Nursing Praxis in New Zealand

KAWA WHAKARURUHAU

CULTURAL SAFETY IN NURSING EDUCATION IN AOTEAROA (NEW ZEALAND)

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First I must acknowledge the ancestors of our peoples and the guidelines they have left for the people of the future. Then I acknowledge the energies and commitment of other Maori who have given time to the work of cultural safety, and to my family who have provided a safe place when the road has been rough. Tauiwi, people who are not Maori have often been strong and indeed brave in helping this process of positive change in nursing service.

I also wish to acknowledge the work of Madeleine Leininger as the nurse theorist who first addressed the issues of race relations in nursing. Her work has provided a body of knowledge which introduces nurses to the very notion of cultural difference, and has been a way of shifting nursing philosophy from the ethnocentrism of the nineteenth century English, Nightingale stance.

Nursing has entered the last decade of the twentieth century and the time to review the philosophy which underpins the service we offer to our fellow human beings has well and truly arrived. These last few years before the new century give nurses time to review the nursing story, to analyse the behaviours of people being nurses, to listen to the impact that those behaviours have on others and to adjust our service accordingly. We can no longer afford to think that nurses give service irrespective of nationality, culture, colour, age, sex, political or religious beliefs, or social status. One word needs to change, that word is respect. Our service delivery must be respectful of all those things. And the recipients of our service must be able to say that it is so.

The view which human beings have of themselves, of what they hold to be important, and of their own way of doing things is fundamental to human existence. Conflicts which are happening all over the surface of the Earth today, attest to that.

Nurses move through the landscape of others, through the experiences of other people and other realities. Nurses often do not know the meanings of the signs in the landscapes of others.

When people move into the nursing reality and become labelled as patients or clients, there are powerful attempts to reshape them to conform to the culture of nursing, often with a great deal of success because nurses are very powerful. Nursing culture is upheld by specialised knowledge. People need what we have to offer and they cannot readily obtain it elsewhere.

A TIME OF REDEFINITION

Historians will describe this period in the Pacific as post-colonial. A time of redefinition of identity, of argument for the redistribution of power and resources from the indigenous peoples and frequently of conservatism and retrenchment by the descendants of the colonists. In common with indigenous peoples the world over, the Maori of Aotearoa are beginning to recover sufficiently from the horrors of the colonial experience to carry out a process of analysis and examination of the New Zealand health service. It has not stood up well to scrutiny in local or in international terms.

The people who now share the collective name Maori, are descended from the magnificent navigating and seafaring men and women who were moving regularly around Te Moananui a kiwa (the Pacific Ocean) before the Vikings left their land (Campbell 1989:32).

Prior to Tupaea the Tahitian aristocrat guiding James Cook to Aotearoa, several Polynesian cultures had established their civilisations and grown and multiplied as human beings do. In common with the rest of the Pacific cultures, Cook's arrival heralded the beginning of a devastating experience for the local people.

The Treaty of Waitangi is a document which was carefully considered by the Maori signatories and was seen as an agreement for the future. After the Maori agreement with the British Crown permitted emigration to Aotearoa, colonial activity accelerated at an unimagined pace. The importation of the normal western infectious diseases to the Polynesians quarantined in the Pacific for three thousand years, the wars to preserve the land and home and the powerful legislative processes which followed rapidly reduced most Maori to landless poverty. The resulting change in numbers permitted the imposition of another law and another series of beliefs threatened the every core of the Maori world view. The result has been a serious failure of the Maori future by the systems established to enable the colonists to make a profitable life for themselves in the new land. Data collected from the health, education, criminal justice and social welfare systems demonstrate unequivocally that the descendants of the great Polynesian mariners have been very poorly served. The development of the nursing service and the education of nurses is part of that story.

The powerful drive for change has come from the people at risk. There are now sufficient numbers of people beginning to recover from the horrors of colonisation. A thin middle class of urban educated Maori pragmatists is addressing issues of institutional racism at all levels of government and social institutions.

Maori have identified education as a critical area to effect rapid change and a great deal of energy has gone into creating an independent Maori pre-school movement, a Maori primary school system and now the first secondary school. All the usual curricular subjects are taught and they are completely taught in Maori.

Nursing education has been similarly identified. The change process which has been adopted is well known in health promotion.

Raise awareness

Increase knowledge

Change attitudes

Change behaviours

The last two can be reversed.

My own experience has been in education where I have been able to work on a national basis. The issues have been:

1. Attitude and behaviour change in nurse teachers

2. Attitude and behaviour change in student nurses

3. Curriculum change, recruitment and retention and the maintenance of the cultural safety of Maori students.

4. Changes in service delivery to Maori and to people of other cultures.

To this end the process and outcome called cultural safety was designed. It is in line with the requirement that nurses be legally, ethically, and physically safe to practice and that practice is underpinned by a sound knowledge base. Cultural safety differs in some fundamental areas from the idea of transcultural nursing.

CULTURAL SAFETY

As the architect of this work and as a person who belongs to a culture which has experienced the impact of colonisation and the social dislocation and destruction which it brings, I find the notion of establishing any cross cultural communication which is not bicultural, a dual relationship with the people I nurse, unacceptable. Multiculturalism is simply a statement of the range of cultural groups present in a society if those people do not have the power to define and negotiate the policies and practices which would ensure cultural safety for their own people.

From my position as an indigenous woman, transcultural nursing assumes an external and observer position. Nurses are taught to observe people according to their culture specific behaviour from a multicultural model. They therefore think that they require a sort of cultural check list. A cultural smorgasbord. Such a model does not allow for the diversity within cultures, for the differences between conservative and liberal, age and youth, urban and rural, rich and poor and gender interaction.

Cultural safety contends that all nursing interactions are bicultural, that interaction can only be with one person at a time. There is one giver of a message and one receiver regardless of the number of people or the number of cultural frameworks through which the message is filtered.

Cultural safety also contends that transcultural nursing does not require nurses to examine their own cultural realities, their own attitudes and behaviours and the impact that that has on others. The nurse as a culture bearer is the focus of cultural safety. The educational process is designed to alert nurses to their own behaviour and to the behaviour of colleagues which may place people at cultural risk. It is much more common for nurses to consider that what they are offering is what people want. The focus is often on clinical and technical competence. This is only correct up to a point. What is critical cross culturally is how that service is delivered. Without an established process of consultation and feedback with consumers of their service, that is what nurses will continue to think. The frank opinion of people who are culturally different must be included in any assessment of service delivery and cultural risk must be included as a legitimate category for assessment.

Cultural risk in nursing describes a process whereby people from one culture believe that they are demeaned, diminished and disempowered by the actions and the delivery systems of people from another culture (Wood & Schwass, 1993:2).

The conscious or unconscious behaviours of people whose culture has the power to define service policies and practice may cause those from other cultural groups to feel powerlessness, anger and humiliation often resulting in avoidance of the service. In Maori that response is called whakama. to make things white. an emotional whiteout. There will be equivalents in all cultures.

The objectives of cultural safety in nursing education are:

1. To educate registered nurses to examine their own cultural realities and the attitudes they bring to each new person they encounter in their practice.

2. To educate registered nurses to be open minded and flexible in their attitudes toward people from differing cultures to whom nurses offer and deliver service.

3. To educate registered nurses not to blame the victims of historical and social processess for their current plight.

4. To produce a workforce of well educated, self aware registered nurses who are culturally safe to practice.

CULTURAL SAFETY IN NURSING EDUCATION

After the experience of teaching student nurses from a culture different from mine, I very rapidly learned that there needed to be a different process of education for change. It was clear that I could not influence students who voted with their feet, they simply boycotted my classes. There is no 'trickle up' pedagogy.

I learnt that if change in attitude was to be achieved two things had to happen. The first was that the power holders in nursing education had to be convinced that there was credibility in changing the curriculum to include an intensive process of historical and cultural self examination for students. The second was that this process had to be related to nursing practice. Marketing attitude change in race relations is a long term matter and this work was urgent.

In 1989 I was appointed to the Education committee of the Nursing Council of New Zealand on which several New Zealand nursing visionaries were sitting. This was the first Maori appointment.

In 1990 a report on cultural safety in nursing education was commissioned by the Heads of Department of all but one of the schools in New Zealand. This report described ways in which cultural safety might be incorporated into nursing education. The report was the result of discussion with Maori who were nurses and other Maori (Ramsden 1990).

The decision was made by the Nursing Council Education Committee to require nursing schools to build obligations to the Treaty of Waitangi into their mission statements and into their nursing philosophies. The New Zealand Nursing Council is required by statute to examine the curriculum of every school of nursing and to set and administer the national State examinations for registration as nurses or midwives.

In 1991 cultural safety became a fixed curriculum requirement because Nursing Council introduced a twenty percent factor of cultural safety into the national examination for Comprehensive Registration. This was based on the categories of safe knowledge base as demonstrated by academic and clinical competence, legal safety and ethical safety. Cultural safety was added to the nursing vocabulary.

In 1992 the Nursing Council commissioned me to write a set of guidelines for the

content of cultural safety in curricula throughout the country. In these guidelines it has been made emphatically clear that Maori do not wish nurses to become ethnologists studying the 'habits and customs of the natives' in a nineteenth century armchair anthropological style.

Extinguishment of stereotype is fundamental to introducing nurses to the range of people who come within a definition of Maori. Until the recent and massive urban migration of Maori (eighty percent of the population since 1945) the majority of pakeha responded to a stereotype of Maori which has its roots in the early 19th century. Happy go lucky, childlike and not too bright, were some of the less pejorative components. This was refined within nursing to include irresponsibility and non-compliance, having far too many children and living in sub standard social conditions and therefore bringing misfortune upon themselves. This stereotype and the element of victim blaming are very common in cross cultural power imbalance.

Nurses in New Zealand, without the benefit of a broadly based social education, were confusing the cultures of the indigenous people with the culture of poverty into which the indigenous people have been driven. It follows then that cultural safety requires nurses to become expert in understanding the poverty cycle and the various histories and socio-political conditions which establish and maintain it. Nurses as the front line workers in primary health settings need to understand the effects of unemployment and the attempts of indigenous peoples to re-establish economic, social and emotional stability within their own cultural frameworks.

Nurses have very cogent political roles in working beside and behind these initiatives rather than directing and 'matronising or patronising' the efforts of people to take control of their own health, politics and status. Because of the importance of this role nurses from the dominant British based cultures are taught to recognise the unconsciously held attitudes of their Victorian forbears within themselves.

The issue of replacing the history of race relations in Aotearoa was of critical importance because like all countries which have undergone the colonial experience, the colonists have suffered a case of historical amnesia when it comes to describing the facts of the imposition of one culture upon another. Revisionist history is included as a replacement for that omission in the formal primary and secondary education system so that nurses are enabled to understand the background to the range of Maori responses which they will encounter in their practice.

The goodwill toward the idea of change has been clear in almost all the teaching institutions but the management of the change has been extremely variable and often naive. Because the employers have been from the dominant culture they have often defined the bicultural content of their programmes by employing people who conformed to their own stereotypes of Maori. This has led to the employment of Maori who are often not professional nurses and generally have little formal western education or who are employed in pakeha institutions as teachers of selected parts of Maori cultures. In the power relationship between the lucrative nurse employer and 'cultural' teacher, the Maori response has often been angry, romantic or unrelated to nursing.

Student nurses have strongly objected to being taught songs, games and prayers in Maori, or to being unskillfully challenged, asking instead for education in issues relating to Maori health. While they value some subjective discussion as well as the

experience of spending time in the cultural environment of Maori people, the political, emotional and cross cultural preparation needs to be extremely skilled.

The rush to find Maori to work in nursing education institutions has had a curious effect. Notions of affirmative action while constructive in themselves, have led to the employment of second level nurses to teach in the Comprehensive diploma, highlighting the professional knowledge deficit undermining credibility and reinforcing the stereotype of the poorly educated Maori.

The recruitment of Maori students straight from programmes who have had no practice as comprehensive graduates also seriously undermines their credibility. Often with the best will in the world Maori teachers in nursing can be set up to fail. This situation is usually further complicated by the very few numbers of Maori nurse graduates who have been able to obtain university degrees, often because of family income requirements to work in a time of very high Maori unemployment.

Currently Maori nurses are facing the need to obtain masterates to work in the mushrooming climate of nursing degrees. Affirmative action programmes need to go further than simply bringing a Maori into a teaching environment. Bringing people to the starting line after over a hundred years of educational disadvantage is not enough. If Maori are to remain safe as teachers and indeed, if they are to succeed in the teaching workforce there must be pro-active policies which enable this group of people to achieve the required standards.

Post graduate nursing education must also teach cultural safety so that potential nurse leaders and educators are prepared to work with the concept and the reality.

Experience is beginning to show clearly that cross cultural exposure for the predominantly conservative nursing students in New Zealand society needs to take place after the first year of the programme. The new degree programme at the Otago Polytechnic Department of Nursing and Midwifery has adopted a completely different approach to cultural safety. The first year is an exercise in cultural relativism. The students are placed in an historical and social evolutionary context. They examine the development of their own culture in relation to the great mainstream cultures of the world. The aim of this approach is to introduce students to ethnocentrism and enable them to understand the evolution and practice of personal and institutional racism so that ultimately they may recognise it in their own practice and that of colleagues. Students are taught that all cultures are prejudiced about other cultures, but only those who have the power to enforce their ignorance in their personal behaviour and in institutional policy and practice can be truly described as racist.

This Department shares the legal ownership of the curriculum, the intellectual property ownership of the process and the Treaty partnership model with the tribal group, Ngai Tahupotiki, who helped devise and implement it. A second school is moving in this direction with the establishment of a treaty based curriculum. A further school of nursing provides opt out time for Maori students which gives them specialised information on internal cultural matters which strengthens them in their own direct intracultural practice. Since there are over 43,000 non-Maori nurses and approximately 1,700 Maori, this process is intended to strengthen Maori nurses so that they can also lead the service given by non-Maori.

The evaluations of the Otago approach are coming through very favourably from students, tutors and from people of other

cultures who are using the nursing service. Much of cultural safety can be taught by people from the dominant cultural group after they have been through an educational process which ensures that they are culturally safe to teach. This process is a norm in several polytechnics where ongoing staff development in race relations and education in Treaty of Waitangi issues has been integrated into routine staff development. Some polytechnics have provided courses for specialised nurse trainers in treaty issues who regularly teach in the surrounding communities at a profit to their institution.

The basic requirements for inclusion in cultural safety education as required by the Nursing Council of New Zealand are:

Racism awareness training-specialised course.

Treaty of Waitangi training-specialised course.

Understanding attitude.

Discovering self and examination of own cultural norms.

The colonial process.

Political processes and their value bases.

Social control.

Urbanisation.

The causes of violence.

Demography and demographic projection.

Unemployment and the poverty cycle.

Institutional racism and the development of policy.

Specialised cultural information (taught by people from within the culture concerned).

Maori health initiatives.

Maori social responses.

The international view.

Cultural safety is about power relationships in nursing service delivery. It is also about power relationships between tutors and students of differing cultures. It is about setting up systems which enable the less powerful to genuinely monitor the attitudes and service of the powerful, to comment with safety and ultimately to create useful and positive change which can only be of benefit to nursing and to the people we serve.

The unique bicultural focus in Aotearoa has provided a seedbed of change for all cultures which have emigrated there by virtue of the Treaty of Waitangi and the agreement of Maori to permit immigrants to live in peace. Signed in 1840 this agreement was written for the future.

Nursing in New Zealand has moved with this relationship with the indigenous people and is at the forefront of real change. Change has been naive, painful, misunderstood and resisted. It has also been exciting and at times triumphant, and is absolutely inevitable. It is the right time for this idea. This is part of the process toward the maturing of the new societies which make up the recent story of the islands which some call New Zealand and some call Aotearoa.

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