, Moana Jackson did not agree with Colleen Singleton that the meaning would not change if the name did. He believes that the softening of the term will lead to its neutralisation and ultimately to its de-politicisation. He believes that any change in

the term would lead to a change in its presentation and teaching. Kere Pomare agrees with Jackson:

> I think the concept is being redefined into cultural appropriateness and cultural competency, it is heading toward habits and customs and that will be its death. You know, its continued misinterpretation has meant that it has become more complicated than it was ever meant to be, it's so important that it's taught right, that they refer to the original report. (Kere Pomare, interviewee)

Changing the name means changing the concepts

Thus, the attempts to change the name are symptomatic of attempts to change the fundamental features of Cultural Safety. These have been outlined in previous chapters, but the key feature, as I stated in the introduction, is that Cultural Safety is about the nurse rather than the patient.

> The Cultural Safety model is an ecological model that actually argues for the health care professional to take into consideration the socio-political reality of the patient – not the cultural stuff alone in isolation – especially not as it is interpreted within the ideological framework of multiculturalism, but rather, in terms of the political status and historical experiences of the patient/group with which one is dealing. (Jiwani, 2000, p. 4).

This is not necessarily an easy thing to do, and it is therefore not surprising that there has been a continual tendency to shift the focus of analysis away from the nurse and back towards the patient. In the translation, the locus of power is shifted from the patient to the nurse and the interaction ceases to be analytical and becomes descriptive. A simple description or reflective exemplar from the nurse rather than commentary from the patient or concerned others who are involved in the interaction is produced. The fact that the nurses' own estimation of their own practice is accepted as a valid commentary is a dubious form of evaluation. Elaine Papps discusses Nursing Council's 1996 definition of Cultural Safety in comparison with the 1992 definition which she saw as much more clearly stated:

> I'm not sure that anything has changed with the concept except that it has perhaps been defined by Nursing Council in a way that I'm not sure I agree with…it's still there in the polytechs. The Council's definition in its glossary in the Guidelines I think, defines it as an outcome of nursing and midwifery education **and that's a rather nothing statement.**

> **It doesn't say what it is. It says it's an outcome and it's almost as though it has been neutered** [my emphasis]. My difficulty with that is that I think that definition supersedes the earlier 1992 definition of the Kawa Whakaruruhau Guidelines which I always thought was a very clear definition. (Elaine Papps, interviewee)

Because the term Cultural Safety is drawn from nursing language, with specific reference to the word '*safety'* and its relationship to the public good and the responsibility of nurses to maintain all aspects of patient safety, it is understandable that the public does not understand the internal professional use of the term and would attempt to adjust it to the more generic and commonly held meanings of the words culture and safety. The public certainly felt that they had the right to comment on the educational content and processes selected by nurses in the education of their potential peers and did so vociferously, sustained by the news media.

It is my belief that the argument is greater than semantics and has to do with the right of nurses and midwives to educate their peers in preparation for practice as they see professionally fit. It is also to do with the public perception of nurses as a secondary helpmate to doctors and that they do not have professional autonomy in education or in practice. Any deviation from the trusted stereotype of nurses as followers, rather than pace setters, has the potential to create unrest in the public mind. The public aspects of commentary through talkback radio and letters to the editor, of the Cultural Safety debates, were good examples of this.

Who Should Teach Cultural Safety

Although the 1996 Guidelines for Cultural Safety in Nursing and Midwifery Education (Nursing Council of New Zealand) stipulated that teachers of Cultural Safety need to be registered nurses and not teachers from Maori Studies Departments, Maori who had some previous contact with the health services are often employed by Nursing Departments to teach students. In my experience, examples of people employed in the past to teach Cultural Safety to nurses and midwives have included many Maori Studies employees, a former cook from a psychiatric institution, a former spy, a former taxi driver and a former ambulance officer. None of these people were nurses, midwives or teachers.

Their appointments to teach nurses simply because of their ethnicity as Maori were inversely racist. No other teachers were employed by ethnicity and the Maori teachers were not required to have the same qualifications as the other teachers in the faculties. Where this occurred students often protested. The responsibility for teaching Cultural Safety was often to be seen as belonging to Maori teachers and although there was interest from other teachers, primary responsibility for Cultural Safety tended to rest with Maori. This responsibility also included anything to do with the Treaty of Waitangi and its application to health and illness. This process left Maori people in an extremely vulnerable position, students were poorly served and the potential for patient care was disastrous.

Transcultural ideas persisted in that Cultural Safety continued to be associated with Maori and ethnicity. After the 1996 Nursing Council Guidelines required nursing registration as a basic prerequisite for the teaching of Cultural Safety, Maori nurses were frequently sought as teachers, some with little or no formal education apart from nursing education, and others as new graduates with little or no practice. It was a rare combination of Maori nurse or midwife who was appropriately educated for Cultural Safety and had the type of nursing practice which consolidated educational theory and it was a rare nursing or midwifery programme which offered that type of education at undergraduate level. Although many of these activities were done with apparent goodwill, Atareta Poananga expressed cynicism:

> I have little faith in process of the appointment of Maori people to fulfil pakeha agendas. Even if the conscious agenda is to meet perceived Maori needs the outcomes don't change. Who defines the needs and whose agenda is really being met?
> (Atareta Poananga, interviewee)

The teaching of such delicate issues as treaty education and the cause and effect relationship of colonisation and ill health was largely left to Maori. Some polytechnics were aware of the anomalies and made stringent efforts to acquire specialists in teaching workshops in respect to the treaty to the extent of educating several non-Maori nurses to become proficient in this skill and some continue to do so. They are in the minority. Kere Pomare remembers being taught by an informally educated Maori teacher in her undergraduate programme. Her experience of being Maori did not match his.

> There were a whole lot of looney things being said in the name of Maori and we didn't question the Maori teacher. There was a high level of cultural cringe.
> (Kere Pomare, interviewee)

These situations have tended to undermine the credibility of Cultural Safety and reduce it to the most simple, teachable components which are usually associated with stereotyping of cultures. In addition, Cultural Safety can only be taught and reinforced in nursing education, provided that there are sufficient trained teachers available. This has not been the case, and therefore Cultural Safety has been taught by untrained teachers who have interpreted and taught Cultural Safety according to their own viewpoints. These usually tended towards the framework of Transcultural Nursing although it was called Cultural Safety.

Education of Cultural Safety Teachers and the General Public

There has not been the opportunity to take a national overview of the education and training of Cultural Safety teachers since the dissolution of the role of Education Officer in the former Department of Education in 1989. Apart from the 1992 and subsequent 1996 Guidelines (Nursing Council of New Zealand 1992; 1996) there have been no other attempts to guide, influence or nationally support the people who are teaching in this area.

There is considerable confusion about what Cultural Safety is, on the part of pakeha and on the part of Maori nurses, as well as amongst politicians and the general public. These difficulties are not insurmountable, but overcoming them would require a number of features that are not currently common in Aotearoa and Te Waipounamu such as a collective standard of education reached by all citizens with respect to New Zealand history, requiring a level of understanding and employment of Critical Social Theory which is not available in the education system available to most New Zealanders. Cultural Safety teachers need to be fully conversant with the colonial history of New Zealand in order to address the issues of racism inherent in that history. Feminist theory has to some degree been helpful in addressing racism and many of the teachers of Cultural Safety who have not experienced colonisation have been drawn from a background in feminist theory.

The development of specialised education to prepare nursing and midwifery teachers to teach Cultural Safety safely and also to provide decolonisation courses for those Maori students who opt for it, is urgently required. There is no sign of the political will on either the part of local polytechnics or universities which offer nursing and midwifery programmes, or on the part of the Nursing Council of New Zealand, to encourage such preparation and education.

Ethnicity in the effective teaching of Cultural Safety is relevant in explaining the subjective experiences of people in relation to the topic where ethnicity has been a major contributor to the differentiating factors. The explanation can only be personally subjective. The aspects of Cultural Safety which relate to power and powerlessness can be taught by teachers who understand these issues and can teach them in a framework which helps to transform the thinking and the practice of the student (Wood & Schwass, 1993).

As the interviews for this project with people who supported Cultural Safety illustrated, understanding the politics of marginalisation and the need for attitude leading to behaviour change, whether through the experience of difference by gender, sexuality, social or economic status, disability or ethnicity, all have contributed to being able to recognise the power relationships which Cultural Safety seeks to identify and address. Teaching in this area is therefore not restricted to Maori people unless it addresses the subjective experience directly related to being Maori. The history of New Zealand from a power relations viewpoint can be taught by non-Maori and the responsibility for teaching Cultural Safety could be shared by a greater base of teachers.

The dual issues of not being able to recruit and train teachers and update their knowledge and ideas, will help contribute to the breakdown of Cultural Safety as it was originally envisaged and will reinforce its progress toward the ideas which are recognisable as Transcultural Nursing. There is no regular forum for the transmission of new ideas and the review of old ones and the production of new material. The inevitable end of Cultural Safety as an exploration of power relations seems nigh if it has to depend on such a fragile infrastructure.

Multiculturalism

> But if you were to say to me, was...was incipient racism part of it, I would say yes, without any hesitation. And that was probably one of the most devastating parts of it, that that was there in the background all of the time...One of the issues that kept on emerging and being debated was that New Zealand is multi-cultural why isn't the same emphasis being given to the Chinese, the Indian, the Asian communities generally. Why is it that Maori is given this pre-eminent place and it was almost as though people asking that question were not prepared to give credibility to the bi-cultural heritage of this nation and ... the impact of that and the changes in attitudes as people began to understand was quite incredible, but it got lost. (Margaret Austin, interviewee)

The ideology of multiculturalism fits well with Transculturalism and comes naturally to New Zealand nurses currently. To turn attention back onto the emic nurse, and away from the etic and exotic patient requires a consistent and major shift in ideology. This can be maintained by continual reinforcement and support for nurses who endeavour to implement Cultural Safety in their practice. Without knowledgeable people who can provide such support, Cultural Safety is in a precarious position in the future.

> We can theorize as educationalists, as professionals, whatever we are, about the theory, but sooner or later we have to come back to the people we're supposedly working for and say to them, is this right, are we actually moving? (Mereana Roberts, interviewee)

Cultural Safety can only survive if it is embedded in the community rather than being something that is taught and practiced only in an academic situation. Moana Jackson has a clear opinion of the future.

> One of the reasons there has been so much fear and opposition to the whole concept of Cultural Safety is because it requires consideration of issues of power. And not just the imbalance of power between a patient and a medical professional but the wider origins of that power beyond the hospital…and any programme that is developed by Maori that is seen to affect the power of the crown is a threat and if the Nursing Council was committed to implementing the whole idea of Cultural Safety, then the only way to minimize that threat was to marginalize it alongside the action songs and the poi…and I think that's what they are trying to do. And that then made it essentially as an education tool powerless in terms of structural change…the forces of the state were brought to bear on it and the forces of the state were not as successful as they would have wished but it

> survived that initial reaction. It won't survive in the future without continued effort. Moana Jackson, interviewee)

I agree with Moana that without the right kind of support from people and institutions which understand and believe in the ideology of Cultural Safety it will not survive in the form in which it was intended.

I do see a future for the theory and practice of Cultural Safety if sufficient, appropriately trained people are involved with its teaching. If Maori health and the issues surrounding it were to be taught as a stand alone topic specialised in its own right, the confusion between Cultural Safety and Maori Studies would be removed. Then, Cultural Safety in all its aspects as an examination of power relations between nurse, and patient could be integrated throughout nursing and midwifery programmes and become normal throughout the education of health professionals in New Zealand. By improving the teaching and the education of student nurses and midwives, service delivery to all who come within the care of nurses and midwives can only become better.

Chapter Eleven

Conclusion

The story of Cultural Safety is a personal story, but also a very public one. It is set in neo-colonial New Zealand, but has implications for indigenous people throughout the world. It is about human samenesses and human differences, but is also a story about all interactions between nurses and patients because all are power laden. Finally, although it is about nursing, it is also relevant to all interactions between health care workers and patients.

Although the Cultural Safety story has been very public it has also been an intensely personal one for me. For a considerable time the ideas and implementation of Cultural Safety were generated and sustained largely by my efforts as a single character. At times it has been a lonely journey. At others I have been safely and powerfully accompanied in this work by like minded people, Maori and non-Maori.

As other nurses began to think that the ideas of Cultural Safety had potential to be useful in the education of students and the practice of nurse graduates, support emerged and has continued in a range of ways. Throughout the constructive and the controversial history of Cultural Safety it has frequently fallen to me to explain and defend as well as to support the efforts of others to continue to develop the Cultural Safety praxis. Although others have spoken publicly and often very well indeed, mine has emerged as the most consistent (though not always the most effective) voice over the years.

This experience has meant working with individual teachers and organisations such as Schools of Nursing and the Nursing Council of New Zealand. Making public appearances before the Select Committee on Education and Science, dealing with aggressive and usually uninformed television, radio and press people as well as supporting others embroiled in the stresses and tensions of the Cultural Safety story, has required significant emotional and intellectual resources.

The seamier side of New Zealand society revealed itself in the form of hate mail and death threats as well as a level of vituperative and uninformed opinion on the talkback radio networks. Many nurses, including myself, were propelled into the public arena by the Cultural Safety debate and were seriously disadvantaged by lack of experience in managing interaction with the electronic news media.

Not least among those who have been swept along in the controversy of Cultural Safety have been Maori people, many of whom have needed personal support as they have dealt with racism, misinformation and confusion. Others have been part of the consistent redefinition of Cultural Safety from a political to an ethnographic and idealised view of Maori. These experiences have been painful and ridiculous, joyful and essentially human. For me to be able to respond to these situations positively has taken a consistent type of energy and commitment as well as a personality able to persist in the face of constant multifaceted challenge. It has therefore been very relevant to this study, that you as the reader have some insight into that personality and the context in which it developed.

Although the evolution of Cultural Safety is grounded in the context of current New Zealand society, the theory of Cultural Safety draws on work by other researchers who have been concerned with social boundaries and margins. These have included both indigenous (e.g Trin T. Minh-ha) and some non-indigenous theorists (e.g. bell hooks) who have been concerned with social justice, teaching to transform and life on the social margins of more powerful groups of people. Cultural Safety is about the formation of trust and the components of trust becoming recognisable and tangible to patients and to nurses. Only when trust has been established can exotic differences be revealed, discussed and negotiated in the actions of giving and receiving nursing care. This often involves the transfer of power from nurse to patient and the renegotiation of traditionally held positions. Such a radical change in the theoretical orientation of nursing teaching and practice would be difficult in any circumstances, and it is therefore not surprising that the story of Cultural Safety has been tumultuous, stressful and chaotic in New Zealand.

Cultural Safety is about issues of access to service and communication, rather than technical skills. Culturally safe practice in health service delivery is embedded in the notion that it is the confident culture of the person and the institutional philosophy

delivering the service which, by its very nature, creates service barriers. This requires an approach to education which should be designed to create emancipatory change. Education to understand physical disease has followed a model of describing the aetiology and the development of disease in order to understand the symptoms. The same model can be used in gaining insight into the state of social dis-ease.

In the neocolonial environment this requires a profound understanding of the history and social function of racism and the colonial process. It also requires a critical analysis of existing social, political, and cultural structures and the physical, mental, spiritual and social outcomes for people who are different. It is a given that this type of knowledge is not taught in a general educational pedagogy which is normally about maintaining the status quo which underpins a conservative economic system based on individual success. This usually means that most people have little understanding of Treaty of Waitangi issues and New Zealand history. It is consequently very difficult to move the issues of Cultural Safety in relation to Maori health forward since the basis of this work lies in establishing an understanding of national and local issues and their impact on health.

The basic population of New Zealand is still not prepared to hear and cope with the colonial history and will not be so while the general education system does not include this material for all citizens to evaluate for themselves. It is from this level of educational paucity that nursing and midwifery students, practitioners and teachers are usually drawn. For patients to be considered in terms of their political status and historical circumstances requires an understanding and knowledge of history which continues to be uncommon in New Zealand currently.

This work is internationally new and there are no academic models although there are theorists who have contributed to building the New Zealand framework. Cultural Safety has been developed almost entirely from the interactive experience of the indigenous people with a nursing and midwifery service largely derived from a migrant ethnic group thus making it unique to this country although there are elements of international comparison. As Aotearoa/New Zealand moves forward toward maturity, it is inevitable that these processes for examining ourselves and the society in which we live will arise. There will be further changes in education as people seek to broaden and deepen their skills in service delivery and their lives as New Zealanders.

One of the other unique features of nursing in Aotearoa and Te Waipounamu has been the development of Cultural Safety as a way of looking at and doing nursing. Because it has arisen from the indigenous people it must pose the question, are nurses part of the problem? The answer is yes, nurses are part of the problem. It has certainly been often stated by Maori that many changes need to happen to nursing legislation, administration and education as well as practice, we must ask ourselves as a profession what we will do about it?

Our nurses are rightly due praise for the excellent work we have done. There is not the time to address all the solutions but I have attempted to identify some of the problems. Solutions require time, processes, resources and trust.

What is important is that there are more and more people who will be responding as I have done to history and to the current economic and social environment in our country. There will be more and more critical analysis. The issues will be about political interaction, meaningful representation on decision making bodies everywhere and negotiation about resource shift. In essence, tino rangatiratanga. If we want to provide a service in which people feel that they can safely approach health workers, then we who provide the service need to know something about ourselves.

Cultural Safety is simply a mechanism which allows the consumer to say whether or not our service is safe for them to approach and use. Safety is a subjective word deliberately chosen to give the power to the consumer. Designed as an educational process by Maori, it is given as a koha to all people who are different from the service providers whether by gender, sexual orientation, economic and educational staus, age or ethnicity. It is about the analysis of power and not the customs and habits of anybody. 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.

Cultural Safety and Kawa Whakaruruhau have arisen from the agony which Maori suffered through the experience of colonisation. Such loss and grief and pain should not be experienced without learning. What we have learned is that we cannot revisit the subjective experience of being deprived of precious things but rather we should learn

from the experiences of the past to correct the understanding of the present and create a future which can be justly shared.

Appendix 1: Biosketches

Allison Chappell Allison Chappell is a Registered General Obstetric Nurse and a registered midwife, who trained in the 1960's. Christianity has been an important part of Allison's life and she has maintained an interest in a range of areas including psychology, sociology, anthropology and religious studies.

Colleen Singleton After completing her nursing training at the Mater Hospital in Auckland in 1965, Colleen worked as a theatre nurse in private hospitals both here and overseas. She has also worked as a court reporter in New York and as a Hansard reporter with the New Zealand Parliament. Colleen has one son, Matthew.

Elaine Papps Following her job as a tutor at Nelson Polytechnic, Elaine worked at the Otago Area Health Board as the Chief Nursing Officer and she has completed a Masters Degree in Education. She returned to nursing education as a lecturer at Otago Polytechnic in 1993.

Janet Davidson Janet completed a Diploma of Nursing at the Advanced School of Nursing Studies and in 1971 became a tutor at the Hawke's Bay School of Nursing. Ten years later, she took up the position of Education Officer (Nursing) with the Department of Education. Latterly she has been working in the palliative care area at Mary Potter Hospice.

Moana Jackson Moana is of Ngati Porou and Ngati Kahungunu descent. He has been involved in numerous roles as an expert lawyer and has contributed extensively in the area of legal work on Maori rights. He was a member of the United Nations Working Group on the Rights of Indigenous Peoples from 1991 – 1996.

Atareta Poananga Atareta is of Ngati Porou, Rangitane, Ngati Kauwhata and Te Whanau Apanui affiliation. She currently works for the Community Law Centre in Gisborne and is a Gisborne City Councillor. From 2000 Atareta has been a member of the Health Research Council of New Zealand Ethics committee.

Alison Dixon Alison has had a long nursing career and has played an important role in nursing education and has been a member of the Nursing Council of New Zealand. She lives in Dunedin. Alison was Professor, Department of Nursing and Midwifery at Victoria University from 1998-2000.

Gillian Grew Gillian trained as a nurse in the United Kingdom. She came to New Zealand and worked in the former Department of Health setting up the National

Cervical Screening Programme. She took up the position as Chief Nurse in the Ministry of Health in 1993.

Keri de Carlo Ahuarangi Keri grew up in Rotorua and Auckland. He is of the Werikaitawa hapu. Keri trained initially as a teacher in the '70's and then went on to do his nursing training at Auckland Public Hospital, later specialising in mental health. He began tutoring in 1985 and then moved to Waikato Polytechnic and teaches in the mainstream and Tihei Mauriora undergraduate nursing programmes.

Kathryn Wilson Kathryn completed her nursing training during the 1960s. She attended the Hui Waimanawa in her position as the Head of Department of Waiariki Polytechnic. After leaving that job, Kathryn took up the Nursing Advisor position at Rotorua Hospital and went on to complete a Masters degree in 1993.

Fuimaono Karl Puloto-Endemann Karl was born in A'taufusi, in Western Samoa in 1950 and came to New Zealand in 1959. He identifies as Samoan and fafafine. He is one of 11 children and completed both his Psychiatric and General and Obstetric nursing training in Auckland. He currently works as an independent consultant focussed in the areas of Pacific Island health, sexuality and HIV Aids.

Kere Pomare Kere is of Ngati Toa, Te Atiawa, Rongomai-wahine and Rongowhakaata descent. She is the mother of three children. Since completing her midwifery training in 1992 she has worked as a midwife and independent practitioner in both hospital and community settings.

Margaret Austin Margaret was educated at the University of Canterbury graduating in science and biology and taught for thirty years before entering politics. She was a member of and later chaired the Education and Science Select Committee during the time of the Cultural Safety Inquiry.

Robin Kearns Robin was born in England and came to New Zealand as a 4 year old. He completed a PhD at McMaster University in Canada looking at community experiences of former psychiatric patients. He lives in Auckland with his wife and two children.

Annie Collins Annie worked as a film editor from1976. After ten years of that she switched to working as a trainer for anti-racism workshops as part of the 'Double Take Anti-Racism Training' team and it was during this time that she met with Irihapeti to discuss the process used by anti-racism trainers to address attitudinal change and how that might be applied in nursing education. She is now working again as a film editor.

Judy Kilpatrick Judy trained as a nursed at Christchurch Hospital. She started teaching at the Auckland School of Nursing in 1977 and then completed her diploma in Nursing before becoming charge nurse of A&E at Greenlane Hospital. She was Head of the School of Nursing and Midwifery at Auckland Institute of Technology from 1991.

Isabelle Sherrard Isabelle did her nursing training at Christchurch Hospital. She began teaching at Auckland Institute of Technology in 1979 and in 1985 was appointed to head the Nursing Education Programme at Carrington Technical Institute which later became UNITEC. Isabelle was Head of School at UNITEC up until 1997. She was a member of the Nursing Council from 1990-1996.

Mata Forbes Mata belongs to Ngati Tama and Ngati Mutunga iwi and comes from Taranaki. She trained as a nurse at Waikato Hospital. Mata has worked in the critical care area at Auckland Hospital for over 40 years and she is now involved in delivering a Maori health service at the hospital. Mata is a long-standing member of the National Council of Maori Nurses.

Mereana Roberts Mereana is of Te Aupouri, Ngati Kuri and Pakeha descent, she lives in Dunedin and trained at Christchurch Polytechnic. She has worked in a variety of nursing settings including psychiatric, medical/surgical, cardio/thoracic, respiratory and oncology. She took a short break from nursing before returning to work in the education area as a lecturer in Cultural Safety at Otago Polytechnic.

Lou Te Hine Pouri Simmonds Lou is of Ngati Raukawa and Ngati Huri descent. She first trained as an enrolled nurse and then went to Whangarei Polytechnic and graduated in 1990 as a Registered Comprehensive Nurse. She later worked as a tutor at Northland Polytechnic.

Rebecca Fox (Becky) Rebecca is Ngati Porou and Ngati Kahungunu. She is a Registered Nurse and Midwife and has worked in Papua New Guinea and Australia as well as New Zealand. Becky has tutored at Waikato Polytechnic since 1989 and was responsible for the establishment of the parallel nursing programme, Tihei Mauri Ora, in 1993, at Waikato Polytechnic.

Janice Kuka Janice of Ngati Ranginui and Ngai Terangi iwi. She set up one of the first marae based health trusts in New Zealand, Whairanga Trust, working there for ten years before taking up a position as a Maori social worker at Tauranga Hospital.

Robyn Pope Robyn has worked extensively in the social services area. She is currently working as the Community Services Manager at the Wesley Wellington Mission. She had had minimal contact with hospital services up until the time of having her children who were four years old and ten months old at the time of her interview.

Robert Consedine Robert lives in Christchurch. He was involved in setting up Project Waitangi in the mid 1980s and now works as a consultant running treaty workshops throughout New Zealand.

Wendy Bunker After completing her nursing and midwifery training in Britain and gaining some initial practice experience over there, Wendy returned to New Zealand to work as a midwife. In 1992 she was seconded into the Nursing Advisor position at Western Bay Health in the Bay of Plenty.

Jocelyn Keith Jocelyn trained at Auckland School of Nursing and became a Public Health nurse soon after graduating. She has had a long and distinguished career in the public health area. She has also had a number of roles in a variety of other fields including primary health care and working with the Royal Commission on Social Policy.

Patricia French Patricia did her Comprehensive nursing training at Wellington Polytechnic. She has been a Nurse Advisor to the Nursing Council of New Zealand. At the time of her interview for this project, she was working as Programme Manager of the Nursing and Midwifery Programme at the Open Polytechnic.

Karen Guilliland Karen lives in Christchurch. She is a Registered General and Obstetric nurse. Karen has been very active and influential in the establishment of midwifery training programmes and the promotion of midwives and midwifery practice in New Zealand. She is also well respected internationally for her work in this area.

Ketana Saxon Ketana had been away working overseas for many years before she returned to New Zealand and decided to train as a nurse in 1993 at UNITEC. After completing her training, Ketana worked at Auckland Hospital for nineteen months before moving to Nelson.

Appendix 2a: Ethics Approval Letter

WELLINGTON
ETHICS COMMITTEE COPY CENTRAL RHA
TE HONGA HAUORA

29 May, 1997

Irihapeti Ramsden
Department of Nursing and Midwifery
Victoria University
PO Box 600
WELLINGTON

Tena Koe Irihapeti

97/21 - A descriptive chronology and theoretical analysis of cultural safety in nursing and midwifery education with particular reference to Maori health.

Further to our meeting and your letter on 21 May I advise that the revision of your title and aims is approved by the Committee.

This study is approved. It is a condition of Ethics Committee approval that you provide a brief progress report no later than May 1998 and at the completion of the study a copy of any report/publication for the Committee's records. Please notify the Committee if the study is abandoned or changed in any way.

We wish you well with your research.

Yours sincerely

Alison Douglass
CHAIRPERSON

Room 425, Fourth Floor, Community & Support Services
Wellington Hospital, Private Bag 7902, Wellington South
Tel: 04 385 5999 Ext: 5185 Fax: 04 385 5840 Email: sharonb@wec.org.nz

Appendix 2b: Information Sheet

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wananga o te Upoko o te Ika a Maui

April 1997

Full Project Title

Cultural Safety in Nursing and Midwifery Education and Practice in Aotearoa and Te Waipounamu.

Who is doing this research?

Ko Aoraki me Tararua nga maunga, ko Waimakariri me Manawatu nga awa, Uruao, Makawhiu, Tainui me Kurahaupo ko nga waka. Mihi atu ra.

My name is Irihapeti Ramsden, I am a Maori woman who has registration as a general nurse. My interests are in the anthropology of nursing and this research is part of my studies toward a Doctorate in Nursing and Midwifery Education at Victoria University in Wellington.

Lis Ellison-Loschmann of Ngai Tahu, Ngati Toa Rangatira, Ngati Raukawa and Te Atiawa will be working as the research assistant on this project. Lis will also be in contact with you regarding travel arrangements to Wellington, the university and home again if you decide to take part in this study.

What is this research about?

Since the introduction of the ideas and teaching of Kawa Whakaruruhau/Cultural Safety to nursing and midwifery students in 1988, there has been a wide interpretation of what Cultural Safety might be. It has been interpreted to mean many things to many people and has been the cause of a range of responses from numerous people and news media culminating in a Parliamentary Select Committee enquiry.

This study attempts to bring together key people who were involved in the development or the implementation of Cultural Safety in education and in practice as well as people who have been students and users of the health service. Your ideas and experiences will be gathered, and analysed in order to record the history of Cultural Safety accurately and your experiences will be compared with international theorists and educationalists who have worked in the area of emancipatory education. The development of an educational model for this country is the intended outcome. It is particularly important to discover whether there have been changes in nursing care since the introduction of Cultural Safety, which have been beneficial to patients.

What will you have to do?

If you agree to take part in the study it will involve either talking to the researcher about you experiences with Cultural Safety in an individual interview or as part of a

DEPARTMENT OF NURSING AND MIDWIFERY
P.O. Box 600, Wellington, New Zealand, Telephone +64-4-471 5363 or Freephone 0800 108 005
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group discussion with other study participants particularly if you have been a member of a committee or teaching team. In some cases, some of the participants would be asked to contribute in both individual and group interviews. You will be asked several questions just to focus you on the issues otherwise the interviews will be informal and open ended.

An important part of this research is to provide some kind of permanent record or you ideas and experiences as they form a vital base for the establishing of a history of race relations in this country with particular emphasis on health care and health services. For that reason we would like to both audiotape and videotape the interview with the view to retaining the videotapes at the end of the research and compiling an archive of the information which would be kept at the Nursing and Midwifery Department at Victoria University.

What happens to the information?

After the interviews Lis will transcribe the tapes, the transcription of your conversation will be sent to you (in a stamped addressed envelope) to check for accuracy and to give you the opportunity to edit material which you may subsequently wish to change or remove. You will also have the option of viewing the video or listening to the audiotape of you interview and making changes and/or editing the material as you wish.

Throughout the duration of the research, all information regarding the study will be stored and coded to protect your identity while the research is in progress. At the completion of the research, all information relating to the study will be destroyed except for the videotapes which will be kept to form part of an archive on the history of nursing and midwifery in New Zealand, with your permission. The final written copy of the research project will be available to you through Victoria University Library, the nursing and Midwifery Library and Te Runanga o Ngai Tahu.

Maori who wish to have information (tapes) held in a specific section of the archive with Kaitiakitanga (Maori guardianship) may opt to do so as may Midwives. It is not envisaged that there will be much information which people will wish to keep confidential, but if this is the case provision will be made to place protective access conditions around it. Further dissemination at hui, through Maori radio or other Maori media as well as to the Health Research Council through reports and hui.

Travel arrangements

It is hoped that all the interviews will take place in Wellington so this may involve extensive travel for you which would involve the best part of a day and for those involved in both individual and group interviews two days. Your travel fares have been included in the budget for the research which also includes taxi fares to and from the airport. Where possible either myself or Lis will pick you up and return you to the airport or your home if you live locally. We have also made provision for a small koha to thank you for your time and energy.

What are the benefits of the research?

Participants will be making a significant contribution to the development of a model for the teaching of Cultural Safety in New Zealand. This will assist the development of ways to enable Maori People to establish a code of rights and ethics in relation to Cultural Safety. The study will also be making a significant contribution to the establishment education programmes and provision of health care and health services which reflect the rights and needs of both Maori and non-Maori.

Appendix 2c: Participant Consent Form

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wananga o te Upoko o te Ika a Maui

PARTICIPANT CONSENT FORM

English	I wish to have an interpreter	Yes	No
Maori	E hiahia ana koe ki tetahi hei kai whakamohio.	Ae	Kao

1. Project title
Cultural Safety in Nursing and midwifery Education and Practice in Aotearoa and Te Waipounamu.

2. Researcher
Irihapeti Ramsden. Ngai Tahupotiki, Rangitane, Ngati Raukawa. Registered General and Obstetric Nurse (RGON), Midwife Hon (1994), Bachelor of Arts (B.A) Anthropology, Nursing Educationalist. Currently completing a PhD in Nursing and Midwifery Education at Victoria University.

3. Venue
Individual interviews and group interviews will take place at the Department of Nursing and Midwifery, Victoria University, 81 Fairlie Tce, Kelburn, Wellington or The Theatre and Film Studio, Victoria University, 77 Fairlie Tce, Kelburn, Wellington.

4. Aims and purpose of study
The aim of this study is to document the history and experience of people who have been involved in the development and/ or implementation of cultural safety education or been users of health services since its beginnings. Your ideas and experiences will be compared with international theorists and educationalists who have worked in the area of emancipatory education. This information will be important for the development of an educational model for cultural safety in New Zealand.

5. Description of inconvenience
There are no real or potential hazards anticipated for anyone taking part in this study. You will have full control over what and how much information you wish to share with the researcher. Transport will be provided if you require it for getting to and from the place of interview.

DEPARTMENT OF NURSING AND MIDWIFERY
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Facsimile +64-4-496 5442 E-mail Nursing-Midwifery@vuw.ac.nz

6. Ethical issues

I am aware that I may be involved in either an individual interview and/or may take part in a group interview. I understand that the interviews are being both audio taped and videotaped and that the videotape will be retained as a permanent record for public viewing as part of an archival history to be stored at the Department of Nursing and Midwifery at Victoria University. I will have the opportunity to view all the material concerning my interview and am free to edit or make changes in any way to the information that I have supplied for the research.

- I have read and understood the information sheet and consent form and have had the opportunity to discuss the study with the researcher, Irihapeti Ramsden.
- I know that I may withdraw from the study at any time and I understand that this withdrawal will not adversely affect my further health care.
- I understand that this study has been approved by the Central Regional Health Authority Wellington Ethics Committee and if I have any concerns about the study, I may contact the Ethics Committee, Wellington Hospital. Telephone 385-59999, ext 5185.

I .....(full name) hereby consent to take part in this study.

Date.

Signature.

Irihapeti Merenia Ramsden.

Phone : (04) 4721000 ex. 8891 or (04) 3861301

Appendix 3a: Te Tiriti O Waitangi

(From: Orange, C, ***An Illustrated History of the Treaty of Waitangi*,** 1990. This treaty text was signed at Waitangi, 6 February 1840, and thereafter in the north and at Auckland. It is reproduced as it was written. The original, in long-hand, is held by National Archives, Wellington).

TE TIRITI O WAITANGI

Ko Wikitoria to Kuini o Ingarani i tana mahara atawai ki nga Rangatira me nga Hapu o Nu Tirani i tana hiahia hoki kia tohungia ki a ratou o ratou rangatiratanga me to ratou wenua, a kia mau toms hoki to Rongo ki a ratou me to Atanoho hoki kua wakaaro is he mea tika kia tukua mai tetahi Rangatira - hei kai wakarite ki nga Tangata maori o Nu Tirani - kia wakaaetia a nga Rangatira maori to Kawanatanga o to Kuini ki nga wahikatoa o to wenua nei me nga motu - na to mea hoki he tokomaha ke nga tangata o tons Iwi Kua noho ki tenei wenua, a e haere mai nei.

Na ko to Kuini a hiahia ana kia wakaritea to Kawanatanga kia kaua ai nga kino e puts mai ki to tangata maori ki to Pakeha a noho tore kore ana.

Na kua pai to Kuini kia tukua a hau a Wiremu Hopihona he Kapitana i to Roiara Nawi hei Kawana mo nga wahi katoa o Nu Tirani a tukua aianei amua atu ki to Kuini, e mea atu ana is ki nga Rangatira o to wakaminenga o nga hapu o Nu Tirani me era Rangatira atu enei tore ka korerotia nei.

Ko to tuatahi

Ko nga Rangatira o to wakaminenga me nga Rangatira katoa hold ki hai i uri ki taua wakaminenga ka tuku rawa atu ki to Kuini o Ingarani ake toms atu - to Kawanatanga katoa o o ratou wenua.

Ko to tuarua

Ko to Kuini o Ingarani ka wakarite ka wakaae ki nga Rangatira ki nga hapu - ki nga tangata katoa o Nu Tirani to tino rangatiratanga o o ratou wenua o ratou kainga me o ratou taonga katoa. Otiia ko nga Rangatira o to wakaminenga me nga Rangatira katoa atu ka tuku ki to Kuini to hokonga o era wahi wenua a pai ai to tangata nona to wenua - ki to ritenga o to utu a wakaritea ai a ratou ko to kai hoko a meatia nei a to Kuini hei kai hoko mona.

Ko to tuatoru

Hei wakaritenga mai hoki tenei mo to wakaaetanga ki to Kawanatanga o to Kuini Ka tiakina a to Kuini o Ingarani nga tangata maori katoa o Nu Tirani ka tukua ki a ratou nga tikanga katoa rite tahi ki ana mea ki nga tangata o Ingarani.

[signed] W. Hobson Consul & Lieutenant Governor

Na ko matou ko nga Rangatira o to Wakaminenga o nga hapu o Nu Tirani ka huihui nei ki Waitangi ko matou hoki ko nga Rangatira o Nu Tirani ka kite nei i to ritenga o enei kupu. Ka tangohia ka wakaaetia katoatia a matou, koia ka tohungia ai o matou ingoa o matou tohu.

Ka meatia tenei ki Waitangi i to ono o nga ra o Pepueri i to tau kotahi mano a ware rau a wa to kau o to tatou Ariki.

Ko nga Rangatira o to Wakaminenga

A p p e n d i x 3 b : The English Translation of the Maori Treaty Text

(This English translation of the Maori treaty text, made by Professor LH. Kawharu, was printed in ***Report of the Royal Commission on Social Policy*****,** Wellington, 1988, pages 87-88. A comparison of this text with the English text of the 'official' version shows the crucial differences of meaning, especially in the first and second articles).

THE TREATY OF WAITANGI

Victoria, The Queen of England, in her concern to protect the chiefs and subtribes of New Zealand and in her desire to preserve their chieftainship and their lands to them and to maintain peace and good order considers it just to appoint an administrator one who will negotiate with the people of New Zealand to the end that their chiefs will agree to the Queen's Government being established over all parts of this land and (adjoining) islands and also because there are many of her subjects already living on this land and others yet to come.

So the Queen desires to establish a government so that no evil will come to Maori and European living in a state of lawlessness.

So the Queen has appointed me, William Hobson a captain in the Royal Navy to be Governor for all parts of New Zealand (both those) shortly to be received by the Queen and (those) to be received hereafter and presents to the chiefs of the Confederation chiefs of the subtribes of New Zealand and other chiefs these laws set out here.

The First

The Chiefs of the Confederation and all the chiefs who have not joined that Confederation give absolutely to the Queen of England for ever the complete government over their land.

The Second

The Queen of England agrees to protect the Chiefs, the subtribes and all the people of New Zealand in the unqualified exercise of their chieftainship over their lands, villages and all their treasures. But on the other hand the Chiefs of the Confederation and all the Chiefs will sell land to the Queen at a price agreed to by the person owning it and by the person buying it (the latter being) appointed by the Queen as her purchase agent.

The Third

For this agreed arrangement therefore concerning the Government of the Queen, the Queen of England will protect all the ordinary people of New Zealand and will give them the same rights and duties of citizenship as the people of England.

(signed) William Hobson

Consul and Lieutenant –Governor

So we, the Chiefs of the Confederation and the subtribes of New Zealand meeing here at Waitangi having seen the shape of these words which we accept and agree to record our names and mark thus.

Was done at Waitangi on the sixth day of February in the year of our Lord 1840.

The Chiefs of the Confederation

Appendix 3c: The Treaty of Waitangi – English text

(This English treaty text was signed at Waikato Heads in March or April 1840 and at Manukau harbour on 26 April. A total of 39 chiefs signed. The text became the `official' version).

THE TREATY OF WAITANGI

Her Majesty Victoria Queen of the United Kingdom of Great Britain and Ireland regarding with Her Royal Favor the Native Chiefs and Tribes of New Zealand and anxious to protect their just Rights and Property and to secure to them the enjoyment of Peace and Good Order has deemed it necessary in consequence of the great number of Her Majesty's Subjects who have already settled in New Zealand and the rapid extension of Emigration both from Europe and Australia which is still in progress to constitute and appoint a functionary properly authorized to treat with the Aborigines of New Zealand for the recognition of Her Majesty's sovereign authority over the whole or any part of those islands - Her Majesty therefore being desirous to establish a settled form of Civil Government with a view to avert the evil consequences which must result from the absence of the necessary Laws and Institutions alike to the native population and to Her subjects has been graciously pleased to empower and to authorise me William Hobson a Captain in Her Majesty's Royal Navy Consul and Lieutenant Governor of such -parts of New Zealand as may be or hereafter shall be ceded to Her Majesty to invite the confederated and independent Chiefs of New Zealand to concur in the following Articles and Conditions.

Article the first

The Chiefs of the Confederation of the United Tribes of New Zealand and the separate and independent Chiefs who have not become members of the Confederation cede to Her Majesty the Queen of England absolutely and without reservation all the rights and powers of Sovereignty which the said Confederation of Individual Chiefs respectively exercise or possess, or may be supposed to exercise or to possess over their respective Territories as the sole sovereigns thereof.

Article the second

Her Majesty the Queen of England confirms and guarantees to the Chiefs and Tribes of New Zealand and to the respective families and individuals thereof the full exclusive and undisturbed possession of their Lands and Estates Forests Fisheries and other properties which they may collectively or individually possess so long as it is their wish and desire to retain the same in their possession; but the Chiefs of the United Tribes and the individual Chiefs yield to Her Majesty the exclusive right of Preemption over such lands as the proprietors thereof may be disposed to alienate at such prices as may be agreed upon between the respective Proprietors and persons appointed by Her Majesty to treat with them in that behalf.

Article the third

In consideration thereof Her Majesty the Queen of England extends to the Natives of New Zealand Her royal protection and imparts to them all the Rights and Privileges of British Subjects.

[Signed] W. Hobson Lieutenant Governor

Now therefore We the Chiefs of the Confederation of the United Tribes of New Zealand being assembled in Congress at Victoria in Waitangi and We the Separate and Independent Chiefs of New Zealand claiming authority over the Tribes and Territories which are specified after our respective names, having been made fully to understand the Provisions of the foregoing Treaty, accept and enter into the same in the full spirit and meaning thereof in witness of which we have attached our signatures or marks at the places and the dates respectively specified.

Done at Waitangi this Sixth day of February in the year of Our Lord one thousand eight hundred and forty.

The Chiefs of the Confederation

Appendix 4: Interview Schedule

QUESTIONS FOR ALL PARTICIPANTS IN INTERVIEW AND VIDEOTAPE PROCESS AS PART OF RESEARCH FOR PhD. (IRIHAPETI RAMSDEN)

WITH THANKS TO ALL WHO HAVE GIVEN TIME AND ENERGY TO HELP WITH THIS RESEARCH.

THIS IS A SECTION OF CORE QUESTIONS WHICH WILL BE GIVEN TO EACH PARTICIPANT.

1 When did you first hear about Cultural Safety?

2 What impact did the concept have on you and why?

3 What is your main involvement with Cultural Safety now? Has it changed over time, how?

4 In your view what have been the key milestones or events in the evolution of Cultural Safety? Why? How?

5 What words first come to mind when Cultural Safety is mentioned or which ones do you associate with the concept? Why?

6 Tell us about your view of the evolution of Cultural Safety

- the concept
- in training/ learning environments
- in practice

7 Do you see any parallels between the evolution of Cultural Safety and any other developmental concept? Is so please discuss.

8 Is Cultural Safety safe?

9 What do you see as the greatest threats to Cultural Safety, why?

10 What do you see as the strengths of Cultural Safety, why?

11 How would you describe the current status of Cultural Safety in nursing and or midwifery?

12 Where would you suggest the Cultural Safety concept is heading?

13 Have there been any key turning points for you? Tell us about them.

14 Are you aware of any problems caused by misunderstandings or misinterpretations of Cultural Safety? Tell us about them.

15 What needs to be done to put them right or prevent a recurrence?

16 What effects do you think the media have had on the evolution of Cultural Safety? How? Why?

17 What vision do you have for Cultural Safety in nursing and midwifery? What must happen for that vision to be realised?

18 How would you describe the major characteristics of stereotypes of nurses and midwives in new Zealand?

19 How would you describe the major characteristics of stereotypes of Maori in New Zealand?

20 Please find enclosed several cartoons selected from the 1993 and the 1996 media response to Cultural Safety ideas. What words come to mind as you look at these cartoons what do you think are the concepts or ideas which have influenced the cartoonist's choice of illustration?

Nga mihi atu ra mo nga whakaaro nei me o tautoko. na,

Irihapeti raua ko Lis.

Thank you very much indeed for taking part in this research.

Appendix 5: Resolution to International Council of Nurses

INTERNATIONAL COUNCIL OF NURSES
Council of National Representatives

Resolution proposed by the member association of New Zealand

Indigenous People, Cultural Safety and Nursing

Whereas, 1995 is the start of the United Nations Decade for the world's indigenous peoples in the development of policies, strategies, planning and service delivery to improve their health status;

Whereas, many countries do not provide for full participation of indigenous peoples in the development of policies, strategies, planning and service delivery to improve their health status;

Whereas, the nursing component of the health service involves close and personal contact with a wide range of people receiving health services;

Therefore be it resolved,
That ICN promotes nursing education and practice that expresses respect for individual dignity, affirms that respect, and allows for the cultural expression and concerns of indigenous peoples;

Further be it resolved,
That NNA policies and documentation express respect for cultural expressions and concerns of indigenous peoples;

Further be it resolved,
That ICN develops guidelines for NNA's to encourage cultural safety in nursing education and practice.

Harare, 1995

Appendix 6: Report on Education/Science Committee

REPORT ON THE EDUCATION AND SCIENCE COMMITTEE BRIEFING FROM THE NURSING COUNCIL OF NEW ZEALAND ON THE CULTURAL SAFETY COMPONENT OF THE NURSING EDUCATION CURRICULUM

Introduction

This report is to inform the House on a briefing received on 31 July 1997 from the Nursing Council of New Zealand (the Nursing Council). It concerns the council's audit of comprehensive nursing courses in polytechnics. The impetus for this audit arose from an inquiry the Education and Science Committee in the last Parliament commenced into the cultural safety component of the nursing education curriculum but did not complete. The previous committee made an interim report to the House on this inquiry on 27 August 1996. An account of the progress the previous committee made on this inquiry is attached as an appendix.

Background

To register as a nurse or midwife the Nursing Council requires students to demonstrate that they are culturally safe in their nursing or midwifery practice. In 1995, a public debate on the cultural safety component of the nursing education curriculum culminated in the then Education and Science Committee commencing a formal inquiry into this topic. This led to the Nursing Council developing guidelines for cultural safety in nursing and midwifery education.[11]

Audits

On 12 September 1996, the council resolved to conduct a pilot audit of the comprehensive nursing courses at the fifteen polytechnics that prepared applicants for registration as comprehensive nurses. The purpose of the pilot audit was to obtain baseline data, trial the audit tool, and evaluate the educational processes for preparation of comprehensive nurses for safe practice including cultural safety. The council intend' that future audits will be developed from this experience.

During October/November 1996 and February/March 1997, Nursing Council auditors undertook evaluative research using the pilot audit tool. This tool included examination of written documentation, face-to-face interviews, and site visits during one or two days spent with the fifteen polytechnics preparing applicants for registration as comprehensive nurses.

Audit results

The Nursing Council reports that the audit results show, " Educational processes were of a high standard. The courses retain their comprehensive focus and integrate cultural safety. Concerns expressed by the Parliamentary Education and Science Committee and the Nursing Council Cultural Safety Review Committee in 1995 have largely been resolved and their recommendations implemented.

Where necessary, advice and guidance has been provided in the individual polytechnic audit reports.[2]

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[1] Guidelines for Cultural Safety in Nursing and Midwifery Education, July 1996

[2] Report Audit of Cultural Safety in Comprehensive Nursing Education, Nursing Council of New Zealand, July 1997, p 3

The Nursing Council also states that, "Students informed the auditors that cultural safety education relates to nursing practice, the teaching and learning process is free from threat and guilt, and academic freedom is encouraged." [3]

The Nursing Council asserts that its guidelines provide for national consistency and are being implemented in 1997. "Staff development processes are in place to assist teachers to develop skills in facilitation and conflict resolution. Any previous confusion between Maori studies and cultural safety content and principles has been resolved with input from nurse teachers, including appropriately qualified Maori nurses, answerable to the heads of the nursing departments. All courses and committees are monitored through the New Zealand Qualifications Authority required polytechnic quality systems."[4]

Additional information sought

We sought additional information from the Nursing Council on the

- rationale for the development of the cultural safety component of the nursing education curriculum;
- breadth of the course, including which cultures are focussed on;
- consistency of delivery of the nursing curriculum;
- consistency of assessment in the nursing curriculum; and
- failure rates among nursing students.

Rationale for the development of the cultural safety component of the nursing education curriculum

The Nursing Council states briefly that, "The cultural safety component of nursing and midwifery education is derived from Government led social and health initiatives to improve health outcomes for all people in New Zealand."[5]

A more detailed rationale for the cultural safety component of the nursing education curriculum appears in the council guidelines. It states that, "The purpose of cultural safety in nursing and midwifery education goes beyond describing the practices, beliefs and values of ethnic groups. Learning about the ritual, customs and practices of any group assumes that by learning about one aspect, insight can be gained into the complexity of human behaviours and social realities. The assumption that cultures are simplistic can lead to a checklist approach by service providers.

Cultural safety education is focussed on the self-knowledge of the nurse or midwife rather than on attempts to learn accessible aspects of other groups. A nurse or midwife who understands his or her own culture and the theory of power relations can be culturally safe in any human context.

Nurses and midwives work with the pragmatic daily social realities of people, many of whom do not have their own `cultural information'. Nurses and midwives require knowledge and skills to work with behaviours that result from a series of sophisticated social and personal events.

Past codes of ethics stated that people should receive care `without regard to their sex, race or culture, or their economic, educational or religious backgrounds'.[6] While the intent was that all

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[3] Op cit, p 4
[4] Ibid
[5] Report of the Nursing Council of New Zealand for the year ended 31 March 1996, p7

people should receive care as of right, the emphasis on universal equality *regardless of* these diversities tended to negate individual differences. Cultural safety requires that all human beings receive nursing and midwifery care *regardful of* all that makes them unique." [7]

Breadth of the course, including which cultures are focussed on

The Nursing Council claims that the breadth of the integration of cultural safety into the comprehensive nursing courses is covered in the four cultural safety principles set out in the council's guidelines. They are in summarized form.

- Cultural safety aims to improve the health status of New Zealanders and applies to all relationships;
- Cultural safety aims to enhance the delivery of health and disability services through a culturally safe nursing and midwifery workforce;
- Cultural safety is broad based; and
- Cultural safety has a close focus on the understanding of self, the rights of others and the legitimacy of difference.[8]

Consistency of delivery of the nursing curriculum

The Nursing Council informed us that the *Standards for Registration of Comprehensive Nurses* and the *Guidelines for Cultural Safety in Nursing and Midwifery Education* provide for national consistency. The fifteen nursing departments, audited in October/November 1996 or February/March 1997, all comply with the structure, process and outcome standards. The guidelines are being implemented in 1997.

Consistency of assessment in nursing education curriculum

The Nursing Council states that the fifteen polytechnic nursing departments set formative and summary assessments throughout the pre-registration courses. All applicants for registration must sit the State examination required in the *Nurses Regulations 1986.* The polytechnic assessments are subject to the rigorous New Zealand Qualifications Authority approved quality assurance processes required for all units of degree courses. This includes internal and external moderation processes. The external moderators are nurse educators with appropriate expertise from two other polytechnics.

Failure rates among nursing students

Failure rates are very low. They range from 1.62 to 4.01 percent for the five years from 1992 to 1997.

Value of the Education and Science Committee Inquiry

The Nursing Council has informed us that, although the previous Education and Science Committee's inquiry was suspended and, therefore, not completed, it has acted as an incentive for the Nursing Council to audit carefully how the polytechnics were delivering the cultural safety component of the nursing education curriculum. The results of the audit are satisfactory to us and we hope they will allay any misgivings that were held by many students and commentators

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[6] For example, Auckland Hospital Board, circa 1970s, 1980s: Code of Rights and Obligations: Patients and Staff. All Hospital Boards had similar publications that were distributed to patients and used as a basis for teaching ethics to nurses.

[7] Guidelines for Cultural Safety in Nursing and Midwifery Education, July 1996, Nursing Council of New Zealand, p 10

[8] Op cit, pp 10-12

on the this course component two years ago. The Nursing Council intends to continue conducting regular audits of this programme. This should identify any further problems should any arise.

Conclusion

We are satisfied that the cultural safety component of the nursing education curriculum is now taught by polytechnics in a professional and educationally sound manner. We will, therefore, not re-initiate the previous Education and Science Committee's inquiry. However, should any further problems arise with the teaching of the cultural safety component of the nursing education curriculum, we will discuss with the Nursing Council what their audits show and whether an inquiry by us is warranted.

Tony Steel
Chairperson
Education and Science Committee

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