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**ARTICULATING CULTURAL PRACTICE
WITHIN A NEW ZEALAND NURSING
CONTEXT**

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requirements for a

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ABSTRACT

The aim of the research was to examine nurses' accounts of how they apply the principles of the Treaty of Waitangi and cultural safety in their practice. In addition to this the research has sought to identify if there is a different understanding of cultural practice between nurses from different backgrounds, and understand how nurses assess that their practice is culturally safe, as determined by the patient.

A qualitative approach was employed for this study and data were collected from 22 registered nurses through semi-structured interviews using open ended questions. Participants were assigned to four groups 1) European nurses trained before 1990 2) European nurses trained after 1990, 3) Māori nurses and 4) International Qualified Nurses. Inductive techniques were used to analyse the data collected.

Four main themes and eight sub-themes emerged from the data in relation to caring for Māori patients and patients from other cultural backgrounds. Participants through their accounts demonstrated their application of the principles of the Treaty of Waitangi and kawa whakaruruhau when caring for Māori patients and whānau, and cultural safety when caring for patients from culturally and linguistically diverse (CALD) populations. Some differences in practice between the participant groups emerged. From their accounts of observing colleagues in practice, participants highlighted that cultural safety was inconsistently applied in practice and marginalization of Māori still occurs within health care environments.

While the results of this research affirm cultural safety as an appropriate framework to enable nurses to meet the diverse needs of patients they care for, they also indicate that further review of the cultural safety model is needed to more effectively address the needs of Māori patients and patients from CALD backgrounds. It is also recommended that the cultural context of practice is consistently integrated into post-registration education in clinical practice and post graduate education.

Dedication

In memory of

Rangi Tearai Baker (nee Morgan)

19 December 1932 - 6 July 2001

And

Keith Wallace Baker

21 February 1928 – 3 February 1987

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Mehemea ka moemoeaa ahau ko ahau anake
Mehemea ko moemoeaa e taatou ka taea e taatou

“If I dream I dream alone. If we dream together then we will achieve...”

Te Puea Herangi

Many people have been part of my nursing journey, my whānau and friends, colleagues I have worked with, patients and families I have care for, all have influenced and continue to influence my own cultural practice.

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TABLE OF CONTENTS

ABSTRACT.....	ii
DEDICATION.....	iii
ACKNOWLEDGEMENTS.....	iv
TABLE OF CONTENTS.....	v
LIST OF TABLES AND FIGURES.....	viii
GLOSSARY.....	ix
CHAPTER 1 INTRODUCTION AND BACKGROUND	
1.1 Introduction.....	1
1.2 Purpose and rationale.....	3
1.3 Background.....	5
1.4 Professional responsibility.....	6
1.5 Summary.....	7
CHAPTER 2 LITERATURE REVIEW	
2.1 Introduction.....	9
2.2 Key concepts.....	10
2.3 Cultural diversity within an international context.....	13
2.4 Cultural diversity within the New Zealand context.....	18
2.5 The international nursing context.....	23
2.6 Nurse-patient encounters.....	30
2.7 Patient autonomy.....	35
2.8 The New Zealand nursing context.....	37
2.9 The development of cultural safety.....	43
2.10 Introduction of cultural safety.....	46
2.11 Cultural safety education.....	49
2.12 Comparisons of cultural safety, cultural competence and transcultural care.....	51
2.13 Application to policy and practice.....	54
2.14 Barriers to application to practice.....	58
2.15 Assessment of culturally safe practice.....	60
2.16 Conclusion.....	62
2.17 Summary.....	63
CHAPTER 3 METHODOLOGY	
3.1 Introduction.....	65
3.2 Qualitative methodology.....	66
3.3 Participant selection and recruitment.....	67
3.4 The participants.....	69
3.5 Data collection.....	71
3.6 Data analysis.....	73
3.7 Ethical considerations.....	76
3.8 Research rigour.....	77
3.9 Summary.....	80
CHAPTER 4 CARING FOR MĀORI PATIENTS: FINDINGS AND DISCUSSION	
4.1 Introduction.....	81

4.2	Establishing positive working relationships.....	82
4.2.1	Communication skills.....	82
4.2.2	Developing relationships.....	88
4.3	Working positively to achieve outcomes.....	91
4.3.1	Models of patient care.....	91
4.3.2	Accessing resources.....	94
4.4	Supporting patient autonomy, empowering patients.....	97
4.4.1	Enabling informed choices and decisions.....	97
4.4.2	Culturally safe care.....	100
4.5	Awareness of and managing personal (nurses') stereotype and power.....	101
4.5.1	Challenging assumptions and stereotypes.....	101
4.5.2	Sharing power.....	103
4.6	Discussion of findings related to caring for Māori patients.....	106
4.6.1	Establishing positive working relationships.....	108
4.6.2	Working positively to achieve outcomes.....	109
4.6.3	Supporting patient autonomy, empowering patients.....	111
4.6.4	Awareness of and managing personal (nurses') stereotype and power.....	112
4.7	Conclusion.....	114

**CHAPTER 5 CARING FOR PATIENTS FROM OTHER CULTURAL
BACKGROUNDS: FINDINGS AND DISCUSSION**

5.1	Introduction.....	115
5.2	Establishing positive working relationships.....	115
5.2.1	Communication skills.....	116
5.2.2	Building relationships.....	121
5.3	Working positively to achieve outcomes.....	125
5.3.1	Models of patient care.....	126
5.3.2	Accessing resources.....	129
5.4	Supporting patient autonomy, empowering patients.....	130
5.4.1	Enabling informed choices and decisions.....	130
5.4.2	Culturally safe care.....	131
5.5	Awareness of and managing personal (nurses') stereotype and power.....	133
5.5.1	Challenging assumptions and stereotypes.....	134
5.5.2	Sharing power.....	134
5.6	Discussion of findings related to caring for patients from other cultural backgrounds.....	135
5.6.1	Establishing positive working relationships.....	136
5.6.2	Working positively to achieve outcomes.....	137
5.6.3	Supporting patient autonomy, empowering patients.....	137
5.6.4	Awareness of and managing personal (nurses') stereotype and power.....	138
5.7	Conclusion.....	139

**CHAPTER 6 CONCLUSION, IMPLICATIONS FOR POLICY AND
PRACTICE, LIMITATIONS, IMPLIATIONS FOR FUTURE
RESEARCH, RECOMMENDATIONS**

6.1	Contribution of the research to understanding cultural safety in practice.....	141
6.3	Implications for practice and policy.....	147
6.4	Limitations of study.....	149
6.5	Implications for future research.....	150
6.6	Recommendations.....	151

APPENDICES

I Consent form..... I
II Participant information sheet..... III
III Confidentiality agreement..... VI
IV Semi-structured interview schedule.....VII
V Vignettes.....IX
VI Ethics approval.....X

REFERENCES.....XII

LIST OF TABLES

Table 1: European nurses trained in New Zealand prior to 1990

Table 2: European nurses trained in New Zealand after 1990

Table 3: Māori nurses trained in New Zealand

Table 4: International Qualified Nurses (IQN)

Table 5: Main themes and sub-themes

Table 6: Proposed cultural theoretical framework

GLOSSARY

Aotearoa	New Zealand
Aroha	love
Hapū	sub-tribe
Hui	meeting
Iwi	tribe
Kaitiaki	guardian, Māori patient advocate
Karakia	prayer
Kaumātua	older man, elder
Kaupapa	purpose
Kawa whakaruruhau	cultural safety within a Māori context
Kia ora	hello
Kōrero	speak
Kuia	older Māori woman
Manaaki	hospitality
Marae	area in front of meeting house
Mokopuna	grandchildren
Pākehā	non-Māori, European
Pōkai	assembly (especially Tainui/Waikato)
Rangatiratanga	sovereignty
Tangata	people
Tangata whenua	people of the land
Taonga	treasure
Tangi	funeral
Tapu	sacred
Te reo Māori	Māori language
Te Tiriti o Waitangi	the Treaty of Waitangi
Te Whare Tapa Whā	the four cornerstones of a house
Te Wheke	the octopus
Tikanga	custom
Tino rangatiratanga	self-determination
Tupuna/tipuna	ancestors
Waiata	song
Wairuatanga	spirituality
Whakapapa	ancestry
Whakawhanaungatanga	kinship ties
Whānau	family

CHAPTER ONE

Introduction and background

1.1 Introduction

Cultural safety was introduced in New Zealand nursing initially as a strategy to address health issues for Māori and improve access to health services. Cultural safety education enables nurses and students to examine their own culture and theory of power relations in the nurse-patient relationship (Cooney, 1994; Coup, 1996; Ramsden, 1990a, 1990b, 2000; Spence, 2003). However, previous research indicates that it is unclear how the principles of the Treaty of Waitangi and cultural safety are applied in nursing practice, and how these impact on health outcomes for Māori and patients from other cultural backgrounds (Clear, 2008; De Souza, 2005; Mortensen, 2010; Richardson, 2004; Richardson & Williams, 2007; Wilson, 2008). Evidence indicates indigenous people may be reluctant to utilise health services, or they delay seeking treatment, in response to inappropriate care in relation to their cultural values and beliefs, victim blaming, stereotyping, previous negative health experience, and racism experience, all of which contribute to poor health statistics (Ramsden, 1990a, 1990b; Turale & Miller, 2006; Walker, Cromarty, & Kelly, 2009; Wilson, 2008). The relevance and effectiveness of cultural safety for culturally and linguistically diverse (CALD) populations is also being questioned and nurses express they need more knowledge of values and beliefs for different ethnic populations (De Souza, 2005, 2008; Mortensen, 2008, 2010; North, Lovell, & Trlin, 2006).

Previous studies related to cultural safety in nursing generally focus on the theories and concepts underpinning cultural practice, together with the principles, the value of cultural safety, related education programmes and implications for practice. However, there is limited evidence of the application in practice or efficacy of cultural safety for the benefit of the patient (Clear, 2008; Cooney, 1994; Coup, 1996; Mortensen, 2010; Ramsden, 2000; Spence, 2003; Wilson, 2008). This may be influenced by the fact that asking patients if the care they have received has been culturally safe, has the potential to put them in a difficult situation, because of fear that if they express a negative opinion, this might compromise their future care (Wilson, 2008). In other words, although cultural safety is a concept integrated into nursing education and

practice in New Zealand, it is not necessarily understood by patients. New Zealand researchers have highlighted that further research on application to practice is required (Clear, 2008; Mortensen, 2010; Richardson, 2004; Richardson & Williams, 2007; Wilson, 2008) as the Nursing Council (2007, p.9) requires nurses to “practice nursing in a manner that the client determines as being culturally safe”. Throughout this research the term ‘patient’ is used in preference to other commonly used terms such as client or health consumer. The purpose of this research is not to examine care from the patients’ perspective but focuses instead on developing an understanding of how nurses describe and assess the cultural care they deliver during their practice is culturally safe.

This thesis was undertaken to examine registered nurses’ articulation of their cultural practice within a New Zealand context, specifically the application of the principles of the Treaty of Waitangi, the principles of kawa whakaruruhau (cultural safety in the Māori context), and cultural safety to practice. Although these are required core competencies for the registered nurse scope of practice under the Health Practitioners Competence Assurance (HPCA) Act (2003), there is little evidence of how these principles are applied to clinical practice (Clear, 2008; Richardson, 2004; Richardson & Williams, 2007; Wilson, 2008). Richardson and Williams (2007, p.706) suggest:

The risk of misconceptions around the concept of cultural safety remains and potentially forms a barrier to implementation into practice. Cultural naivety is often still expressed even when cultural safety is taught. Cultural assumptions continue to risk negative outcomes and provide an environment for misinterpretation. Continued failure to recognize the potential implications can negatively impact on delivery of patient care.

In addition, anecdotal evidence is that some nurses remain unsure of the differences between the frameworks and application to their clinical practice. This research shows that research participants from different backgrounds, based on their ethnicity and training background, in general used these frameworks as the basis for their practice when caring for both Māori patients and patients from other cultural backgrounds. However, some European participants trained in New Zealand prior to 1990, tended to base their cultural practice on the individualistic and holistic nursing philosophies that prevailed in the period when they trained. Some differences in practice between the participant groups emerged. Generally, participants viewed culture as an expression of ethnicity, rather than as a broader social construct.

Although participants shared many experiences demonstrating culturally safe practice, some participants, particularly Māori nurses, shared experiences where they felt patient autonomy and empowerment had been diminished and cultural safety had not been practised by colleagues. Participants were unable to identify a common frame for assessing that the care they provided was culturally safe, as determined by patients. The research indicates that development of models for nurses to assess their cultural practice with Māori and patients from other cultural backgrounds is required.

1.2 Purpose and rationale

The purpose of this research project is to explore nurses' articulation of cultural practice within a New Zealand context. The aims are: 1) to explore how nurses described their application of the principles of the Treaty of Waitangi, kawa whakaruruhau and cultural safety in their everyday practice; 2) to determine if there were differences in understanding of cultural practice between nurses from different backgrounds; and 3) to understand how nurses assess their cultural practice is culturally safe, as determined by the patient. There were many reasons, both professional and personal, for undertaking this research. From a professional perspective, it is a regulatory requirement for all nurses to demonstrate application of the principles of the Treaty of Waitangi and cultural safety to their practice. However, nurses may have varying exposure to cultural safety education, as defined by the Nursing Council of New Zealand (NCNZ, 2011a), which may impact on their ability to meet the Council expectations. To determine different perspectives, participants were assigned to four different groups based on ethnicity and country of birth, and where and when they trained. These groups are: 1) European nurses trained in New Zealand prior to 1990; 2) European nurses trained in New Zealand after 1990; 3) Māori nurses trained in New Zealand both prior to and after 1990; and 4) International Qualified Nurses (IQN). The purpose of these groupings was to establish if differences in nurses' backgrounds, including exposure to cultural safety in their training, influences perception and application of cultural practice, and the frameworks used, to underpin their cultural practice. Previous studies have not explored cultural practice as articulated by nurses from diverse backgrounds.

My personal interest in this topic is fourfold. Firstly, it stems from my current role as a nurse co-ordinator of the Professional Development and Recognition Programme (PDRP) at the Waikato District Health Board (DHB) and in this role, assessment of

nurses' cultural practice to meet NCNZ requirements. Secondly, it builds on a quantitative study (Baker, 2010) I undertook which sought to identify the impact in clinical settings of nurses approved on the PDRP. And thirdly, in my current role I work in a Treaty Based Partnership Model as the Māori partner. Although I have not undertaken formal education on cultural safety (I trained prior to 1990), cultural knowledge and experience and reflection of practice has been gained through a number of pathways. These include: my personal experiences as a nurse from Māori and European ethnicity, an extensive background of working with Māori and other patient groups within a family centred model of care in neonatal intensive care, educating nurses on implementation of family centred care, and knowledge gained from participating in and facilitating workshops on the Treaty of Waitangi, and application of the principles to practice. I have also contributed to the implementation of organisational Treaty of Waitangi training for all staff to improve health outcomes for Māori. And finally, my current role enables me to work with nurses at all levels across the DHB, as well as external providers, supporting them to understand the meaning of cultural practice, application to practice, and describing their application.

My work with nurses involves assisting them to understand, and then describe, how they apply the principles of the Treaty of Waitangi and cultural safety in practice. In my experience, the mention of these frameworks often elicit uncertainty, anxiety, and in some cases resistance, which has made me wonder if by framing cultural practice around the Treaty of Waitangi and cultural safety, a barrier is created for some nurses. This perceived resistance is not so apparent when talking in more general terms to nurses about building relationships with Māori and patients from other cultural backgrounds, and how they assess holistic needs, deliver care responsive to those needs and evaluate outcomes. Discussions on culture and cultural practice with nurses can be challenging and I have experienced a range of behaviours exhibited by nurses. These include: European nurses becoming defensive and evasive; being visibly uncomfortable and avoiding eye contact; becoming disengaged from the discussion and, appearing as if they cannot wait for sessions to be over. As a facilitator this is challenging and requires skill to re-engage nurses in meaningful discussions. In contrast, Māori nurses on their own become very engaged in discussions relating to culture, particularly related to the care of Māori patients and whanāu, and how they can make a positive difference to health experiences for Māori. However, it is more difficult to gauge reaction and understanding of cultural practice from nurses from other ethnic groups, specifically Pacific, Asian and Indian nurses, as they are often in a minority and tend to be less interactive in discussions.

Their viewpoint would provide valuable insight into the likely myriad of opinions relating to how these nurses understand cultural practice, and its transference to the clinical setting.

It is anticipated that this research will be of interest to a range of stakeholders. These include: nurses who have difficulty understanding the difference between the principles of the Treaty of Waitangi and cultural safety; nursing students; nurses describing their cultural practice to meet Nursing Council requirements for continuing competence; Nursing Council of New Zealand; cultural safety educators in nursing programmes; and recipients of health care.

1.3 Background

The Treaty of Waitangi was signed in 1840 between the British Crown and Māori as tangata whenua and is recognised as the founding document of Aotearoa New Zealand. The Treaty of Waitangi is a living document that continues to legitimise Māori as the indigenous people, recognising the right of the Crown to govern and make laws for the common good, while also allowing Māori self-determination. In 1988 the Royal Commission on Social Policy described the principles of partnership, protection and participation inherent within the Treaty of Waitangi. These principles provided the foundation for the development and implementation of kawa whakaruruhau and cultural safety.

The introduction of cultural safety into nursing education in 1992 was a controversial move by the Nursing Council which created considerable public debate, extending into parliamentary discussion, and leading to a national inquiry (Cooney, 1994; Coup, 1996; Ramsden, 1990a, 1990b, 2000; Spence, 2003). Cultural safety was originally grounded in the principles of the Treaty of Waitangi and biculturalism, introducing into nursing a socio-political definition of culture. The emphasis of cultural safety on the Treaty of Waitangi and meeting the needs of the indigenous people of Aotearoa, inflamed the media and the public, and was criticised as focusing on Māori to the exclusion of the rest of the population. Cultural safety was condemned, claiming that its inclusion in nursing training compromised the credibility of nursing education and replaced more traditional nursing knowledge content (Papps, 2002). Despite opposition, cultural safety was introduced into and continues to be an integral component of nursing education.

The Treaty of Waitangi and kawa whakaruruhau, provide frameworks for nurses to engage with Māori patients in a manner that is responsive to their needs, and work together to achieve positive health outcomes. Cultural safety provides the context for nurses to establish relationships with patients from other cultural backgrounds, identify and be responsive to individual and cultural needs, and work together to improve health outcomes. Culture in the context of cultural safety is defined from a social construct and is not restricted to, age, gender, education and economic backgrounds, disability, sexual orientation, religious beliefs and ethnicity. Application of the principles of the Treaty of Waitangi and cultural safety is a professional responsibility for every nurse.

1.4 Professional responsibility

Nurses are professionally accountable to the patient, to the profession and their employer. The Code of Health and Disability Services Consumers Rights (1996) sets out ten legal rights for patients and the care they receive from health care providers, and provides a mechanism for patients to make complaints about health and disability services provided. Cultural safety and the principles of the Treaty of Waitangi are embedded within the Code of Rights, specifically the following patient rights: to be treated with respect; no discrimination or coercion in decision making; to be listened to, understood and receive information in ways to ensure understanding, including provision of an interpreter; to be given choices for possible treatment; to give informed consent; and the right to complain. Nurses observe these rights by applying their nursing knowledge and experience when assessing the needs of patients, identifying individual goals, preparing a plan of care, delivering and evaluating the effectiveness of care, with patients and their family. Nurses are accountable to their profession by adhering to the Nursing Council of New Zealand (NCNZ) Code of Conduct (2012a), working within a Code of Ethics (New Zealand Nurses Organisation, 2010) and meeting the requirements for continuing competence, including culturally safe practice (NCNZ, 2007). Nurses must also act in accordance with organisational policies to provide safe and competent clinical and cultural care (Papps, 2002).

Health practitioners also have to practice under a range of other legislation related to, but not limited to, privacy, medicines, health and safety, health and disability and human rights. Health service providers are required to operationalise the requirements of relevant legislation to organisational policies, and staff must work

within these policies to ensure the safety of patients. Therefore, the infrastructure of health providers to enable practitioners to demonstrate clinical and cultural competence influences the reality of application.

Regulatory authorities under the Health Practitioners Competence Assurance (HPCA) Act (2003) prescribe the required qualifications, determine the scopes of practice, review training programmes, and monitor the continuing competence of practitioners. These authorities also set the standard for clinical and cultural practice, and ethical conduct. The Nursing Council governs nurses' practice by setting and monitoring standards for nursing education and competencies for registration, to ensure health consumers receive safe clinical and cultural care. The principles of cultural safety, the Treaty of Waitangi and Māori Health, are reflected in the Council's standards and codes of practice (2012a, 2012b), and competencies for scopes of practice (2007 & 2010). To meet the NCNZ continuing competence requirements for Annual Practising Certificates (APC), nurses are required to demonstrate their ability to apply the principles of the Treaty of Waitangi to nursing practice, and practise nursing in a manner that the patient determines as being culturally safe. Evidence of this practice may be through self declaration on application for APC, the NCNZ audit process, or a PDRP. Nurses (and presumably other professionals) can struggle to articulate how they apply cultural safety in their practice. However, it is not clear how practitioners (nurses, midwives and physiotherapists) evaluate whether the care they provide is culturally safe, from the perspective of those receiving care.

1.5 Summary

In this thesis I describe all stages of the qualitative research project that I began in October 2011, to explore how registered nurses articulate their cultural practice within a New Zealand context. This chapter has introduced the research and relevant policy in legislation, identified the purpose and rationale for my research, and presented a brief background to the initiation of cultural safety in the nursing curriculum. Cultural practice has been positioned as a critical component of professional responsibility for all nurses.

Chapter Two provides a comprehensive review of relevant New Zealand and international literature related to cultural practice in the care of indigenous peoples and culturally and linguistically diverse (CALD) populations. Cultural safety, cultural competence and transcultural care are defined and critiqued. Cultural diversity within

an international and New Zealand context is examined as well as its implications for health. Patient expectations of nurses, nurse-patient relationships, and patient health experiences are explored to identify key strategies to meet the cultural needs of Māori patients and patients from other cultural backgrounds. The New Zealand nursing context is defined, nursing and the meaning of culture in nursing, and the development and implementation of cultural safety, are also discussed. Application of cultural safety in policy and practice is investigated, potential barriers to application identified, and assessment of culturally safe care is evaluated. From the literature reviewed conclusions are made to provide justification for my research as well as further research.

Chapter Three sets out the theoretical frameworks underpinning the research approach, and justification for the approach. The research process is described and then participant selection and recruitment is outlined and participants introduced. The data collection and interview process are presented and the data analysis described. Finally, ethical considerations and strategies to promote rigour in the research process are highlighted.

The findings in relation to how nurses described their care of Māori patients are presented and discussed in Chapter Four. Four main themes are identified, along with two sub-themes for each main theme. The main themes are: 1) Establishing positive working relationships; 2) Working positively to achieve outcomes; 3) Supporting patient autonomy, empowering patients; 4) Awareness of and managing personal (nurses') stereotype and power. The findings and themes are then discussed against the research objectives. These four themes and sub-themes are the same for Māori patients and patients from other cultural backgrounds.

Using the same thematic framework as in Chapter Four, Chapter Five offers the findings and discussion related to how nurses articulated their care of patients from other cultural backgrounds.

Chapter Six concludes the thesis by presenting conclusions, implications for practice and policy, limitations of the research, implications for future research and recommendations.

CHAPTER TWO

Cultural practice in nursing: a literature review

2.1 Introduction

In this chapter literature is reviewed to explore nursing from a cultural perspective and positions this practice within the New Zealand nursing context. The review provides rationale and justification for this research to explore nurses' articulation of their cultural practice. The key cultural concepts are defined and provide a foundation for the literature review. The review begins with an overview of cultural diversity from an international and New Zealand perspective, with their implications for health services. Patient expectations of nurses are examined as the foundation for establishing nurse-patient relationships and effective communication, as well as exploration of patient autonomy as a social construct. Literature positioning nursing within an international context, together with the discourse on transcultural care is also introduced. Defining the role of nursing in New Zealand is then followed by discussion on the introduction of cultural safety. Finally the application of cultural safety to practice is explored along with potential barriers to its application.

Search strategy

An initial search was conducted via CINAHL Plus and MEDLINE databases using the keywords: nursing, culture, cultural competence, cultural education and cultural safety. Articles published in English from 1990-2011 were obtained and their reference lists scrutinized to identify other relevant background literature. Additional searches were then conducted on CINAHL Plus and MEDLINE databases using the keywords: patient rights, patient experiences, patient-nurse relationship, Maori health, indigenous health and disparities, cultural diversity. Manual searching of reference lists and texts was also undertaken. English language publications were selected for review if they met the following criteria: (i) theoretical frameworks for nursing and cultural practice; (ii) development and implementation of cultural education in nursing training internationally and in New Zealand; (iii) application of cultural training into practice; (iv) the patient perspective and expectations of nursing

care; (v) patient–nurse relationships; and (vi) experiences of health services by patients from diverse cultural backgrounds.

2.2 Key concepts

This section defines culture as a social construct and outlines the framework for discussion of culture throughout the thesis. Three key cultural practice frameworks explored and compared in the thesis are outlined to identify specific differences and provide the foundation for all subsequent discussions in the literature review, as well as the findings and discussion chapters.

Culture

The discourse on culture is complex and can be examined from many different perspectives. The Social Report (2010, p.84) relates culture to “customs, practices, languages and world views that define social groups such as those based on nationality, ethnicity, religion or common interests”. For the purpose of this literature review, culture is examined from a social constructionist framework. Wepa’s (2005, p.31) definition reflects the complexity of culture and situates culture within a social context:

Broadly speaking, culture includes our activities, ideas, our belongings, and relationships, what we do, say, think, are. Culture is central to the manner in which all people develop and grow and how they view themselves and others. It is the outcome of the influences and principles of people’s ancestors, ideology, philosophies of life and geographical situation. Culture is never completely static and all cultures are affected and modified by the proximity and influences of other cultures.

The Nursing Council (2011a) describes culture as inclusive of age, gender, religion, sexual orientation, socio-economic background, disability and ethnicity. For the purpose of this research, the term culture encompasses Wepa’s and NCNZ’s broad definitions.

Kawa Whakaruruhau/Cultural Safety

Kawa Whakaruruhau (Cultural safety in the Māori context) provides nurses with a framework to: reflect on how their own culture influences their behaviours and values; gain an awareness of what they bring to nurse–patient relationships; understand the

impact of colonisation and monoculturalism on the health of Māori; and work effectively with Māori, to improve health outcomes. Cultural safety provides a model for nurses to work with patients from other cultural backgrounds in a culturally safe manner. Cultural safety was originally defined as “Any actions which diminish, demean or disempower the cultural identity and well-being of an individual (Whanāu Kawa Whakaruruhau, 1991, p.7, cited by Wood & Schwass, 1993). Kawa Whakaruruhau/Cultural safety was initially introduced as an indigenous model specifically to improve the health of Māori by working more effectively and responsively with them, and has since been broadened to include other cultures and sub-cultures, while not losing the focus on Māori. Cultural safety would therefore be met through “actions which recognise, respect and nurture the unique cultural identity of tangata whenua, and safely meet their needs, expectations and rights” (Whanāu Kawa Whakaruruhau, 1991, p.8, cited by Wood & Schwass, 1993). Cultural safety places emphasis on the patient experience and the patient determining whether the care provided has been culturally safe.

Today cultural safety is defined by the Nursing Council (2011a, p.7) as:

The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual beliefs; and disability.

The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual.

Cultural safety relates to the broader context of culture whereas over time the term kawa wakaruruhau has been interpreted as cultural safety within a Māori paradigm. While cultural safety does not equip nurses with knowledge of many different cultural values and beliefs, it is expected that it will support nurse to engage with patients and develop relationships that enable patients to express what is important, to meet their cultural needs. The nursing profession remains committed to the concept of cultural safety along with the midwifery and physiotherapy profession (Bassett & Holt, 2002; Bassett & Tango, 2002; Durie, 2001a; Haswell, 2002; Midwifery Council of New

Zealand, 2004; Nursing Council of New Zealand, 2007; Physiotherapy Board of New Zealand, 2005; Ramsden, 2000).

Cultural competence

The Health Practitioners Competence Assurance (HPCA) Act (2003) requires all health practitioners to demonstrate cultural competence. As mentioned above nursing, midwifery and physiotherapy have determined that their framework for demonstrating cultural competence is cultural safety. Medicine has chosen cultural competence as their framework to meet the requirements of the HPCA Act. Durie (2001a, p.6-7) suggests that cultural competence places an emphasis on the doctor-patient relationship that requires doctors to have an understanding of different worldviews to health and western medicine; to appreciate “the values upon which cultural integrity is based” and “values related to the utilisation of space and time”; as well as the role of family and community in the health experience. Although doctors’ engagement with patients and acknowledgement of their cultural realities is essential, according to Durie, the focus of cultural competence is about improving health outcomes. The preferences for using cultural safety or cultural competence frameworks may reflect the differences in practitioner and patient interactions between nurses and doctors and may influence how cultural care can be evaluated. Betancourt, Green, Carrillo & Ananeh-Firempong (2003, p.297) describe cultural competence as a framework that enables:

Understanding the importance of social and cultural influences on patient’s health beliefs and behaviours; considering how these factors interact at multiple levels of the health care delivery system;and finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations.

Therefore, the cultural competence concept endeavours to prepare practitioners to have an understanding of what is important for patients from different cultural groups. However, the emphasis is on the practitioner to improve health outcomes, rather than on the experience of the patient.

Transcultural care

The notion of transcultural care emerged in the 1950s in the United States as the “settlement of multi-ethnic refugee and migrant groups characterised immigration in the post-war period in North America” (Mortensen, 2010, p.10-11). Transcultural care

focuses on the values and beliefs of diverse cultures and how this knowledge is used to provide culturally specific care to patients from particular cultures (Leininger, 1978, 1991). This requires nurses to have knowledge of the specific cultural values and beliefs of a wide range of racially and ethnically diverse populations in order to provide culturally congruent care. Although Leininger's transcultural care model (1978, 1991, 2002) is the most well known and written about, a number of other concepts are discussed in the body of the literature review.

The next section sets the international stage for the culturally diverse nature of populations worldwide. This discussion is located primarily in the United States, Canada and Australia as comparable countries to New Zealand, due to their similar experience of colonization, health issues and health disparities for indigenous people, and increased cultural diversity as a result of migration. The notion of other worldviews of health is also introduced to acknowledge a broader context for responsiveness to health needs, for culturally diverse populations.

2.3 Cultural diversity within an international context

Cultural diversity in developed countries has grown over the last three decades in response to globalization and the migration of many peoples to other countries. This places an increased burden on available resources, including health. The increase in culturally and linguistically diverse populations brings different values and beliefs about health and healing, which may not be acknowledged or responded to within western health service models (Doolen & York, 2007; Wolf, 2003). Cultural diversity from an international perspective most often relates to ethnicity, this includes refugee and immigrant groups as well as indigenous people.

Contributors to cultural diversity

Populations, and increasingly, entire cultures are migrating to richer countries due to the economic changes from globalization, and environmental factors of resources and climate. Other influences on migration include displaced populations or populations under threat who become refugees fleeing danger, loss of jobs and poverty. Migration also occurs voluntarily as a result of personal choices (Wolf, 2003). Globalization is the primary factor in the current migration patterns and has led to increasing cultural diversity in many countries. This cultural diversity is reflected in the numbers of different ethnic and religious groups represented in countries such as

the United States, Canada, Australia and New Zealand (Doolen & York, 2007; Wolf, 2003).

In the United States approximately 30 per cent of the population is made up of ethnic minorities, the largest and fastest growing minority being the Hispanic/Latino population, which is now higher than the Black/African American population. The native American/Alaskan native population is less than one per cent of the cultural diversity of the United States (Doolen & York, 2007). Transcultural care is inclusive of indigenous people and its emergence was a response to the increasing cultural and racial diversity to support nurses to provide culturally congruent care (Leininger, 1978, 1991, 2002). However, racial and ethnic disparities in access and outcomes of health services continue to grow in the United States (Institute of Medicine, 2003).

The population of Canada before 1915 consisted primarily of people from British and French origin with indigenous peoples, including Inuit, as the minority. After the First World War migrants came primarily from Britain and Europe. A noticeable change in this trend occurred after 1960 with the migration of people from Asia, Africa, and South America. This has led to an increasing multicultural society. Changes to the demographics in Canada, has resulted in social construction of racial difference and unequal opportunities for people of colour such as, reduced earnings in comparison to white men for minority groups, and unequal social value placed on people of different origins (Li, 2000).

Johnstone and Kanitsaki (2007, p.96) state the population of Australia is:

....comprised of people from over 200 different countries, practising over 116 religions, and speaking over 180 languages with over 16% speaking languages other than English at home. Add to this the cultural and linguistic diversity of the Indigenous Peoples of Australia, and the multicultural nature of Australian society is underscored. These demographics indicate that Australia is not just a 'multicultural society', but also one of the most culturally diverse societies in the world.

Migration and increased cultural diversity impacts on resources, including health services, and indigenous people have to compete for their fair share of these resources. As studies cited by Johnstone and Kanitsaki (2007) indicate, health services have not responded well to meet the needs of indigenous peoples, or culturally and linguistically diverse (CALD) populations. The result of this means that the health status of indigenous peoples in the United States, Canada, Australia and

New Zealand is well below that of the average population in their countries with for example, life expectancy and infant mortality being higher than the national average.

Indigenous peoples

The term indigenous generally refers to ethnic groups who have historical ties to groups that existed in a territory, prior to colonisation or formation of a nation state. These groups tend to have a degree of separation from the mainstream culture and political system of the nation state (Peoples & Bailey, 2003). A direct effect of colonisation is a loss of control of economic resources, including land, and lack of autonomy. The indigenous people of the United States, Canada, Australia and New Zealand share a common history of colonisation, which has had far reaching influence on health and increasing disparities for their populations (Willis, Rameka & Smye, 2006).

In general, people with historical connection to land prior to colonisation are referred to as indigenous. However, indigenous peoples around the world have determined how they prefer to be named. In Canada, First Nations is used to identify all indigenous people, including Métis and Inuit peoples. In Australia, the use of Aboriginal does not include Torres Strait Islander but indigenous capture both groups. In New Zealand, Māori are known as tangata whenua (people of the land), they are not referred to as Aboriginal, indigenous or First Nation (Peiris, Brown and Cass, 2008; Turale & Miller, 2006; Willis, Rameka & Smye, 2006).

Peiris, Brown and Cass (2008) suggest the on-going impact of colonisation continues to be the key barrier to accessing health services in the United States, Canada, Australia and New Zealand. However, the experiences and results of colonisation for indigenous people in other countries may be different. The impact of colonisation has included attempting to:

- destroy indigenous culture and race through genocide, apartheid policies, forcible removal and segregation of children, separation of families and clan, herding of people onto mission stations and reserves, forceful taking of land, and through various failed assimilation attempts (Turale & Miller, 2006, p.171-172).

Marginalization and social injustice have continued to disadvantage the indigenous people of Australia and resulted in significant health disparities (Turale & Miller,

2006). Aboriginal nurses, Juanita Sherwood and Tahnia Edwards (2006, p.183) believe:

The critical issues that underlie the lack of improvement in Aboriginal health are the continuation of colonisation, through the dominance of western worldviews in research, policy, planning, and praxis; the lack of Indigenous health models and the dominance of the bio-medical model; and everyday personal and institutional racism.

They suggest changes in health provision policies and organisational culture and education on de-colonisation, are needed to reduce barriers to health care for Aboriginal people, and provide more culturally acceptable and responsive health care. Indigenous Australians have not been protected in the same way as Māori in New Zealand, where the Treaty of Waitangi has helped to protect the culture and support equitable access to the benefits of modern society (Turale & Miller, 2006).

Health provision in the United States, Canada Australia and New Zealand is generally founded on western values and beliefs using a bio-medical model. However, these may not be congruent with indigenous beliefs or beliefs of those from CALD backgrounds. Alternative worldviews of health and healing can influence when and how people may access western health services, and how they may express and respond to their health issues.

Worldviews of health

As countries such as the United States, Canada and Australia become increasingly culturally and linguistically diverse, with many different languages spoken and religions practised, values and beliefs on health and healing also differ from western beliefs. How people are brought up and the values and beliefs instilled in them by their parents and families, influences how people respond to health issues. For example how people respond to pain, including when and how to ask for treatment (Kemp, 2005; Narayan, 2010). A number of studies cited by Kemp (2005) and Narayan (2010) identified differences between cultural groups on how they tolerate pain, how they express pain and the language used to describe pain. Their expression of pain may be from a different framework from that of the health professional and may influence responses to minimise pain. People from other cultural groups may also use more traditional ways to treat their pain such as medicinal herbs, touch, acupuncture and yoga rather than western treatments (Kemp, 2005; Narayan, 2010a, 2010b). When the patient and the nurse are from

different cultural backgrounds, there is the potential for miscommunication resulting in individual patient needs not being met.

Different worldviews of dying and death also influence how people make end-of-life care decisions. The western worldview is generally that patients value their control and autonomy and like to be informed about their illness, treatment and prognosis. However, some cultural groups may not talk openly about death and dying (Kemp, 2005). In some Asian cultures the family do not like the patient to be told about their illness as they believe this may hasten their death when they want their relative to have hope. In other cultures they may be fatalist about death, believing that it is God's decision and they cannot change that. Therefore, how decisions are made and who in the family makes the decision, challenges western values of patient control and autonomy (Doolen & York, 2007; Kemp, 2005).

Indigenous people also have differing worldviews of health when compared to western and CALD worldviews. The First Nations people of Canada have a traditional worldview of health which is grounded in the healing properties of the natural world, natural products and natural life processes. When a person becomes unwell a traditional healer is called upon to correct any imbalances between the spirit, body and mind (Walker, Cromarty, Kelly, & St Pierre-Hansen, 2009). This can create tension between traditional and western health care and to meet the needs of First Nations people, both may need to be incorporated into the care to achieve the best outcomes.

The indigenous peoples of Australia are often reluctant to access western health care. This may be the result of previous health experiences being culturally inappropriate and unwelcoming, and preferring traditional views on health and health care (Turale & Miller, 2006). With increasing culturally diverse populations, health practitioners are challenged to understand how different cultural groups respond to health issues, in order to provide culturally responsive care. It would be impossible to know the different cultural values and beliefs of all immigrant populations, but it should be an expectation that health practitioners have some knowledge of the values and beliefs of their indigenous people. It is important for health professionals to be aware that when caring for indigenous people and CALD populations, patients may have a different perception from the health professional of what is happening to them and why. The worldwide cultural diversity and the impact of colonisation on

indigenous people in the United States, Canada and Australia, is also reflected in New Zealand.

The following section reviews cultural diversity in Aotearoa New Zealand firstly from the perspective of the indigenous people, Māori as tangata whenua. The significance of the Treaty of Waitangi to health and the health disparities that exist for Māori is then discussed. Finally the CALD populations living in New Zealand are considered along with the impact on health services and health providers.

2.4 Cultural diversity within the New Zealand context

Culture for many New Zealanders relates primarily to race and ethnicity and has become increasingly complex since the 1970s as New Zealand has become an increasingly multicultural society. At the same time, there was increasing evidence of health disparities for Māori and recognition of the Treaty of Waitangi in legislation (1975) (Durie, 1998; Ramsden, 1990a, 1990b, 1993). The role of the Treaty of Waitangi as the basis for New Zealand's bicultural foundation as a nation, the inherent obligations to Māori as the indigenous people under the Treaty, and the growth of cultural diversity continue to be contentious and divisive issues for New Zealanders (Mortensen, 2010; Wilson, 2008).

The Treaty of Waitangi and health

The Treaty of Waitangi is recognised in legislation (1975) and is acknowledged as the founding document of Aotearoa New Zealand. The Treaty of Waitangi was signed in 1840 between Māori and the British Crown, and although many New Zealanders have viewed the Treaty of Waitangi as an historical document, for Māori it remains a living charter to determine on-going relationships with governments, institutions (including health providers) as Treaty partners. The Treaty of Waitangi guarantees Māori, as the indigenous people, specific rights in Aotearoa New Zealand. The Treaty loosely accommodates the transfer of sovereignty, offers significant guarantee of protection of Māori taonga, as well as Māori retaining control over Māori resources. Māori are also assured of the same rights and privileges as British subjects. Although two versions of the Treaty of Waitangi (Māori and English) have resulted in different interpretations of the guarantees embedded in these documents, under international law recognises the Māori version as the correct account (Quentin-Baxter, 1998). The perception that issues related to the Treaty of Waitangi are Māori issues, has

contributed to non-acceptance of the Treaty by many non-Māori New Zealanders. The differences in interpretation between the two versions of the Treaty has inflamed the debate and the resulting discontent led to the establishment of the Waitangi Tribunal, under the Treaty of Waitangi Act (1975), to settle on-going disputes.

Following implementation of the Act, the then Director-General of Health, Dr George Salmond, recommended that the Treaty of Waitangi be integrated into health services (Wepa, 2005). The Royal Commission on Social Policy (1988) identified the principles of the Treaty of Waitangi as one of the foundations for New Zealand society and the economy, and concluded that the Treaty was relevant to all social and economic policies in the future. The Commission recommended three principles relevant both to social policy and the Treaty of Waitangi: partnership, participation and protection. These principles have provided a foundation for the development of health services responsive to the needs of Māori, including the introduction of Māori Health Providers, to address health disparities and improve access to health services for Māori (Durie, 1998, 2001b).

In the 1980s and 1990s Māori participants at health hui (meetings) claimed health as a taonga which, under Article 2 of Te Tiriti o Waitangi, was entitled to protection. This was not accepted by the government who would not agree to privilege Māori over other New Zealanders. However, Article 3 was seen to have a more direct and obvious link to health and implied that in having the same rights and privileges as British subjects, there would be no serious gaps between Māori and other New Zealanders. Therefore, Article 3 was also about equity and in the 1980s and 1990s, there was increasing evidence of significant health disparities between Māori and non-Māori (Durie, 1998).

Health disparities

Culture is one of many social determinants of health which includes housing, employment, education and poverty. Culture has a significant impact on the health of indigenous people:

....because culture influences behaviours through customs, traditions, beliefs and values. In the Māori worldview, there is a fundamental belief that understanding and being connected to the past are important for both the present and the future (Jansen & Jansen, 2011, p.54).

Māori are often over-represented as living in poor housing, being unskilled or not employed and leaving school without qualifications. These circumstances have contributed to poor health outcomes and health disparities for Māori (Durie, 1998; Ramsden, 1990a, 1990b; Reid & Cram, 2004). However, it is important not to generalise Māori and acknowledge that not all Māori are poor, uneducated and unemployed. However, Reid & Cram (2004, p.34) suggest there are two worldviews co-existing in Aotearoa New Zealand:

One is called Aotearoa where Māori are tangata whenua and our ways of being, doing, and knowing are normal and accepted. The second country is called New Zealand where a Pakeha majority control who and what is normal and Māori are often portrayed as different, difficult or radical.

For Māori who live in Māori communities, are involved in marae activities, speak Māori language in their home, educate their children in total immersion education from pre-school to high school, and socialise primarily with other Māori, this may be their reality (Reid & Cram, 2004). Their values and beliefs and worldview of health may not align with the dominant western view, and these need to be considered in any interactions with health professionals (Durie, 1998; Reid & Cram, 2004).

It is helpful for health professionals to understand that while there may be a logical scientific reason for illness occurring, a Māori worldview may be quite different. A Māori patient may believe the illness is the result of an infringement against the law of tapu and this may negatively reflect on the whānau. The concept of tapu and the perception of illness as a breach of tapu are central to much of the anxiety and depression which surrounds Māori patients while in hospital (Durie, 1977). These conflicting worldviews influence perceptions of health and illness and are also potential barriers to health services, both financial and non-financial.

Difficulty accessing health services is a significant barrier for many Māori. Under the protection principle of the Treaty of Waitangi, there is an obligation to enable Māori to achieve the same health outcomes and experience the same access to health services as non-Māori. However, financial as well as non-financial barriers continue to exist. Jansen (2009) identifies a number of non-financial barriers to primary health care services for Māori. These include: communication barriers and differences in health literacy; knowledge of how services are organised or accessed; prior experience of unfavourable attitudes to Māori in health care; distance to travel for rural Māori; availability of suitable appointment times; need to take time off work to attend clinic appointments; the cultural fit of health provider with patient beliefs; Māori

patient perceptions of being patronised; previous experience of bias; different perceptions of illness and death; little acknowledgement by health practitioners of desire for whānau to be present; and the reluctance of Māori patients to question treatment recommendations. Some of these barriers may be overcome by nurses and other health professionals engaging with Māori, by developing therapeutic relationships to work together to plan care, and provide information in a manner that is understood by the patient and whānau, and to enable informed decision making (Durie, 2001b; NCNZ, 2011; Ramsden, 1993, 2000; Wepa, 2005; Wilson, 2006, 2008). Some barriers may be related to organisational and political policies which are beyond the control of health professionals. However, nurses and other health professionals have a professional responsibility to advocate for their patients, ensure they have the resources necessary for self-management, and are able to access the appropriate health and social services, to optimise their health outcomes. These aspects of practice are embedded in the registered nurse scope of practice and competencies as part of professional responsibility, management of nursing care and interpersonal relationships (NCNZ, 2007, 2011a, 2012a).

The increasing health disparities between Māori and non-Māori populations in New Zealand are well documented in the literature (Durie, 1998, 2001b; Reid, Robson & Jones, 2000). The health outcomes for Māori when compared to non-Māori show a distinct gap between male and female life expectancy at birth, increased public hospital utilisation, and effects of increasing deprivation (Reid, Robson & Jones, 2000). Statistics show disparities with more Māori women dying from lung carcinoma and higher rates of Māori dying from heart disease, respiratory disease, and cervical cancer (Ramsden, 1990a). The higher rates of neonatal deaths and incidence of hepatitis B and rheumatic fever and renal disease also reflect significant disparities when compared to Pakeha. Although there have been some improvements, health disparities remain an issue (Ellison-Loschmann & Pearce, 2006).

Prior to 1970 culture in New Zealand was primarily based on ethnicity, the predominant ethnicities being Pakeha and Māori along with some other minority groups. Since the influx of Pacific people in the 1970s to build up the workforce and the increasing number of immigrants and refugees since then, the cultural diversity of New Zealand has changed significantly.

Culturally and Linguistically Diverse Populations

Increasing cultural diversity has resulted from changes to immigration policies to encourage immigration and attract more skilled workers and professionals, and this is reflected in the 2006 Census in relation to ethnicity and demography. The particular areas of growth have been primarily Asian populations but also of Middle Eastern, Latin America, African and other populations (Ministry of Social Development, 2010; Statistics New Zealand (SNZ), 2006) This has had an impact on health and the provision of health care to a culturally diverse population.

New Zealand has one of the highest proportions of overseas born residents (22 per cent) when compared with other countries in the Organisation for Economic Co-operation and Development (OECD), close behind Australia at 24 per cent. Canada has 17 per cent while the United States has 10 per cent (SNZ, 2006). This rapid growth of overseas born residents of other ethnicity in New Zealand has been most significant in the Auckland region since the early 1990s (Ministry of Social Development, 2010). Within the Auckland region there are over 230 diverse ethnic groups, with the highest proportion of people being from the Pacific Islands and Asia (SNZ, 2006). The Asian population is made up of people from China (45 per cent), India (27 per cent) and Korea (9 per cent) and other groups include Thai, Filipino, Japanese, Sri Lankan, Laotian, Cambodian, Vietnamese, Burmese, Bhutanese, Nepalese, Tibetan and Indonesia groups (Asian Public Health Project Team, 2003). Auckland and Wellington are identified as the main cities where new immigrants settle.

A study undertaken by North, Lovell and Trlin (2008) explored the impact of the changing immigrant population on primary health services. Health professionals in this study highlighted that their lack of knowledge, skills and access to support services for cross cultural communication and health care, challenged their ability to meet the health needs of immigrant patients. The research identified other findings such as: overuse of emergency departments by immigrants, difficulties posed by language, communication and culture, and acknowledged that immigrants expressed their concerns and symptoms differently. Recommendations included: increased funding to provide appropriate written information; improved access to trained interpreters and allowing more time for consultations; and more education for health professionals to support cross cultural health care and cross cultural communication. Further research was suggested to understand why immigrants access an

emergency department rather than primary health care services, and explore barriers to accessing health services. This research clearly identified that nurses and health professionals do not feel well prepared to meet the needs of CALD populations. This is supported by Mortensen (2010 p.7) who states:

These demographic changes have important implications for New Zealand health services in terms of the cultural competence of the workforce and cultural responsiveness of the services provided for the CALD [Culturally and Linguistically Diverse] populations served.

Mortensen recommends that further development of cultural safety education is required to provide culturally acceptable healthcare for CALD populations. With the changing cultural demographics in New Zealand it is important that nurses are able to communicate, identify and respond to the health needs of culturally diverse populations, in a culturally safe manner.

The next part of the review presents an overview of nursing models and theories promoted overseas to enable nurses to meet the individual needs of culturally diverse populations. These models have been chosen as they encompass the fundamental principles of humanistic and relational nursing theory which I believe have congruence with the cultural practice principles of the Treaty of Waitangi and cultural safety.

2.5 The international nursing context

The international nursing context is based on many diverse nursing philosophies and theories. For the purposes of this literature review, the international focus is primarily on Watson's theory of caring, transcultural models such as Leininger's model of cultural care diversity and universality theory, the sunrise theory, and Campinha-Bacote's cultural competence model.

Watson's theory of caring

Watson's philosophy and theory of transpersonal caring emphasises the development of a helping-trust relationship, as well as recognising the influence of internal and external environments on the health and well-being of individuals. Watson places the transpersonal caring relationship between the patient and the nurse at the centre of her theory. This humanistic philosophy recognises the human

potential for self healing and loving kindness for self and others as part of caring. Knowledge, clinical competence and healing intention underpin the ten caritas processes of Watson's theory (Falk Rafael, 2000; Parker, 2006; Watson, 1997; Watson & Foster, 2003).

Watson's caritas resonate with the underlying principles of cultural safety, and her theory of human caring provides an empirical foundation to support cultural safety as a concept. Watson's first three caritas place importance on the preparation of the nurse by raising consciousness and introspection, as well as a focus on transpersonal caring relationships (Falk Rafael, 2000; Watson, 1997; Watson & Foster, 2003). This process can be related to raising cultural awareness which is the first stage of becoming culturally safe. Caritas processes four to ten address the caring process and the assessment of health priorities and needs, planning and delivery of care, evaluation of the effectiveness of the caring process, and promotion of healing. The nurse and the patient work together through this caring process (Falk Rafael, 2000; Watson, 1997; Watson & Foster, 2003). These caritas broadly reflect the Treaty of Waitangi principles of partnership, participation and protection, and the principles of cultural safety. Although not influenced by an indigenous worldview, Watson's theory is founded on a humanitarian worldview and the uniqueness of each person and their relationship with the nurse in the caring process. These features are fundamental to cultural practice in New Zealand nursing.

Watson's theory provides a generic theoretical and empirical foundation for cultural practice. However, transcultural models have also emerged developed primarily from the dominant culture perspective in relation to the care of patients from different ethnic backgrounds. These models include Leininger's cultural care diversity and universality theory, Giger and Davidhizar's model of transcultural nursing and Purnell's model of transcultural health care.

Transcultural models of nursing care

Leininger's cultural care diversity and universality theory and the sunrise theory are perhaps the most well known and written about transcultural models. Her theories are based on anthropological observations and studies of culture, cultural values, beliefs and practices. Leininger states "care is the essence of nursing and a distinct, dominant, central and unifying focus" (2002, p.192). These models focus explicitly on a holistic approach to culture and care of people from diverse cultures to achieve culturally congruent care outcomes (Leininger, 1978, 1991, 2002). Although these

theories are complex and emphasise cultural sensitivity and cultural congruence, they have been criticised for their assumptions that knowledge of different cultures will improve care and services (Culley, 1996, 2000). For example, the emphasis on cultural differences and deficits potentially identifies culture as a problem, thus introducing the risk of 'victim blaming' and stereotyping and therefore, perpetuating the power imbalance between the nurse and the patient (Coup, 1996). Other transcultural models share similar principles to Leininger as well as some additional principles.

Giger and Davidhizar's model of transcultural nursing (1999) recognises individuals as unique beings underpinned by culture, ethnicity and religion, which includes political, economical, religious, kinship and health systems. This model has six key areas of human diversity and variation: communication, time, space, environmental control, social organisation and biological differences. These six areas borrow from a wide range of biomedical and social science disciplines, and provides a comprehensive structure and organisation relating to human thinking, beliefs and activities, where cross-cultural differences and similarities may be observed. This theory argues that knowledge of biological variations can enable nurses to provide care that is culturally competent and non-harmful (Giger & Davidhizar, 1990, 1999). While this model acknowledges biological variations across ethnic groups, these must be understood to avoid generalisations and stereotyping people.

Purnell's model of transcultural care (1998) conceptualises the development of cultural competence along an upward curve of learning and practice, where the practitioner progresses through four levels: 1) unconscious incompetence; 2) conscious incompetence; 3) conscious competence; 4) unconscious competence. The concepts of Purnell's model are similar to those found in Leininger's and Giger and Davidhizar's models, but extends on some of the categories under which the concepts are organised from macro and micro aspects. The macro aspects describe the influence of global society in shaping a person's worldview, the shared interest and common identity held by a community, the structure and role of the family, and the person who is constantly adapting. The micro aspects are made up of 12 domains which include communication, family roles and organisation, high risk health behaviours, nutrition, pregnancy and child bearing practices, death rituals, spirituality, health care practices and health care practitioners (Purnell & Paulanka, 1998). This model attempts to be all inclusive but requires the health practitioner to have a

breadth and depth of knowledge and skills, matched to the requirements of health care users.

The aim of these transcultural models is to provide care that is culturally congruent with individuals' cultural values, beliefs and practices. Key criticisms of transcultural models are that they do not take into account the influence of power relationships or issues related to social and political inequalities for minority ethnic groups or other marginalised groups, they are based on the 'white' ethnic groups as the norm, and they risk stereotyping (Culley, 1996; Talabere, 1996). They are also very complex to understand which may lead to difficulties for application to practice. These models consider culture from the dominant culture perspective, whereas the concepts of cultural safety and Te Tiriti o Waitangi are founded on an indigenous worldview, with an emphasis on working in partnership with patients who are active participants in planning care and making informed decisions.

Cultural competence nursing model

Campinha-Bacote's model (1994, 1999) of organising cultural competence has six critical elements: cultural awareness, cultural knowledge, cultural skill, cultural encounter, cultural desire and cultural assessment. Through reflection, nurses become more culturally aware of the values, beliefs and practices of the patient and more conscious of their own values, biases and prejudices. It is anticipated that with increasing cultural awareness nurses will become more sensitive to cultural diversity and modify their own attitudes and beliefs accordingly. As nurses gain knowledge about other cultures, they begin to appreciate the diversity in worldviews that occur across cultural/ethnic groups. Armed with this knowledge, nurses are able to become skilled at systematically collecting relevant cultural information in partnership with the patient, and from this interpret the information to develop culturally congruent nursing interventions. Nurses have the opportunity to experience cross-cultural interactions and reflect on the experience to integrate learning into cultural care, and integrate cultural sensitivity into nursing care. The desire to engage in the process of cultural competence is viewed as an intrinsic desire that comes from the individual. Using this model, cultural assessment is required on all patients and is not restricted to specific ethnic groups (Campinha-Bacote, 1994, 1999; Campinha-Bacote & Campinha-Bacote, 1999; Campinha-Bacote, Yahle, & Langenkamp, 1996). This model resonates well with cultural safety and the Treaty of Waitangi as it supports nurses to reflect on their own cultural values and beliefs and understand that others may not share the same values and beliefs. However, the expectation of acquiring knowledge

of many different ethnic groups remains an important principle of this model, as with the transcultural models already highlighted.

Despite increasing cultural diversity in developed countries, such as the United States, Canada and Australia, there does not appear to be consistent agreement on the cultural component of nursing education, to enable nurses to care appropriately for indigenous peoples or CALD populations.

Cultural education in nursing- the international experience

A review of multicultural nursing education undertaken by the Commonwealth Department of Education, Science and Training (2001), studied pre-registration nurse education programmes in the United States, United Kingdom and Australia. Transcultural models are the predominant framework for cultural education in the United States, although not consistently applied across nursing programmes. The cultural component of nursing education in the United States focuses on the acquisition of factual knowledge about the values and beliefs of people from different ethnic groups.

The key feature of cultural education using a transcultural framework is the dominance of a western worldview and western models of care, to determine the cultural needs of patients. This discourse does not acknowledge the significance of other factors or influence of globalisation on individuals within cultures. Therefore, the impact of cultural factors such as age, gender, disability, sexual orientation and socio-economic background, may not be considered as relevant to assessment and care planning. Duffy's (2001, p.493) critique maintains that although cultural education in nursing is important, it "has not evolved to meet the demands of a multicultural, global society". She suggests that cultural education needs to move from an anthropological approach to transformative education in order to promote personal growth as well as enhance care provided for others. She promotes the use of critical self reflection to confront and challenge perspectives that do not consider multiple points of view.

Cultural nursing education in the United Kingdom is primarily based on the notion of cultural competence. Cultural competence is acknowledged as essential for nursing graduates and curricula includes cultural awareness, cultural sensitivity (Burnard, 2005; Sargent et al., 2005) and anti-racism (Nairn et al., 2004; Cortis & Law, 2005). In this approach, nurse educators also have professional development on anti-racism

and cultural competence, to ensure students from different ethnic backgrounds have safe learning environments (Narayanassamy & White, 2005). The use of cultural competence as a framework has also been criticised as having the potential to reduce cultural practice to a technical skill (Chenoweth, 2006). There is also the risk of focusing only on the culture of the patient and not the impact of the nurse's culture and beliefs on the relationship with the patient (O'Hagan, 2001).

Internationally there appear to be commonalities between models of nursing education however two main approaches have emerged in Australia. One is the vertical and horizontal integration of culture threaded through a broad based curriculum. The curriculum is built around a number of themes that are woven through all levels of the nursing programmes. This includes the theme of 'Respect for Cultural Identity and Cultural Safety' which can be integrated into all subjects. The other approach places the emphasis on stages of educational development or on specific marginalised groups. Courses specifically focusing on transcultural nursing are offered mainly in the third year or as post-graduate electives. Australian nursing faculties in remote areas are more likely to include specific marginalised groups within their community throughout their curriculum development but not other cultural groups (Chenoweth, Jeon & Goff, 2006; Omeri & Raymond, 2009; Seaton, 2010; Turale & Miller, 2006). Although there has been no agreement on adhering to one specific model to promote cultural competence, there is recognition of the need for change (Seaton, 2010; Turale & Miller, 2006).

The teaching of culture in Australian nursing education appears to be one of emphasising differences between cultures and creating stereotypical understanding. If there is agreement on one consistent model, it will be important that cultural education does not lead to stereotyping; weaken the understanding of ethnicity and culture; lead to completing a cultural checklist or create an 'us' and 'them' landscape. Overall, cultural education is not inclusive of indigenous health or the health needs of immigrants and refugees. Nor does it examine the history of indigenous people or the impact of this on health and health outcomes (Seaton, 2010; Turale & Miller, 2006). It is evident there is no consistent national curriculum for transcultural care or cultural safety in the Australian nursing curriculum. Cultural modules appear to be an option rather than a compulsory component with expected measurable outcomes.

A review of cultural education in nursing in Canada examined the theoretical and educational approaches utilised, to promote culturally safe practice and implications of cultural safety in the care of First Nations People and the multicultural society of

Canada (Roy-Michaeli, 2007). Roy-Michaeli's review identifies areas of congruence with cultural safety and how these can be linked to addressing issues related to health inequities and racism. There is evidence that some Canadian nurse educators are drawing on the cultural safety framework to provide a supportive learning environment for indigenous nursing students, preparing nurses to work with rural communities and indigenous people, and provide opportunities to reflect on the impact of culture on the health of people from different cultural backgrounds (F. Richardson & Carryer, 2005; Syme, Rameka, & Willis, 2006). From the literature Roy-Michaeli reveals an inconsistent approach to the inclusion of cultural care in nursing education programmes, and courses on culture and health are not a compulsory requirement for graduation (Purden, 2005). Cultural safety has not been fully integrated into undergraduate nursing education and there is some resistance to introducing cultural safety as the framework for cultural practice (Varcoe & McCormick, 2007). It is evident that although there is acceptance for a cultural safety framework to be used to engage with and provide culturally responsive care for the indigenous people, there is debate about the relevance of cultural safety for people from other cultures.

In summary, internationally there is no consensus on theoretical frameworks to support nurses to develop their cultural practice at undergraduate or post-registration level. Transcultural and cultural competence models provide a foundation that can be used to develop cultural practice. However, these models do not consider the impact of colonisation and loss of autonomy for indigenous peoples, and their specific needs may not be addressed which can result in increased health disparities. In Canada and Australia, where significant health disparities for indigenous populations exist, nursing recognises the need to implement changes in nursing education to meet the needs of indigenous and culturally and linguistically diverse people. The cultural safety concept implemented in New Zealand is being considered as a potential framework for cultural practice in both countries.

Meeting the cultural needs of patients is the underlying principle for the described models, therefore it is essential to consider what the patient expects from health professionals, in particular nurses. The next section explores nurse-patient encounters from the perspective of the patient, the qualities and attributes that they value in nurses caring for them, the nurse-patient relationship and the concept of patient autonomy and how this relates to indigenous peoples and CALD populations.

2.6 Nurse-patient encounters

The relationship between the health care provider and the recipient of health care is often defined in terms of how the recipient responds to health care provision. Draper (1997) defines the most commonly used terms which identify recipients of health care. The term 'patient' implies someone to whom health care is provided but who has no power in health care decision making. A customer is defined as someone who, if not satisfied, can walk away. It also implies paying for a service. A consumer is someone who is getting something, perhaps without choice, and will have something to say if he/she does not like what they are getting (Draper, 1997). It is fair to say that definitions continue to be a point of contention although anecdotally nurses consistently use the term 'patient'. For the purpose of this research the term 'patient' is used but is defined as an active partner in the health care experience and decision making to the extent the person's condition allows. This definition acknowledges that some patients may be compromised by illness, while others are quite empowered in seeking help. Of all the health professionals in a hospital setting, nurses spend the most time with patients. Nurses may also be the first health professional patients encounter when they access health services.

Patient expectations of nurses

Patients have certain expectations of nurses and they appreciate specific attributes and qualities in the provision of nursing care. Empathy and compassion expressed as kindness, joy, warmth, tenderness, smiling, a positive disposition, politeness and understanding, are perceived by patients as valuable attributes for the provision of high quality care (Irurita, 1999; Thorsteinsson, 2002). Reynolds and Scott (2006, p.226) define empathy as "the ability to perceive and reason, as well as the ability to communicate understanding of the other person's feelings and their attached meanings, is held to be a core characteristic of a helping relationship". Studies suggest that when nurses are empathetic this is likely to positively influence patient health outcomes, for example; more effective pain management, improved cardiac and respiratory function, and reduced anxiety (Gerrard, 1978 & Rogers, 1957, cited by Reynolds and Scott, 2000). Although patients expect that nurses have the technical skills and knowledge to provide competent nursing care, they also recognise that nurses' ability to communicate and develop caring and compassionate nurse-patient relationships, is critical to provide quality nursing care (Calman, 2006; Conway, Culbert, Gale, Coulden, & Tulloch, 1996; Shattell, 2004). Other studies

(Blockley & Alterio, 2008; O'Connell, Young, & Twigg, 1999; Sorlie, Torjuul, Ross, & Kihlgren, 2006; Walker, 2002) support these findings. Willingness to go the extra mile, taking time to get to know the patient, being helpful, sharing their own life, using humour and being friendly, are seen as essential for patients (Blockley & Alterio, 2008; O'Connell et al., 1999; Walker, 2002). When patients felt listened to and seen as a person, and cared for by nurses who went 'the extra mile', they experienced reduced feelings of vulnerability (Blockley & Alterio, 2008). These critical attributes identified by patients and the establishment of quality nurse-patient relationships, underpin the concept of cultural safety. The principles of the Treaty of Waitangi and cultural safety provide a foundation and framework for nurses to engage with and work in partnership with Māori and other patients from different backgrounds, to promote self management and independence and positively influence health outcomes. How nurses do this in their everyday practice, within the current environment and constraints, is central to the research.

Henry's (2008) exploration of the perceptions and experiences of Māori whānau caring for technology dependent children at home identifies the importance of cultural support to assist families to negotiate the care they require. Key themes emerging from her research were 'care co-ordination', 'cultural values' and 'being heard'. Continuity of care was valued by families and the ability to negotiate partnerships with health professionals in some situations, was assisted by whānau or kaitiaki. Parents gained strength from the cultural support provided by those working within health services as they also had an understanding of the internal networks and 'culture' of organisations involved.

Koea (2008, p.10-11) identified that Māori expectations are not dissimilar to other patient expectations:

Overall, patients valued competence, warmth, honesty, respect, and a caring attitude in their health professionals. Cultural expertise was not mentioned, rather a ability to meet patients halfway in terms of cultural needs and the ethnicity of the health professional was less important than the qualities they demonstrated. Poor experiences of Māori in the health system arose when professionals were not perceived as responsive or caring to either patients or their whānau.

Patients place high expectations on how nurses behave when interacting with them, their attributes and their communication skills. The nurse-patient relationship is the foundation for the provision of nursing care and the quality of this relationship can

significantly influence the health outcomes of patients. The qualities and attributes nurses bring to developing effective therapeutic relationships with patients are enhanced by their understanding of power dynamics within nurse-patient relationships and their ability to reflect on this, along with their ability to effectively communicate with patients from culturally diverse backgrounds.

The nurse-patient relationship

The nurse-patient relationship is critical to achieve excellence in patient care. Therapeutic relationships are established when: patients perceive the nurse as friendly and helpful; nurses recognise the patient as an individual and enable them to express their needs; nurses provide information to promote informed decision making and; nurses assist patients to use their own resources to become independent and self managing (Reynolds & Scott, 2000). Humanistic and relational nursing approaches (Christensen, 1990; Watson, 1997; Watson & Foster, 2003) underpin how nurses establish, maintain and conclude therapeutic relationships, work in negotiated partnerships with patients, families/whānau and communicate effectively (NCNZ, 2007). A holistic approach to care enables nurses to individualise care by integrating psychological, social, emotional and spiritual needs, as well as physical needs to the plan of care. Humanism enables nurses to demonstrate caring with knowledge, sincerity, humility, empathy and caring (Coulon, Mok, Krause, & Anderson, 1996). Nurses recognise the importance of establishing and maintaining therapeutic relationships with patients and their families/whānau but find this challenging in current work environments. Staff shortages, increased workloads, the need for increased productivity to meet health targets, all challenge nurses' capacity to provide holistic individualised care and meet the expectations of patients, families/whānau (Clendon & Walker, 2011; Richardson & MacGibbon, 2010; Richardson, Williams, Finlay, & Farrell, 2009). However, despite these constraints, nurses are responsible and accountable for providing a safe and competent standard of care for all patients they care for, and this includes culturally safe care.

Effective nurse-patient partnerships are established when the nurse and patient are comfortable discussing problems, nurses recognise individual patient preferences, and care is managed with patients who are able to make informed decisions/choices for on-going care and treatment. Nurses and patients are partners in all aspects of care, where information/care/empathy is provided in a timely manner and patients have an increased awareness of their illness (Calman, 2006; Irurita, 1999; Reynolds & Scott, 2000; Thorsteinsson, 2002). However, communication can be the main

barrier to the development of nurse-patient partnerships when cultural differences, language, literacy, lack of interpersonal skills, barriers to listening, power and lack of compassion, interfere with building a therapeutic relationship (Keatinge et al., 2002).

The literature of Māori patient experiences of health appears to focus more on the barriers to accessing health services (Bolitho & Huntington, 2006; Theunissen, 2011; Wilson, 2006, 2008) and the actions of the nurse, more than Māori patient expectations of health professionals when accessing services. Wilson (2006, p.xii) identified four strategies to improve the quality of Māori experiences of health care services and communication:

1. Promoting 'connecting' and 'relating with indigenous patients and their families through positive strategies and an individualised approach to establish trust.
2. Maintaining the integrity of the indigenous person and their family by respecting their worldview and incorporating their knowledge and healing practices.
3. Facilitating access and use of health services by creating an environment conducive to enabling informed choice.
4. Building on existing strengths by recognising the concept of resilience, the patient's life circumstances and the knowledge and skills they possess.

Key components of cultural safety are that nurses understand the importance of attitudes, recognise and understand the powerlessness of patients and the power of nurses, and the centrality of open-mindedness and self-awareness (Papps & Ramsden, 1996; Ramsden, 1993, 1994; Wepa, 2005). Cultural safety has a close focus on (NCNZ, 2011a, p.6):

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

Cultural safety acknowledges nursing power as a social and cultural construct based on a long standing hierarchical tradition (Jefferies, 2001). It can be argued that the greater power implicitly sits with the professional in relation to knowledge and skills but the challenge is to acknowledge the respective power of parties in the therapeutic

relationship including the family. When power dynamics are not acknowledged in the relationship this may be detrimental to health outcomes, particularly in relation to disparity and inequality (Richardson & Williams, 2007). Providing information in meaningful ways for patients to enable them to make informed decisions about their on-going care and treatment, may overcome this. Cultural safety calls for patients to determine that they have 'felt safe' when accessing health services which then places the locus of power on the patient. Empowerment of patients supports their self determination and independence and also facilitates and encourages the patient as their own expert, to actively engage in their health care. Nevertheless, studies indicate that some nurses may not be willing to share their decision making powers or do not encourage patient and family input in the belief that the nurse 'knows best' (Henderson, 2003; Keatinge et al., 2002).

When the nurse and patient do not share a common language other factors such as personal space, time, body posture and language may also lead to miscommunication. Effective cross-cultural communication relies on the nurse's ability to establish rapport and trust with the patient by using a range of verbal and non-verbal communication strategies. For patients from CALD backgrounds, cross-cultural communication relies heavily on the availability and access to authorised interpreters. Mortensen (2010, p.13) suggests:

Nurses who can use interpreters effectively, and communicate cross-culturally are more likely to elicit accurate information, ensure that the client [patient] understands the result of tests and screening, and provide the client [patient] with information and instructions on medications, treatments and follow up.

This implies that nurses play a key role in ensuring high levels of health literacy. Health literacy is an empowerment strategy that makes it possible for patients to understand health information provided, make informed health decisions, have increased control over their health, take responsibility for their decisions and feel confident accessing information and health services (Clendon, 2012). Clendon concedes that research shows that the average New Zealander has low health literacy skills and that Māori have lower health literacy skills than non-Māori. Low health literacy rates increases the likelihood of hospital admissions, increased access of emergency services, and incorrect medication compliance.

Cultural safety introduces a reflective model that "is effective at the individual, institutional and professional levels, and encourages identification of the assumptions and preconceptions that structure practice" (Richardson & Williams, 2007, p.703).

Reflection allows nurses to consider clinical decision making and analyse their actions, their feelings and opinions and the effectiveness of the intervention itself (Taylor, 2006; Timmons, 2006). Nurses are also able to consider the broader social, cultural, political and professional issues related to their practice (Cooke & Matarasso, 2005). Tanner's clinical judgment reflective model (2006, p.204):

....emphasises the role of nurses' background, the context of the situation, and nurses' relationship with their patients, as central to what nurses notice and how they interpret findings, respond, and reflect on their response.

There is an expectation that nurses "reflect on their own practice and values that impact on nursing care in relation to the client's [patient's] age, ethnicity, culture, beliefs, gender, sexual orientation and/or disability" (NCNZ, 2007, p.9). The principles of the Treaty of Waitangi and cultural safety provide frameworks for nurses to reflect on their cultural practice when caring for Māori patients and patients from other cultural backgrounds. Reflection allows nurse to also reflect on their professional, ethical and legal responsibilities, this includes support for patient autonomy.

2.7 Patient autonomy

The New Zealand Nurses Organisation Code of Ethics (2010) identifies autonomy or self determination as an underlying value of nurses' ethical practice. This assumes that patients have the wisdom and ability to make the best choices for themselves and patients want to make their own decisions. The Code incorporates the principles of cultural safety as part of autonomy by nurses' awareness and acceptance of cultural differences, as well as recognising the importance of collective decision making for some cultural groups.

Patient Rights

In New Zealand the Code of Health and Disability Services Consumers' Rights gives rights to all consumers and places particular obligations on people and organisations providing health services. The Health and Disability Commissioner Act (1994) established a national consumer advocacy service to promote patient rights and assist patients who felt their rights had not been respected. However, the Health and Disability Commissioner's jurisdiction is restricted to the quality of care and does not cover issues of entitlement to a service. This legislation and code emerged in response to an inquiry into the unethical nature of cervical cancer treatment and as a

consequence placed the patient at the centre of the inquiry (Bryder, 2009; Committee of Inquiry, 1988; Coney, 1988). The Cartwright Report (1988) concluded that a group of women, as a result of receiving conservative treatment for cervical cancer, had reduced quality of life and an untimely death. The Inquiry also resulted in the reform of health practitioner regulation, increased professional accountability and recommended changes to research ethics approval processes (Bickley Asher, 2008; Bryder, 2009; Committee of Inquiry, 1988; Coney, 1988, 1993).

The Code of Consumer Rights came into effect on 1 July 1996 and identifies specific patient rights that all health providers and health practitioners must comply with. These include the right to be treated with respect, and freedom from discrimination, coercion, harassment and exploitation. Patients are entitled to receive services of an appropriate standard and be provided with information in a manner they understand in order that they can make informed choices. Patients also have the right to refuse to be part of teaching and research. The Code is based on assumptions of patient autonomy and the notion of informed consent (Murtagh & Hepworth, 2003; van Kleffens, van Baarsen, & van Leeuwen, 2004). Since the introduction of the Code of Consumer Rights (1994) patients and families have been able to make complaints about the quality of care at service level, at organisational level, and nationally, to the Health and Disability Commissioner. Providers have integrated the Code into organisational policies and regulatory authorities require health practitioners to comply with the Code in interactions with patients. The Code of Rights provides patients with information about the standard of care they should expect from health professionals and health service providers.

In each health care encounter it is expected that medical information is disclosed to enable the patient to make informed decisions. It is assumed that the ability to make informed decisions provides patients with autonomy and once information has been disclosed, that all patients will want to participate in decision making (Followfield, 2001; Murtagh & Hepworth, 2003; van Kleffens et al., 2004). However, Murtagh and Hepworth (2003) argue that the notion of patient autonomy and ability to make choices is “far from being emancipatory [and] serves to intensify the power relations” (p.1643). They examine autonomy from a feminist ethics perspective using menopausal women’s choice to use hormone replacement therapy or not. They conclude that power relations in doctor-patient consultations are based on foundational medical ethics which may limit decision-making by women and influence power relations. Therefore further work needs to be undertaken to transform power relations and understand patient autonomy and informed decision-making.

Studies determined that factors such as personal values, beliefs and morals (Huijer & van Leeuwen, 2000), and religious beliefs (Wreen, 1991) can influence end of life decisions (Detillo, 2002; Sensky, 2002). Van Kleffens et al. (2004) investigated how moral deliberations impact on acceptance and refusal of cancer treatment and found three factors influence patient autonomy. First, the cancer and treatment experiences of others close to them had a significant impact on the patients' decisions. Second, decisions were also influenced by the opinions of others and by physicians. And third, in contrast to physicians, patients implied that despite the information they received on treatment options for cancer, choice did not also include options not to treat and therefore this limited their ability to choose. Their findings suggest that freedom and independence to make life choices are major factors in patient autonomy.

Thomas et al., (2008) reviewed literature on preferences for end-of-life (EOL) care and the role of family in decision making for Italian, Chinese, Japanese and Hispanic people, and their choice to care for their ill relative, until they died at home. They (2008, p.154) cited findings from research carried out by Duffy et al. (2006):

Arabs expected decision making to reflect their desire that their family members look after them and did not want to extend life; Hispanics wanted to die with dignity without suffering and without feeding tubes and did not want to go to a nursing home; blacks and whites did not want to burden their families; and black men were most distrustful of physicians' decision making (Thomas et al., 2008, p.154).

It is important for health professionals to be aware that people from culturally diverse backgrounds may have different preferences for decision making and consideration needs to be made to respect their choices. The following section examines culture and nursing in the New Zealand context and the introduction of cultural safety to the nursing education programmes.

2.8 The New Zealand nursing context

Christensen (1990) provides a comparative theoretical approach to Watson's theory of caring, for the New Zealand nursing environment. Although Christensen's theory of partnership preceded the formal introduction of cultural safety it is inclusive of the principles. Her theory centres on equality and respect while providing security to enable and empower the patient. Her framework recognises patient vulnerability and

lack of personal power, as well as diverse values, power sharing, and recognising the legitimate claims of Māori as tangata whenua. Within this partnership model the nurse and the patient are active participants in the health experience with both recognizing their rights, obligations and roles in relation to achieving a negotiated outcome (Christensen, 1990). Although Christensen's original grounded theory research was based in a surgical setting, further revision reveals application across other practice settings, including the community.

Christensen's revised model of partnership reflects the involvement of nurses in more long term relationships, health promotion and health maintenance. Her theory is founded on the giving and receiving of nursing care with the emphasis on the role of the patient and the nurse in developing the relationship, entering the nursing partnership, negotiating the nursing partnership and leaving the partnership. Christensen highlights the contextual determinants that impact on the relationship and partnership. These determinants include the culture of the nurse and the patient, the range of hospital and community services available, what has led the patient to require nursing care, and environmental factors influencing behaviour during a health related event. Christensen acknowledges the emerging need for nurses to be culturally safe and recognises that "professional competence is multifaceted and requires the nurse to perform safely in the socio-cultural context in which nursing is given and received" (1990, p.189). The nursing partnership model enables the nurse to care for the person throughout the health experience and "articulate nursing' specific contribution to care in any situation" (p.209).

Developing cultural practice in the New Zealand nursing context has followed a distinctly different path from other countries. Cultural safety emerged in response to indigenous nurses challenging nursing education that did not support them to provide appropriate care for their own families. Cultural practice within the New Zealand nursing context is underpinned by the principles of Te Tiriti o Waitangi, kawa whakaruruhau and cultural safety. These principles provide a framework to enable nurses to engage with patients in meaningful ways that are inclusive and responsive to patients' cultural and holistic needs. Integrating these principles into everyday practice enables nurses to establish therapeutic relationships that support informed decision making and empower participation in care planning. These practices have the potential to promote improved health outcomes for Māori patients and other patients from diverse cultural backgrounds.

Under the Health Practitioners Competence Assurance Act (2003) nurses are required to demonstrate cultural competence. However, registered nurses have different experiences of cultural safety education dependent on when and where they trained. Nurses trained in New Zealand prior to 1992 may not have completed cultural safety as part of pre or post-registration education. English speaking nurses trained overseas may not have completed cultural safety education within the New Zealand context to gain their New Zealand registration. Other overseas trained nurses, who have English as a second language, are required to complete a Competence Assessment Programme (CAP) (NCNZ, 2011b) to gain New Zealand registration. This programme provides an introduction to cultural safety. Despite different backgrounds, all registered nurses practising in New Zealand are required to meet the same cultural practice requirements as nurses who have completed cultural safety as part of an undergraduate nursing programme. Although it is twenty years since the introduction of cultural safety as a fundamental component of nursing education in New Zealand, there is limited evidence on how nurses integrate the principles of the Treaty of Waitangi and cultural safety into their practice, or how they assess that their care is culturally safe for patients. Therefore, it is timely to examine how the diverse backgrounds described above influence cultural practice in nurses' everyday practice.

Defining nursing

The NCNZ (2010a, 2010b) defines nursing in terms of scopes of practice and sets the standards for clinical and cultural competence and ethical practice as required by the Health Practitioners Competence Assurance Act (HPCAA) (2003). Nursing professional organisations and theorists (Benner, 1984, Christensen, 1990; Watson, 1997) describe nursing from many perspectives, including: the role and function of the nurse, the theories that support practice, knowledge and technical skills, the provision of care to individuals and communities, and the impact of nursing practice on health outcomes. The public characterises nursing from their experience of what nurses do and how they deliver nursing care (Calman, 2006; Conway et al., 1996; Irurita, 1999).

As health practitioners, nurses in New Zealand are legally obligated to work within their scope of practice and provide evidence of how they meet the NCNZ competencies (2007, 2010b) for these scopes, as well as other requirements for continuing competence. In order to promote nursing, it is important that nurses are able to articulate how nursing contributes positively to health outcomes, for Māori and

other patients who access nursing and health services. From personal experience of supporting nurses to reflect on their clinical and cultural nursing decisions and practice, nurses find this articulation very challenging. Nurses more commonly describe their practice by what they do, thus reducing nursing to tasks, rather than focusing on their approach to practice. Practice includes nursing knowledge and critical thinking to support clinical and cultural decision making and problem solving. Although the nursing workforce in New Zealand consists of registered nurses, enrolled nurses, nurse practitioners and unregulated health workers, this research focuses specifically on registered nurses who “determine how, when and under what conditions” nursing tasks will be undertaken and by whom (Clendon, 2010a).

Clendon (2010, p.3) defines nursing in Aotearoa New Zealand as:

an evidence-based practice discipline underpinned by nursing theory and research. Nursing’s core focus is people (he tangata) - with or without disease. Professional nursing practice attends to the differing ways in which people experience health, well-being, illness, disability, the environment, healthcare systems, and other people, and brings coherence to all that contributes to positive health outcomes. It is the relational processes, knowledge and skills of nursing that enable people to get on with their lives, whatever their health circumstance. Nursing assures a human face in health care. The discipline of nursing in Aotearoa New Zealand addresses the uniqueness of our cultural experience: professional nursing practice is founded on whakawhanaungatanga, rangatiratanga, and wairuatanga (Clendon, 2010, p.3).

This definition purposefully embeds the uniqueness of cultural practice within the New Zealand context and the quality of nurse-patient relationships as key components of nursing. Nursing is perceived as a caring and compassionate profession that adopts a holistic approach to patient care focusing on the relationship and the interaction between patient and nurse. Studies identify that this humanistic and relational nursing approach has a positive impact on health outcomes (Clendon & Dignam, 2010; Krothe & Clendon, 2006; Sadala, Miranda, Lorencon, & de Campos Pereira, 2010; Yarwood, 2008).

Culture and nursing in New Zealand

Although culture is always socially and politically constructed, this is not always acknowledged. There are many interpretations and definitions of culture which have

changed over time. Culture as a social construct is affected by historical and political factors and has been described as essentialist, culturalist and assimilationist (Browne & Varcoe, 2006; Gray & Thomas, 2006; Vandenberg, 2010). According to their categorisation the essentialist view reduces culture to beliefs and values as understood by an outsider and applied to all people of that culture. Culture from this perspective is static and determines behaviour, however it would not enable nurses to see and understand the complexity of culture. A culturalist attitude views cultures from a narrow perspective, sees cultures as exotic and stereotypes the cultural differences (Gray & Thomas, 2006). Based on this discourse, there is the potential for nurses to stereotype patients and not recognise cultural differences. The assimilationist belief points out differences as abnormal and seeks to suppress difference and support the status quo. This approach introduces a monocultural context whereby everyone conforms to the dominant culture. Syme, Rameka and Willis (2006) argue that assimilation is the dominant attitude in Canada and this has had a negative impact on health outcomes for indigenous people, in terms of access and options for health care. Although a nurse's own individual cultural beliefs and experience may be based on one of these stances, they are not conducive with the principles of the Treaty of Waitangi or cultural safety.

In the 1970s - 1980s the effects of colonisation on the health of Māori saw increasing political awareness and activism by Māori, as well as more Māori working in education, welfare, justice and health. Māori also challenged why they were over-represented in negative statistics in all these areas compared to the general population (Durie, 1994; Ramsden, 2005). The Treaty of Waitangi Act (1975) and the establishment of the Waitangi Tribunal brought the Treaty to the attention of all New Zealanders. The public debate around the Treaty created division between some Māori and non-Māori. At this time culture was aligned to race, race meant Māori and Māori equated to race relations, creating a stronger focus on the socio-political construction of culture (Durie, 1994; Ramsden, 1990b, 1993, 2005). This debate about Māori and non-Māori is reflected in discussions about the notions of biculturalism and multiculturalism. The historical foundation of New Zealand as a nation is based on biculturalism as embodied in the Treaty of Waitangi.

In New Zealand the term *biculturalism* came to represent the relationship between Māori 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 Māori were contesting for resources or arguing for attention to Māori-defined political issues (Ramsden, 2005, p.5).

Multiculturalism reflects a reductionist stance by 'othering' different cultures and measures other cultural practices against the dominant culture's way of doing things (Allen, 2006). Although New Zealand is a multicultural society, the Treaty of Waitangi and cultural safety are based on a bicultural policy as the accepted policy fundamental to New Zealand. Replacing bicultural with multicultural policy has the potential for Māori as tangata whenua to be subsumed with other cultures and ethnic minority populations and the validity of the Treaty of Waitangi may then be questioned.

The notion of cultural safety in nursing and the exploration of culture emerged from the resurgence of Māori rights and acknowledgement of obligations under the Treaty of Waitangi. The historical context has also influenced the perception of culture within a nursing framework. The introduction of cultural safety in New Zealand nursing education positions biculturalism as the context for the Treaty of Waitangi as well as acknowledging the culture of the nurse and the culture of the patient. Cultural safety education supports nurses to be more aware of their own culture, biases, prejudices, and attitudes towards people who are different to them, in order that they are able to care for patients in a non-judgmental manner (Ramsden, 1993). The discourse on culture in New Zealand nursing has changed in relation to interpretations of New Zealand history and changes in nursing practice and professional development. In colonial times culture was interpreted as 'racialised other' in relation to Māori (Richie, 1963; Sinclair, 1960, cited by Spence, 2001) and based on racial differences between Māori and the British settlers. From this time up to the mid 1900s, nurses construed culture in relation to differences between primitive and civilised races, and saw themselves providing civilised health care to the natives. During the mid-twentieth century, the concept of culture was relatively invisible in New Zealand nursing, as priority was given to gaining recognition as a profession, and changing nursing education from hospital to tertiary based training programmes (Spence, 2001). In the 1970s, culture in the New Zealand nursing context was conceptualised holistically and nurses training in the tertiary sector were "taught to assess and respond to patient's physical, emotional, social and cultural health needs" (Spence, 2001, p.54).

Through changes in education, the introduction of anti-racism workshops and integration of the Treaty of Waitangi into health policies and nursing curricula, a biculturalism discourse emerged. In the late 1980s at the Hui Waimanawa, Maori nursing students highlighted concerns about their ability to maintain their integrity as

Maori within current nursing education curriculum, and they questioned the ability of the nursing programmes to adequately prepare them to care for their own people. Their call to move from cultural sensitivity to cultural safety resulted in the development of 'Kawa Whakaruruhau: cultural safety in nursing education in Aotearoa' (Ramsden, 1990) and the re-defining of culture in nursing.

As mentioned previously, culture is a social construct influenced by social interactions, affected by historical and political factors and is identified as a social determinant of health and therefore, has an impact on health outcomes (Brown & Varcoe, 2006). Smye, Rameka and Willis (2006) argue that nurses need to examine culture critically from the power base, socio-political and historical perspectives. This enables them to use a reflective process and a cultural safety framework to explore these elements. Through this process nurses can gain a better understanding of the people they care for. In addition to the culture of the patient and the nurse, nursing also has a culture influenced by attitudes, values, worldviews and power. How these are used can be beneficial or detrimental to the health experience of patients and their family/whānau and/or the community. The culture of nursing, the culture of the individual nurse, as well as the culture of the patient, must be considered in the aim to optimise health outcomes, particularly for indigenous people as well as other groups of patients. The 'culture' of health care organisations also influences how nurses can be responsive to cultural needs, and access resources to improve health outcomes for Māori and patients from other cultural backgrounds.

2.9 The development of cultural safety

The introduction of cultural safety and the integration of Māori models of health, such as Te Whare Tapa Whā (Durie, 1998) and Te Wheke (Pere, 1991) into nursing programmes, has been the nursing profession's response to reducing barriers and providing culturally appropriate care for Māori and other New Zealanders. (Ramsden, 1990a, 1990b; Stout & Downey, 2006; Turale & Miller, 2006; Walker, Cromarty, Kelly & St Pierre-Hansen, 2009; Wilson, 2008). It is disappointing that, despite the introduction of kawa whakaruruhau, there has not been a more significant improvement for Māori's experience of health. There is consistent evidence of disparities in health between Māori and non-Māori New Zealanders (Bramley et al., 2004; Durie, 1998; Reid, Robson, & Jones, 2000). These disparities include life expectancy, public hospitalisations, infant mortality, mortality and morbidity.

In the 1980s making a positive difference to health outcomes for Māori was not only on the nursing agenda but also on a plan for Māori health professionals and the government. Evidence emerged identifying a significant difference in health outcomes for Māori when compared with other New Zealanders. At the same time there was growing awareness of the effects of colonisation, loss of tikanga and te reo Māori, loss of identity, self-esteem and pride in being Māori, and economic status and the impact of all of these on Māori health (Ramsden, 1990a, 1990b; Stout & Downey, 2006; Turale & Miller, 2006; Walker, Cromarty, Kelly & St Pierre-Hansen, 2009; Wilson, 2008). This was the subject of discussion at many hui of Māori, the most notable at Hoani Waititi Marae, Auckland, in March 1984. Māori health professionals attended this hui to discuss concerns about Māori health, including increased Māori involvement in the development of services and delivery to Māori, the need for further research, and recognition of evidence identifying that Māori health issues were different to those of the general population. From the 1980s, Maori models of health and wellbeing (Durie, 1994; Pere, 1991) emerged to support a more holistic approach to health care which were integrated into curriculum by nursing schools. A Model for Negotiated and Equal Partnership (Ramsden, 1989) was presented as a report and accepted by the Department of Education and became the catalyst for the implementation of kawa whakaruruhau into nursing education.

Cultural safety was born from the Māori experience of poor health care and underpinned by a bicultural philosophy. The Treaty of Waitangi was used as the framework for the development of cultural safety and the shift of power from nurses to the recipient of nursing care. Therefore, cultural safety emerged as an approach to enable patients to determine whether or not a nurse had safely met their cultural needs (Papps, 2002; Ramsden, 1993, 2000; Wepa, 2005). One could argue whether meeting cultural needs is the proper focus of nursing! Should it be expressed differently? For example, a nurse should provide nursing care in such a way that safely meets the holistic needs of patients and improves patient outcomes. The Treaty of Waitangi provides the context for nurses' engagement with Māori patients and their whānau. This means involving them in informed decision making, improving access to services to meet their holistic needs, and enabling Māori to achieve the same health outcomes as other New Zealanders.

At the same time as the introduction of kawa whakaruruhau educational institutions adopted a more market-led philosophy, placing an emphasis on the student as a consumer and student satisfaction. This ideology is in conflict with the concept of

cultural safety which requires students to step outside their comfort zone to critique the status quo, examine power relationships and health disparities. From this they are expected to advocate for social change when in reality they may benefit from the status quo (Freshwater, 2000). This is challenging for students as well as educators.

Theory underpinning cultural safety

The concept of cultural safety was “informed by emancipatory educational theory and critical thinking with feminist theory providing much of the theoretical glue” (Ramsden, 2000, p.5). Irihapeti Ramsden (2000, p. 5) acknowledged that the theory of cultural safety was:

...clarified by the works of Paolo Friere, Edward Said, Frantz Fanon, J. Blaut, Ward Churchill and other neo-colonial theorists as well as transformative theorists concerned with the analysis of power such as Henry Giroux and Michal Foucault.

The neo-colonial writings of these theorists were based on the experiences of colonised and marginalised people internationally, as these experiences were similar to those experienced by Māori in New Zealand. Critical theory was developed by the Frankfurt school, a group of writers connected to the Institute of Social Research at the University of Frankfurt, although they did not develop one unified approach. Critical theory challenges the status quo and promotes emancipation and transformation (Kincheloe & McLaren, 2000). Researchers positioning their research from a criticalist paradigm use their work as a form of cultural or social critique and accept basic assumptions as identified by Kincheloe and McLaren, (1994, p.139-140, cited by Ponterotto, 2005):

All thought is fundamentally mediated by power relations that are socially and historically constituted; [b] facts can never be isolated from the domain of values or removed from some form of ideological inscription; [c] language is central to the formation of subjectivity; [d] certain groups in society are privileged over others; [e] oppression has many faces and that focusing on one at the expense of others often elides the interconnections among them; and [f] mainstream research practices are generally implicated in the reproduction of systems of class, race, and gender oppression.

These assumptions are conceptualised in cultural safety and relate to indigenous and other oppressed cultural groups. The cultural safety curriculum challenges nursing students to understand the impact of colonisation on Māori as tangata whenua, and

consider the effect of oppression on other marginalised groups in society. Critical theory perspectives and cultural safety principles are concerned with empowering people to move beyond the race, class or gender constraints that have been placed on them (Kincheloe & McLaren, 2000).

Feminist perspectives view women's diverse situations and the institutions that frame these as problematic. Research using this approach may relate to policy issues, where there are social justice concerns in situations where women are oppressed (Olesen, 2000). Olesen acknowledges that feminism is very complex and that there are many strands that contribute to the complexities of feminist theory which includes women of colour, lesbian research and disabled women. The theoretical and philosophical underpinnings of critical and feminist approaches provide a foundation for cultural safety and have the potential to make a difference for oppressed and marginalised groups of people.

2.10 Introduction of cultural safety

The integration of cultural safety into the nursing curriculum in 1992 was nursing's response to meeting the health needs of all New Zealanders, while also recognising obligations to Māori under the Treaty of Waitangi. The media's portrayal of cultural safety as relating only to Māori, sparked a debate that brought nursing and the Nursing Council of New Zealand under scrutiny. The media and the public perceived that the debate was essentially about culture and therefore about Māori, race relations and politics (Papps, 2002; Ramsden, 1993; Spence, 2001; Wepa, 2005). The public was led to believe that important aspects of nursing education was being replaced by cultural safety, the history of New Zealand and Māori culture. And indeed there was the occasional very public example where the latter were critiqued.

A student at the Christchurch Polytechnic complained that she had been unfairly excluded from a nursing course because she had failed a 'hui' [meeting]. The media were quick to take up her cause though they had not fully appreciated the complexities of the case, nor the position statements which would come, eventually, from the Polytechnic Council and the Nursing Council. Both pointed out that it was not a hui [meeting] which had been failed but an essential component of the nursing curriculum, cultural safety (Durie, 1998, p.114).

Profiling of cultural safety by the media and public and political responses to the 'teaching of colonial history in nursing highlighted' the discomfort expressed by many groups (Ramsden, 2000, p.6). This almost resulted in a parliamentary select committee inquiry into the teaching of cultural safety education in the nursing programme. Even though this did not occur nurses were called to account before the Select Committee on Education and Science, on a number of occasions. A change in the chair of the Select Committee to the Hon. Margaret Austin saw her defend the nursing position and, along with advice from the Chief Nursing Advisor to the Government, helped explain the "realities of nursing education, practice and cultural safety to politicians" (Ramsden, 2000, p. 6-7). The Nursing Council undertook their own review and the New Zealand Nurses Organisation also surveyed members' views of cultural safety. Further reviews by the Polytechnics Association and the Ministry of Health found cultural safety was important in nursing education. Coverage by the media reduced over time as support by nursing and midwifery leadership and the public became obvious. Although the use of 'safety' was challenged by other interested parties, nursing has continued to defend this language in order to remain consistent with practice (Papps & Ramsden, 1996; Ramsden, 1993, 2005).

It is noteworthy that the current and previous definitions have acknowledged cultural safety in terms of a broad definition of culture, with no specific acknowledgement of Māori or the Treaty of Waitangi and yet, this is the component which caused the most controversy in the eyes of the New Zealand public. When reviewing the progress of cultural safety ten years from introduction Ramsden (2000, p.4) stated:

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

Opponents within nursing, tertiary education providers and the students themselves were also vocal about their opposition to the concept of cultural safety and the requirement for nursing students to gain an understanding of things Māori, including the language. Some students publicly objected to visiting marae and learning about Māori culture. In at least some cases depictions of tupuna in marae were interpreted as 'gods' discomfiting some of a different faith (Papps, 2002; Ramsden, 1990a, 1990b, 1993; Wepa, 2005). Although viewed as a controversial change to nursing, proponents of cultural safety and the Nursing Council of New Zealand have remained committed to the inclusion of cultural safety as a core element of nursing training.

The focus of cultural safety is the power relationships and the rights of people, although this was not how it was initially portrayed in the media and public arena.

However, the debate was not inclusive of the impact on growing culturally diverse populations immigrating to New Zealand. This does not appear to have been addressed as part of the introduction or on-going implementation of cultural safety. Although the initial motivation for the implementation of cultural safety was to make a difference to health outcomes for Māori, cultural safety is inclusive of others from many different backgrounds. However, this may not have been translated well into the curriculum as anecdotally, the perception remains that cultural safety only relates to Māori and the Treaty of Waitangi. Mortensen (2008, 2010) questions how well cultural safety meets the needs of CALD populations in New Zealand. This has also been challenged by others (Johnstone, 2008; Johnstone & Kanitsaki, 2007; Richardson, 2004). Wilson (2008) also describes cultural safety from a broad context:

as the capability of the nurse to articulate and demonstrate culturally appropriate and acceptable health services where clients feel culturally safe, and that reflecting the nurse's reflexivity, knowledge and skills, and an ability to work meaningfully with clients to meet their unique health and cultural needs during their health experience (Wilson, 2008, p.185).

Cultural safety also introduced students to a different history of New Zealand to what they may have been exposed to. Students then started to question what they had been taught in school which challenged their own reality, and often created a range of emotional responses. How these responses were addressed was critical to students moving through a three stage process from cultural awareness to achieve cultural safety in nursing practice (Nursing Council of New Zealand, 2011a). These stages are described later in this section. The discourse on there being two different views of the history of New Zealand depending on whether this is experienced from a Māori or a Pakeha worldview, has been supported by nursing leaders (Papps, 2002; Ramsden, 1990a, 1990b, 1993; Wepa, 2005).

Due to changes within the Ministry of Education at the time of the introduction of cultural safety, a national curriculum for cultural safety was not initiated, nor peer review processes for teachers of cultural safety implemented. Although the Nursing Council provides guidelines for cultural safety, Treaty of Waitangi and Māori health in nursing education and practice (2009), nursing education providers have developed their own curriculum to meet their local needs.

2.11 Cultural safety education

Cultural safety in nursing education and practice, provides nurses with a framework to reflect on how their own culture influences their behaviours and values, and thereby gain an awareness of what they bring to the nurse–patient relationship, understand the impact of colonisation and monoculturalism on the health of Māori, and work effectively with Māori to improve health outcomes (Ramsden, 1993; Wepa, 2005; Wilson, 2008). Although originally the cultural safety framework emphasised working with Māori, the framework was also intended to be inclusive of the broader context of culture which included age, gender, sexual orientation, disability, religious beliefs as well as ethnicity (Ramsden, 2000; Spence, 2001, 2003).

There are three phases that nurses progress through when learning about cultural safety. During phase one (dualism), students are made aware of cultural differences in order to understand the emotional, social, economic and political contexts of people's lives. Students are encouraged to move from thinking of the world in absolutes or right and wrong, to see there are many different ways of viewing the world. In phase two (relativism), students develop cultural sensitivity and start to explore their own life experiences, and how these may affect their view of others. They should realise that their opinion may be right for them, but can be different for others. It is at this stage that it is intended that they start to respect and value cultural difference. Phase three enables an evolving commitment, with the expected outcome being a worldview embracing cultural safety. Students are expected to commit to develop strategies which align their behaviours with culturally safe practice, while at the same time being aware that their own views and values will evolve over time (Wood & Schwass, 1993).

The local articulation of cultural safety was a deliberate strategy to encourage tertiary providers to engage with iwi (tribes) to develop the programme curriculum. However, the lack of a national cultural safety curriculum has resulted in inconsistent development and implementation, and confusion between the principles of the Treaty of Waitangi and cultural safety. Jeffs (2001) suggests that different strategies for cultural safety education introduce a range of outcomes that may not be consistent with the principles of cultural safety. For example, where culture is viewed from the dominant perspective rather than in terms of power, cultural safety may be substituted for a course on Māori health, rather than seeing both as essential (Jiwani, 2000). When the relevance of ethnicity is removed and categories of differences as

competing cultures are the focus, this is a form of multi-culturalizing. By placing one form of oppression in competition with others, this may maintain the status quo by a process of 'divide and rule'. The process to de-personalise focuses on the nursing culture rather than the nurse as the culture bearer. The nurse does not examine self culturally in practice but nursing as a culture in practice. This process of rendering the person and their power invisible does not allow for culturally safe practice by design, only by accident (Jefferis, 2001).

The process and teaching of attitudinal change as an essential part of cultural safety education originated from Jefferis' own experience, is based on the work of Wood & Schwass (1993), and informed by the writings of several theorists (Freire, 1972; Giroux, 1988; Hooks, 1994; Ramsden, 1994). They contend that no education is politically neutral and that the inclusion or exclusion of information is politically dictated. Ramsden (1994, p.20) argues that "Education should be emancipatory and liberating. People should be able to use it as a revealing and guiding tool for their lives". The notion of cultural safety challenges educators and students and invokes a range of responses including, students withdrawing, being angry, blaming the educator or absenting themselves from the class. A more positive response requires students to take responsibility for their own learning, including time to process new material.

All undergraduate nursing programmes are required to meet the NCNZ standards for nursing education which is inclusive the Treaty of Waitangi, cultural safety and Māori health. How these are integrated into the nursing curriculum is largely determined at a local level. The different approaches identified have a significant impact on nurses' understanding of the principles of the Treaty of Waitangi and cultural safety and how to apply these principles in their practice. As a result of providing culturally appropriate care to Māori patients, this:

increases the likelihood of Māori engaging with health professionals and health services, improves adherence to treatment plans, and ultimately improves overall Māori health status.... culturally competent practice should include consideration of Māori needs, values and preferences across all domains of practice" (Jansen & Jansen, 2011, p.48).

The cultural safety model is a broad concept which takes into consideration the power held by health professionals, as well as the institutional power of the health system. It is expected that the nurse will play a critical role in social change as a

result of progressing through the cultural safety framework. Within the cultural safety model, a clear theoretical base is needed for the development of cultural safety practices for CALD groups. New Zealand studies have identified lack of cultural knowledge and skills in the health workforce as a major barrier to the provision of accessible, safe and equitable health services for Asian, refugee, and culturally diverse migrant groups (De Souza, 2005, 2008; Lawrence & Kearns, 2005; Mortensen, 2008, 2010). Mortensen (2010) recommends evaluation of the impact and outcomes of culturally safe care for CALD groups, and incorporation of the findings into a review of competency indicators for culturally safe care for CALD groups. She also identifies the need to develop nursing graduate and post-graduate programmes which facilitate culturally competent practice for CALD populations. She acknowledges that communicating effectively cross-culturally depends on nurses' ability to gain rapport with patients, and an ability to adapt to a range of verbal and non-verbal communication styles to avoid misunderstandings (Mortensen, 2008, 2010). All nurse-patient therapeutic interactions are not the same and distinctions may be evident between the short-term, episodic relationships typical of hospitals where technological skills are emphasised and continuing community care where interpersonal skills are a priority (Henry, 2008; Shih & Honey, 2011).

The ability of nurses to engage with Māori in meaningful ways and comply with professional standards and patient rights has the potential to impact positively on health outcomes. However, it is not apparent that we are at a stage where there is a common understanding of cultural safety as a concept, or how this relates to cultural competence and transcultural care. After such a tumultuous beginning, it could be argued that the implementation of cultural safety has not lived up to the expectations. Twenty years after the introduction of cultural safety, this is a significant concern for nursing.

2.12 Comparison of cultural safety with cultural competence and transcultural care

The literature refers to cultural practice in terms of cultural safety, cultural competency and transcultural care. These terms are often used interchangeably but although there is some overlap, there are also some distinct differences between the terms. These differences relate to a number of factors including, their underpinning theoretical frameworks, the role of the health practitioner, and the role of the patient within each framework. Cultural safety and cultural competence may appear similar

because they are both about the relationship between patients and the health practitioner, however, it is the outcomes of the relationship that distinguishes the difference (Durie, 2001a).

Durie (2001a, p.2) argues that “cultural safety centres on the experiences of the patient or client, while cultural competence focuses on the capacity of the health worker to improve health status by integrating culture into the clinical context”. He also suggests that cultural competence places an emphasis on the doctor-patient relationship that requires doctors to have an understanding of different worldviews to health and western medicine, appreciating “the values upon which cultural integrity is based”, and “values related to the utilisation of space and time” (p.6-7), the different worldviews of health and wellbeing, and the role of family and community in the health experience. However, although doctors’ engagement with patients and acknowledgement of their cultural realities is essential, according to Durie, the focus of cultural competence is on the therapeutic relationship to improve health outcomes.

In contrast to this, cultural safety places the emphasis on the manner in which nurses engage and establish therapeutic relationships and work in partnership with patients to meet their holistic needs, while at the same time being regardful of difference. The focus of cultural safety relates to improving health outcomes, and the inclusion of the Treaty of Waitangi, highlights the obligation to specifically improve health outcomes for Māori. Cultural safety emphasises that the patient and family/whānau determine that care has been provided in a culturally safe manner. Cultural safety education also enables the nurse to examine his/her own culture, and nursing’s professional culture of power, in the nurse-patient relationship (Cooney, 1994; Coup, 1996; Ramsden, 1990a, 1990b, 2000; Spence, 2003).

When Mortensen (2010) examined whether cultural safety works in practice for CALD groups, she concluded that further development of the model is needed to prepare nurses to meet the needs and provide culturally safe care for patients from ethnically diverse groups. She made a number of recommendations including clarification of the theoretical base for patients from CALD groups, and review of competencies to integrate the knowledge and skills required to safely care for patients from CALD backgrounds. She also recommended evaluation of the effectiveness of culturally safe care for these populations and the impact on outcomes.

Durie (2001a) implies that medical professionals have chosen cultural competence in order to move away from the political associations of cultural safety and “towards a health-oriented justification” (p.3), in response to a changing demographic profile for Māori and the changing ethnic diversity within New Zealand. The nursing profession remains committed to the concept of cultural safety along with midwifery and physiotherapy practitioners (Bassett & Holt, 2002; Bassett & Tango, 2002; Durie, 2001; Haswell, 2002; Midwifery Council of New Zealand, 2004; Nursing Council of New Zealand, 2007; Physiotherapy Board of New Zealand, 2005; Ramsden, 2000). However, it remains unclear how health practitioners (nurses, midwives and physiotherapists) evaluate whether the care they give is culturally safe, from the perspective of those receiving care.

Transcultural care focuses on the specific cultural values and beliefs of patients and provision of care based on nurses’ knowledge of particular cultural groups (Leininger, 1978, 2001). Transcultural care emphasises ethnicity and does not recognise the potential for subcultures within cultures, or the broader concept of culture, which is an integral part of cultural safety. The descriptive information of different ethnic groups integral to transcultural care risks stereotyping people. Cultural safety acknowledges there are sub-cultures within cultures in relation to age, gender, sexual orientation, disability, ethnicity, and so on. Education based on the transcultural framework concentrates on cultural care differences and similarities, with respect to the comparative values, beliefs, and practices which nurses need to know in order to provide culture specific care (Leininger, 1992, p.39). Within the cultural safety framework, nurses do not learn about the specific values and beliefs of different ethnic groups, but focus on engaging with patients to enable them to feel comfortable sharing what is important for them, what their specific needs are, and how they would like their values and beliefs integrated into their care. Understanding the dynamics of power, race and social inequities are an integral part of transcultural theory. However, the impact of institutional power as a barrier to access for culturally diverse groups, and the reduction of inequalities in the population are not promoted within transcultural models (Cooney, 1994; Coup, 1996; Ramsden, 1990a, 1990b, 2000; Spence, 2003).

There are two different schools of thought in nursing on how the cultural needs of indigenous and minority ethnic groups can be met: transcultural care (Leininger, 1978, 1991, 1996) and cultural safety (Ramsden, 1993, 2000). The notion of cultural care was first conceptualised in Leininger’s theory of transcultural care (1978).

Leininger's blend of nursing and anthropology provides a theory to underpin nurses' practice when caring for people from different cultures. Transcultural nursing education provides nurses with scientific knowledge on a variety of different cultures, although this may not acknowledge differences between patients from the same ethnic background. There is the risk of nurses perceiving themselves as 'experts' of patients' culture, with nurses determining what cultural care is appropriate, rather than the patient. Cultural competence aligns more closely with transcultural care as there is a focus of having knowledge of values and beliefs of different cultural groups. Within the cultural safety paradigm, the patient determines what their cultural needs are and how they would like them met.

There has been considerable debate on the similarities and differences between transcultural nursing and cultural safety. Where New Zealand researchers see differences between the approaches, Leininger argues that these are similarities and contends that cultural safety is embedded in her theory of transcultural care. The most fundamental difference is the origin of transcultural nursing in anthropology and the origin of cultural safety from critical theory. Within transcultural theories nurses learn about cultural differences from the dominant western culture. The power of the nurse is evident in both of these models, but the difference is how that power is shared with the patient. Nurses trained using cultural safety principles learn the importance of sharing power and enabling patients to be active participants in their care choices. This is not the same as the transcultural framework (Cooney, 1994; Coup, 1996; Leininger, 1996, 1997; Mortensen, 2010; Richardson, 2004; Richardson & Williams, 2007; Smith, 1997; Wilson, 2008).

There are divergent opinions on how transcultural care (Leininger, 1978, 1996) and cultural safety (Ramsden, 1990, 1992) meet the cultural needs of indigenous and ethnic minorities. The literature is relatively silent on how effective these frameworks are for the development of cultural practice, how nurses apply the principles to their practice, or if cultural safety education is achieving the outcomes expected. The objective of my study is to explore how nurses apply cultural safety principles to their practice and determine that they have provided care in a culturally safe manner.

2.13 Application in policy and practice

The NCNZ (2007) competencies for the registered nurse scope of practice identify two competencies under Domain One: Professional Responsibility, which specifically relate to application of cultural practice. They are as follows:

Competency 1.2: Registered nurses are required to demonstrate the ability to apply the principles of the Treaty of Waitangi/Te Tiriti o Waitangi to nursing practice. In order to meet this competency nurses are required to provide evidence of one of the following indicators:

- Understands the Treaty of Waitangi/Te Tiriti o Waitangi and its relevance to the health of Māori in Aotearoa/New Zealand
- Demonstrates knowledge of differing health and socio-economic status of Māori and non-Māori
- Applies the Treaty of Waitangi/Te Tiriti o Waitangi to nursing practice (NCNZ, 2007, p.7).

Competency 1.5 Registered nurses must practice nursing in a manner that the client [patient] determines as being culturally safe. In order to meet this competency nurses are required to provide evidence of one of the following indicators:

- Applies the principles of cultural safety in own nursing practice
- Recognises the impact of culture of nursing on client care and endeavours to protect the client's wellbeing within this culture
- Practises in a way that respects each client's identity and right to hold personal beliefs, values and goals
- Assists the client to gain appropriate support and representation from those who understand the client's culture, needs and preferences
- Consults with members of cultural and other groups as requested and approved by the client
- Reflects on his/her own practice and values that impact on nursing care in relation to the client's age, ethnicity, culture, beliefs, gender, sexual orientation and/or disability
- Avoids imposing prejudice on others and provides advocacy when prejudice is apparent (NCNZ, 2007, p.9).

These indicators provide nurses with examples of practice they need to demonstrate in order to meet these competencies. However, nurses often find this challenging. This may relate to the cultural education they have received. Nurses trained in the 1970s and 1980s, and International Qualified Nurses (IQN) may only have attended Treaty of Waitangi workshops, often as part of organisational requirements, and they mistakenly equate this to cultural safety for Māori. The principles of the Treaty of Waitangi and cultural safety may be applied at an individual practitioner level, at a service level, and at an organisational level. However, barriers to application may

exist at each or all of these levels. The more widely the principles and philosophy of care are integrated across a service or an organisation, the greater the potential to reduce barriers to the provision of culturally appropriate health care services.

Nurses have shared their personal experiences of learning from Treaty of Waitangi workshops and cultural safety education, and describe how this learning influences their practice when caring for Māori and other patients with differing needs (Manchester, 2010; Ren, 2009; Yorke, 2009). For example, a Chinese nurse (Ren, 2009) acknowledged how attendance at a Treaty of Waitangi workshop supported her to be more confident when working with Māori patients, and enabled her to support their cultural and spiritual needs, encourage patient participation in planning their care, advocate for patients at multidisciplinary meetings, and access appropriate resources to meet the needs of Māori patients. Ren engaged in discussion with students exploring their understanding of the Treaty principles and application to practice. She also recognised the Treaty principles that apply to Māori and Pakeha, were also relevant for application to relationships with patients from other cultures.

Richardson and MacGibbon (2010) asked nurses how they applied cultural safety in their every day nursing practice. Responses included: providing individualised care including engaging in relationships where the dignity of a person was upheld within the limitations of an established practice; changing practice or routines to meet patient needs; creating space for patient to express needs; being vigilant regarding colleagues practice and intervening in order to ensure cultural boundaries were not violated; and balancing cultural safety with the need for life saving nursing intervention. It is difficult to argue that these examples would fully meet the Nursing Council requirements for cultural practice. However, this may relate to the way participants were asked to reflect on the topic of cultural safety. In contrast, Ren provided more specific application of learning to her practice.

Nurses acknowledge they are continually learning from patients with diverse backgrounds, for example patients with disabilities, prisoners, and they understand the importance of effective communication when establishing and maintaining therapeutic relationships, as well as working in negotiated partnerships with patients and families with diverse needs (Manchester, 2010; Yorke, 2009). These aspects of care underpin the principles of cultural safety. Although the aim of my research is the nursing perspective, the patient experience informs nursing practice and enables nurses to continue to develop their cultural practice. This is an area which needs

further exploration. It is also important to consider that organisational 'buy in' to the concept of cultural safety, supported by policies and structures within a service or the organisation would create an environment that promotes culturally safe care.

At a service level, the growth of Māori nurse-led services and Māori Nurse Practitioners, illustrates how the principles of the Treaty of Waitangi and cultural safety can provide the foundation for building culturally appropriate and responsive health services for Māori patients, whānau, hapu and iwi. A Māori nurse-led service in Taranaki (Manchester, 2009) was established to improve access for Māori and meet their needs across the lifespan. This was achieved through the provision of a mobile Māori nursing service. Through consultation with the community these nurses identified a number of access barriers to timely health care: Māori were not accessing their general practitioner services for follow-up consultations or picking up prescribed medication due to cost; Māori were waiting for the next acute episode and subsequent hospital admission in order to access health services; and Māori were challenged by nursing and medical practices which were at odds with their traditional holistic and spiritually based worldviews. With this information, the mobile nursing service recognised a strong need for a culturally appropriate, affordable and accessible health service and therefore established a kaupapa Māori service based on Treaty of Waitangi principles and Taranaki tikanga values. Their short term goal was to improve entry to health care services for Māori, prevent and reduce the onset of chronic conditions and reduce the number of DNA (did not attend) patients. In the long term they aim to assist Māori to self manage their health outcomes with support of an advanced nursing service, to be a resource for Māori nurses wanting to improve their skills, and develop a Nurse Practitioner workforce focusing on disease state management. Although audits and contract rounds measure the success of services through input and output numbers, these nurses measured their success by how well patients understand their health conditions and medications, and the lifestyle changes that patients have made. Improved health literacy has led to a drop in hospital admissions and improvement in compliance with treatment and medication and patients accessing services earlier, rather than waiting until they reach a health crisis. This service is making a difference to health outcomes for Māori through the implementation of the principles of the Treaty of Waitangi and cultural safety.

The principles of cultural safety have also supported the establishment of organisations to meet health and social needs of different population groups. Otago Health Inc (OHI) is a not-for-profit organisation established in Otago more than ten

years ago by community leaders and health professionals, to meet the unique needs of this community, and provide health promotion, support community development and health education programmes, to improve health outcomes. This community includes Māori and Pacific peoples and low income New Zealanders, who participate at multiple levels in the organisation, as well as governance. The implementation of programmes to address housing, social, economic, environmental and cultural factors affecting families health and wellbeing, have achieved positive outcomes for the community (Manchester, 2007). Although now part of a larger Primary Health Organisation (PHO,) “the essence of Otago Health has always been about the community, rather than health care professionals, deciding what is needed” (Manchester, 2007, p.13).

The principles of cultural safety can be applied by individuals to their own practice to promote self-determination for patients from diverse backgrounds, as well as provide a framework for decision making and community involvement in health care organisations.

Adopting the thinking and processes of cultural safety offers the opportunity to deliver care to diverse groups which is more personal and acknowledges the richness and complexity of each individual health service user.... Cultural safety is a way to work in highly diverse communities in a way that helps remove the barriers of ‘power’ and ‘authority’ and promotes equality. Working in this way places the responsibility for appropriateness firmly with the nurse while giving the service user the right to declare when care does not feel culturally sensitive or safe (De & Richardson, 2008, p.43).

However, implementation of cultural safety is a contested discourse within the New Zealand health care system where more dominant discourses can constrain action.

2.14 Barriers to application in practice

Richardson and MacGibbon (2010) examine the power relationships in clinical practice and the challenges nurses face in implementing the principles of cultural safety into their practice in a hospital environment, which is defined by ‘traditional, nursing and biomedical discourses’. The responsibility for providing culturally safe care generally rests with the individual nurse and does not take into account other power and order factors in the clinical setting. Through their research they identified a number of factors that create actual or potential barriers for nurses implementing

cultural safety. In environments where powerful biomedical discourses dominate practice, nurses struggle with providing a nursing service beyond serving the needs of the physician and dominant biomedical belief. Nurses shared that in some situations existing discourses privilege routines above cultural care and personal preferences, such as interpretation of visiting hours dictates the primacy of the family in the healing process. Other barriers identified are the conflict between requirements of the institution versus meeting the needs of patients, and failure to recognise and respond to power imbalances between patient and nurse. Time is perceived to be the most significant barrier to implementing culturally safe care, and often means spending less time with patients, due to pressures to be more productive in terms of more effective care, and use of time. Working in negotiated partnership with patients is a central tenet of cultural safety, but developing relationships takes time that nurses perceive they do not have. When a patient is viewed as an illness rather than a person, the spiritual needs of the person, the healing relationships, the intimate personal contact through empathy, and the need to develop deeper trust with health care provider, are discounted.

Although it is disappointing that barriers to applying cultural safety exist, perhaps it is encouraging that nurses appear to be able to articulate what they are, and then work at addressing these. Despite the barriers, the professional, ethical and legal frameworks require nurses to apply the principles of the Treaty of Waitangi and cultural safety when caring for patients (NCNZ, 2007, 2009; New Zealand Nursing Organisation, 2010). If nurses are unable to meet these requirements due to perceived or actual barriers then they are not meeting their professional obligations or wider organisational requirements. This has the potential to increase cultural risk for patients.

In response to their research findings Richardson and MacGibbon (2010, p.63) concluded that:

Every day practices of culturally safe nursing are embedded within the nursing relationship and have to compete for legitimacy in settings dominated not only by alternative discourses of nursing, but by medical discourses and practices. Cultural safety provides a discourse that enables a nurse to address the complexity of nursing practice which involves all aspects of physical, social, emotional, spiritual and political concerns of the patient.

In addition to this they:

...believe that the accounts of nurses from a range of healthcare contexts show that cultural safety currently operates at the margins of other more powerful discourses, and that the ability of nurses to change the power relationships within hospital settings is tenuous. The degree to which cultural safety can be delivered continues to be influenced by embedded historical discourses controlling the construction and maintenance of gender roles and the efficient functioning of hospital structures and practices through order and discipline (p.64).

Wilson and Barton (2012) explored Māori experiences of hospitalisation in surgical and medical settings and revealed negative experiences that demonstrated how their needs were not always met. Māori patients and whānau want to understand how the hospital systems and processes work to help them navigate the systems more easily. They want whānau to be involved in their care and help provide personal care, in discussion with a nurse, rather than be forced to do it because the “nursing staff appeared too busy or gave the impression they were a nuisance” (p.6). They wanted nurses to be tolerant of Māori patient needs rather than exhibit behaviour that was seen as discriminatory and racist. Participants in Wilson and Barton’s study expressed the desire to receive culturally appropriate care in a “genuine and non-judgmental manner and aid spiritual well-being” (p.8).

2.15 Assessment of culturally safe practice

Assessment of culturally safe care by patients is clearly an aspect of health care that needs to be explored in light of the continued growth of cultural diversity in New Zealand, as studies identify the need to explore the effectiveness of cultural safety (Clear, 2008; Richardson, 2004; Richardson & Williams, 2008; Wilson, 2008). However, there is increasing knowledge and understanding of health experiences for Māori and CALD populations to assist health professionals to be familiar with strategies that support the cultural needs of a diverse range of patients. Research on Māori experiences of health services and cultural support highlights the whānau priorities (Bolitho & Huntington, 2006; Henry, 2008; Shih & Honey, 2011; Theunissen, 2011; Wilson, 2006, 2008).

Shih and Honey (2011) investigated the impact of dialysis on rurally based Māori and their whānau (families). Along with facing the fears and the stress experienced as

result of having dialysis, education and support were key themes that emerged from this study. The fear was often attributed to lack of information, whereas stress was often related to financial and cultural barriers to health management. “Cultural aspects included a lack of confidence to negotiate for aspects of health care” (Shih & Honey, 2011, p.7). Participants shared that the support of their whānau/families was the most important aspect of care for them along with the respect and support provided by health professionals. The involvement of health workers from the same cultural background was recognised as essential to on-going relationships and enabled better communication and enhanced care being provided by specialist services (Barton & Wilson, 2008; Durie, 1994; Henry, 2008; Shih & Honey, 2011). This is supported by studies concerning refugee and migrant populations (De Souza, 2005; Mortensen, 2010; North, Lovell & Trlin, 2006).

De Souza (2005, p.129) identifies a number of culturally sensitive strategies to improve nursing encounters with CALD populations:

- Collaboration- being open to and respectful of different belief systems and health care practices.
- Finding out about the lived experience of migration. This is particularly effective when working within health promotion and primary prevention.
- Becoming more aware of migrant women’s generations-old preconceptions about pregnancy, delivery and childrearing.
- Acknowledging the significance of religious practices and the important role of the extended family.
- Developing partnerships with cultural intermediaries so that the role of an ethnic support worker can be developed.

Encouraging nurses to gain cultural knowledge that belongs to other people, can be seen to conflict with Ramsden’s concept of cultural safety which promotes engagement, communication and relationship building with patients, rather than becoming an expert on different cultural groups. However, there is support for nurses to develop an understanding of the different values and beliefs systems of CALD populations in order to provide culturally appropriate care (De Souza, 2005; Mortensen, 2010; North, Lovell & Trlin, 2006). How this can be achieved using the cultural safety framework will be a challenge to avoid confusion with transcultural frameworks. Nurses acquiring extensive knowledge of the values and beliefs of CALD populations risks stereotyping and making assumptions based on culture and ethnicity, without considering the impact of the refugee and migrant experience and settling into a new country on the patient and their family.

2.16 Conclusion

Research reviewed in this chapter illustrates that the implementation of cultural safety is a contested discourse within the New Zealand health care system, and more dominant discourses continue to constrain action (De & Richardson, 2008; Mortensen, 2008, 2010; Richardson & MacGibbon, 2010; Richardson, 2004; Richardson & Williams, 2007; Richardson et al., 2009; Spence, 2003). Cultural diversity within international and New Zealand contexts, the place of indigenous people within the cultural diversity discourse, and different worldviews of health and health disparities, places incredible pressure on nurses to deliver culturally safe care to patients with such wide ranging needs. From the exploration of health experiences of Māori patients and whānau, it is evident that their expectations and needs are not always met and health disparities remain (Bolitho & Huntington, 2006; Henry, 2008; Theunissen, 2011; Wilson, 2006, 2008). Some of the literature shows that nurses are not feeling well prepared to meet the needs of CALD populations in an increasingly culturally diverse New Zealand. Nurses are identifying they need cultural knowledge and skills to work competently with CALD patients. Knowledge of beliefs, values and health practices of refugee and immigrant groups are important as these factors influence perceptions of health, illness, disease, families expectations and interactions with health care providers and the health care system (De Souza, 2005; Lawrence & Kearns, 2005; Mortensen, 2008, 2010; North, Lovell & Trlin, 2006).

The body of knowledge and research generally centres on the value of cultural safety, with limited evidence about the application in practice, or efficacy of cultural safety for the benefit of the patient. This may be influenced by the fact that asking patients if the care they have received has been culturally safe, potentially puts them in a difficult situation because if they express dissatisfaction, they may feel their care will be compromised in the future (Wilson, 2008). Although cultural safety was initially introduced as a nursing strategy to more effectively meet the needs of, and provide a more culturally responsive service for Māori patients and their whānau, there is limited evidence on the effectiveness of this strategy in improving health outcomes for Māori (Richardson & MacGibbon, 2010; Richardson & Williams, 2007; Richardson et al., 2009; Wilson, 2006, 2008). This raises questions about reasons for there being a weak relationship between cultural safety and health outcomes for Māori. 1) Theory of cultural safety not strongly embedded in practice, and 2) assumptions about relationships (colonisation–power–nurse) with Māori not accessing health care has not been tested. Cultural safety is based on the assumption that health disparities are

an outcome (causality) of colonisation when perhaps there are other explanations that are as (or more) significant. There is recognition that research is required to explore how the principles of the Treaty of Waitangi and cultural safety are applied in clinical practice (Clear, 2008; S. Richardson, 2004; S. Richardson & Williams, 2007; Wilson, 2008), and how this impacts on health outcomes for Māori and patients from other cultures. The increasing immigrant and refugee populations in New Zealand also raise the question of how cultural safety meets the needs of these groups (De Souza, 2005; Lawrence & Kearns, 2005; Mortensen, 2008, 2010; North, Lovell & Trlin, 2006).

The application of cultural safety to policy and practice for nurses at an individual, service or organisational level is complex. Barriers at different levels make application to practice challenging when other constraints are applied. It is difficult to know if the profession as a whole is practising cultural safety or just some nurses are. The assessment of cultural safety is reliant on nurses completing a self declaration or self assessment against the cultural competencies and other nurses assessing practice is culturally safe. The cultural safety framework does not provide a safe mechanism for nurses to empower Māori patients and patients from other cultural backgrounds, to determine that their care has been provided in a culturally safe manner, and has met their cultural needs. There is a paucity of literature on the determination of culturally safe care by patients, highlighting this as a critical aspect of future research. From the literature it is evident that the potential of cultural safety has not been fully realised as a model for nurses to provide culturally responsive and appropriate care for Māori patients and other patients from different cultural backgrounds.

2.17 Summary

This chapter has reviewed literature and research related to cultural practice in the international and New Zealand nursing contexts, and examined the impact of increasing cultural diversity and the impact on health. Health disparities for indigenous people were explored along with alternative worldviews on health and the significance of the Treaty of Waitangi on health for Māori. The development of cultural safety and the controversial introduction to nursing education were considered and critiqued against cultural competence and transcultural care as alternative models. Finally, application of cultural safety to policy and practice was explored, barriers to application identified, and the lack of mechanisms for

assessment of culturally safe care by patients highlighted. The limited evidence related to application to practice has led to the focus of this research.

CHAPTER THREE

Methodology

3.1 Introduction

This chapter outlines the research methodology used to explore the research questions and includes a description of processes used for participant selection, methods of data collection and analysis, and strategies employed to address ethical considerations and research rigour.

From the literature review, it became apparent that although there were a number of New Zealand studies on the implementation of cultural safety in the nursing curriculum (Mortensen, 2010; Ramsden, 2002; Richardson & Carryer, 2005; Richardson & MacGibbon, 2010; Spence, 2003), there was limited evidence on application of cultural safety and the Treaty of Waitangi to practice. The research questions were informed by the Nursing Council of New Zealand requirements for cultural practice, a review of literature and survey findings from my previous study (Baker, 2010). The research question is:

How do nurses articulate their cultural practice in the New Zealand context? The objectives are: (1) how do nurses apply the principles of the Treaty of Waitangi to nursing practice? (2) how do nurses apply the principles of cultural safety to nursing practice? In addition to this the research sought to: (3) identify if there is a different understanding of cultural practice between nurses from different backgrounds; and (4) understand how nurses assess that their practice is culturally safe, as determined by the patient?

A qualitative approach was employed for this study in order to explore how registered nurses working at the Waikato District Health Board (DHB) described their cultural practice. Qualitative data were collected through semi-structured interviews using open ended questions. In recognition of the diversity of the nursing workforce, participants were given the choice to be interviewed individually or as part of a focus group. Individual and paired interviews were audio recorded (with the permission of participants) and information transcribed. Inductive techniques were used to analyse

the data collected. The following section provides an overview of the methodological approach and links these to the purpose of the study.

3.2 Qualitative methodology

A qualitative approach was the most appropriate methodology to gain an understanding of the meaning nurses give to their cultural practice and the context in which they practice. Interactive, inductive and flexible methods were used to investigate nurses cultural experiences and perceptions, and take into account different interpretations of the same phenomenon. Inductive methods enabled me to be receptive to the emerging ideas from listening to nurses, and examine my own perceptions of cultural practice, during and after data collection. I was able to reflect on and analyse data from and between participants, as well as examine my own preconceived ideas. By using a semi-structured interview schedule I was able to use intuition to continue probing or change direction of the interview, to get closer to nurses perceptions and experiences of cultural practice. This allowed me to build on previous interviews and check on emerging ideas. Through this approach there was an opportunity to explore differences in perspectives, and encourage participants to expand on their responses, which may have also provided participants with new insights into their own cultural practice (Creswell, 1998, 2009; Parahoo, 2006; Punch, 2006; Ratcliff, 1994; Thomas, 2003).

Cultural practice was explored from a social constructivist philosophical worldview (Creswell, 2009; Crotty, 1998; Parahoo, 2006). Social constructivism acknowledges there are multiple meanings to phenomena which can lead to understanding the complexity of views, rather than adopting a narrower focus. Crotty (1998) suggests that people construct meanings from their interpretation of the world, based on their own historical and social standpoint, and their interactions with people and communities. Social constructivism does not support one truth or reality which strengthened my belief that, there is not one reality about cultural practice but multiple realities for nurses, as there are many variables that influence this phenomenon. Identification of multiple realities enables others to learn as it provides alternative perceptions of cultural practice. Therefore, I needed to make sense of the different meanings others have of their cultural practice. The goal of the research was to rely as much as possible on nurses' descriptions of cultural practice, although my own personal, social and historical experiences would be expected to shape interpretations, and position me in the research.

To encourage recruitment of participants willing to share their cultural practice experiences, the research focused on positive aspects of cultural practice and how, through implementation of the principles of the Treaty of Waitangi and cultural safety, nurses can have a positive impact on health outcomes for Māori patients, and patients from other cultural backgrounds. Appreciative inquiry (Cooperrider & Whitney, 1999; Fitzgerald, Murrell & Newman, 2001; Kelm, 2005) provides a positive strength-based approach to identify best practice, and has the potential to influence the practice we want to see more of. Constructivism is identified as one of the original principles of appreciative inquiry, acknowledging that reality is co-created, that there is no one absolute truth, and that reality is constructed through language (Kelm, 2005). Other original principles of appreciative inquiry include the poetic, simultaneity, anticipatory and positive principles. The poetic principle acknowledges the richness of life experience, that whatever we focus on grows, and the aim is to find what we want more of, not less. The simultaneity principle recognises that we live in the world our questions create, and that when we question we begin to change and that unconditional positive questioning can transform practice. The anticipatory principle appreciates that through focusing on positive aspects of cultural practice, this will help to create a positive vision for future practice. The positive principle accepts that promoting positive emotions helps to broaden thinking, while identifying and leveraging strengths (Kelm, 2005). Appreciative inquiry is often used to develop and transform organisations as part of action research (Fitzgerald, Murrell, & Newman, 2001; Kelm, 2005). Therefore, the principles of appreciative inquiry linked well to my research, as working with people in a professional development context, is common to both organisational development and to this study.

3.3 Participant selection and recruitment

Purposive sampling was used to recruit participants in order to gain the required information on nursing cultural practice as a phenomenon within a New Zealand context. This sampling method was used to be able to recruit registered nurses (RNs) from different backgrounds that included country of birth, ethnicity and time and place of nursing training. Enrolled nurses (ENs) were excluded from participating in the study as the previous EN training programmes did not include cultural safety, and they work under the direction and delegation of registered nurses. Organisational variation was limited by recruiting from just one organisation to minimise the cost and time commitment for participants. In line with this participants were limited to RNs working at the Waikato Hospital campus or Hamilton community settings, including

Mental Health and Addictions Services. The advantages of restricting the sample population to Waikato DHB and Hamilton were that the DHB serves a large diverse population, has a significant Māori population and from my own work experience, a diverse nursing workforce.

A recruitment flyer calling for Expressions of Interest (EOI) was distributed using the Waikato DHB senior nurse email group list. Senior nurses were asked to print out the flyer and display on notice boards in clinical areas. The advertisement outlined the purpose of the study, overall objectives, how they (RNs) could contribute, and how anonymity and confidentiality would be maintained. Nurses interested in participating in the research were invited to contact me by phone or email. I followed up with all nurses who expressed an interest and completed a 'criteria selection form' for each person, identifying ethnicity and when and where they completed their nursing training. Potential participants were then assigned to one of the following groups: 1) European nurses trained in New Zealand prior to 1990; 2) European nurses trained in New Zealand after 1990; 3) Māori nurses trained in New Zealand either prior to or after 1990; and 4) International Qualified Nurses (IQN).

A letter and further research information was then sent to all interested participants. The letter asked potential participants to identify their preference to be part of a focus group or an individual interview. The letter also included dates and times for focus groups for the participant group they had been assigned to. They were asked to indicate their availability for one focus group or an individual interview and return the form to me. A consent form (Appendix I) and participant information sheet (Appendix II) was included with the letter. Participants were asked to bring the consent form to the interview. All further contact with potential participants was made by email or phone. Once participants were confirmed for either a focus group or individual interview, they were sent an email reminder one week prior to the interview. The majority of participants were interviewed individually, either by preference or because they were unable to attend a focus group and eight participants were interviewed in pairs rather than in larger focus groups.

Like most beginner researchers my first fear when the notice was sent out for expressions of interest, was that no one would want to participate. I was pleasantly surprised that this was not the case and in the first three days I had received 14 EOI; these were primarily from European nurses trained in New Zealand prior to 1990. A number of EOI were received from nurses working outside Hamilton and these

nurses were notified they did not meet the criteria for inclusion in the study. Further EOI were received over the next two weeks which included European nurses trained in New Zealand after 1990, some Māori nurses and IQNs. At this stage I had identified enough European participants trained prior to 1990 and declined further EOI for this group. I identified that I needed more Maori nurse participants so I sent out a group email as well as hard copy information calling for EOI. This elicited a number of Māori nurses who had trained after 1990, and reached the stage where again I had more participants than I required. In the end Māori participants were the largest of the four groups of participants interviewed (n=7). The smallest group interviewed was the IQNs (n=4). I initially received only two IQN EOI from the general request for participants. Following discussion with colleagues and one of my supervisors, I sent out a further request by email asking for participants who had trained in the United Kingdom and Indian nurses. From this I was able to interview an English nurse and an Indian nurse who had trained in South Africa.

3.4 The participants

I had anticipated interviewing up to 30 participants in either five focus groups or individual interviews but in the end, a total of 22 participants were interviewed. The participants were from a range of clinical areas that included acute in-patient areas, emergency department, specialist services, mental health and addictions services and community services. Ten of the participants were staff nurses in clinical practice and the remaining participants worked in senior nurse roles. Seven of the senior nurses provided care in the in-patient as well as the out-patient/community setting. The title 'senior nurse' refers to registered nurses in senior nurses positions e.g. management, specialist, education and research. Participants not in senior nurse roles are referred to as staff nurses.

The participants in this study were grouped according to whether they trained in New Zealand or overseas, as well as the particular epoch the training took place. Participants trained in New Zealand were further grouped by ethnicity- European and Māori. The International Qualified Nurses (IQNs) self identified as European and Indian. Participants have been identified by pseudonyms depicting their ethnicity. Tables 1– 4 presents the four groups of participants and includes professional status and cultural education. Cultural education includes Treaty of Waitangi workshops and/or cultural safety education as part of undergraduate degree. The majority of participants had been in practice for more than ten years.

Table 1 presents six New Zealand European RNs trained in the period prior to the introduction of cultural safety, predominantly in hospital-based programmes.

Table 1 European nurses trained in New Zealand prior to 1990 (n = 6)

Pseudonym	Professional Status	Cultural education
Kate	Senior nurse.	Yes cultural safety included in bridging programme
Jane	Senior nurse	Yes cultural safety included in plunket training
Kelly	Staff nurse	No
Emma	Senior nurse	No
Jenny	Senior nurse.	Yes cultural safety included in bridging programme
Andrea	Senior nurse	Yes attended Treaty of Waitangi workshop as part of DHB orientation

Table 2 introduces five European nurses trained in New Zealand after the introduction of cultural safety. One of these nurses had trained as an EN prior to 1990 pre cultural safety and completed cultural safety as part of her RN training.

Table 2 European nurses trained in New Zealand after 1990 (n = 5)

Pseudonym	Professional Status	Cultural education
Tony	Staff nurse.	Yes cultural safety in training
Fiona	Senior nurse	Yes cultural safety in training
Sally	Senior nurse	Yes cultural safety in training
Robyn	Staff nurse	Yes cultural safety in training
Julia	Staff nurse	Yes cultural safety in training

Table 3 represents the largest group of participants, Māori nurses. This group includes nurses who trained pre and post cultural safety.

Table 3 Māori nurses trained in New Zealand (n = 7)

Pseudonym	Professional status	Cultural education
Kuini	Senior nurse	No
Pare	Senior nurse	No
Aroha	Staff nurse	Yes cultural safety in training
Te Rina	Staff nurse	Yes cultural safety in training
Rangi	Staff nurse	Yes cultural safety in training
Mana	Senior nurse	Yes cultural safety in training
Moana	Staff nurse	Yes cultural safety in training

Table 4 presents the smallest group of participants, International Qualified Nurses, who self identified as European and Indian

Table 4 International Qualified Nurses (IQN) (n = 4)

Pseudonym	Professional status	Cultural education
Mike	Senior nurse	Yes Treaty of Waitangi workshop as part of induction
Sara	Staff nurse	Yes Treaty of Waitangi workshop as part of induction
Caitlin	Staff nurse	Yes Treaty of Waitangi workshop as part of induction
Nirmela	Senior Nurse	Yes Treaty of Waitangi workshop as part of induction

3.5 Data collection

Data were collected on how nurses described their cultural practice from paired and individual interviews which I personally conducted. An observer was present in the paired interviews to document a written record of the interview to support accuracy of transcription. Prior to the interviews the observer signed a confidentiality agreement (Appendix III). The paired and individual interviews were audio recorded and transcribed by me (the researcher). The information from interviews was stored on a computer to enable analysis of the data. Data were collected using a semi-structured interview schedule (Appendix IV).

I had anticipated that more participants would prefer to participate in focus groups and was surprised that so many participants chose individual interviews. This meant that interviews as well as the transcribing took longer to complete than expected. When applying for ethics approval my decision to do both focus group and individual interviews was challenged, so it was fortunate that I was able to rationalise my position on this, especially if I had changed my approach to only focus groups. Some participants were unable to attend the scheduled focus groups due to other commitments, and in most cases I was able to interview them on their own. There were three participants where I needed to re-schedule interviews a number of times.

A semi-structured interview schedule was developed for all interviews, consisting of preset open ended questions and follow-up probes. The use of probes gave participants an opportunity to explain their answers, as well as allowed me to seek clarification and more in-depth answers. The use of semi-structured interviews enabled me to change words but not the meaning of questions. By doing this I was able to recognise that every word does not necessarily have the same meaning for each participant, and it also provided some flexibility for me as interviewer. There were a number of times when I had to provide further clarification of questions. For Māori nurse participants who completed their BN through a Māori programme, I was able to explore differences in their programme from the mainstream programme. Through this process it was essential that I did not lead or influence participants in any way (Parahoo, 2006). Debriefing with the observer following paired interviews provided me with assurance that I did not lead responses.

Two vignettes (Appendix V) were used to build rapport with participants and put them at ease. The vignettes provided an opportunity for participants to describe how they would respond to the cultural needs of a Māori woman and an elderly male patient, based on the description in the vignette. The vignettes were used at the beginning of the interviews for the first eight participants only. As I became more comfortable interviewing the participants I was able to draw personal experiences of practice earlier in the interview without using the vignettes. Little has been written about the use of vignettes in groups, although it is often used as a warm-up exercise to get participants to start talking to each other (Barter & Renold, 1999). These content specific vignettes were based on hypothetical situations, reflecting common occurrences experienced by participants (Veal, 2002). The vignettes reflected the research question with relevant variables, but were not worded to influence how

participants would respond (Barter & Renold, 1999; Sequin & Ambrosio, 2002; Wason, Polonsky, & Hyman, 2002). It was anticipated that by focusing firstly on familiar experiences, rather than their own personal experiences, this would help participants to feel more comfortable sharing examples of their personal practice.

I had planned to facilitate focus groups based on similar backgrounds in terms of training background and ethnicity. Structuring groups in this manner is known as segmentation and is linked to homogeneity in background. It is a strategy utilised to make participants feel more comfortable sharing their experiences with others (Morgan, 1997). I had anticipated that the focus group process would enable participants to gain an understanding of each others perspectives, and consider if this may modify their own view of cultural practice (Redmond & Curtis, 2009). Unfortunately I was unable to bring together focus groups of four to six participants, but did interview four pairs of participants. The paired participants were respectful of each others viewpoints, at times expressed agreement with other views, and listening to experiences shared by the other participant assisted them to share their own examples.

The interview

All interviews were undertaken in a meeting room in the Professional Development Unit which is located off the Waikato Hospital campus. Refreshments were offered to participants either, before, during or after the interview, depending on the time of the day. Some participants were interviewed at lunch time and had not had time to have their lunch prior to the interview. At the commencement of each interview I asked participants if they needed clarification on the research information before signing the consent form. For paired interviews the observer was introduced, her role explained and I stated that she had signed a confidentiality agreement, so whatever was said within the room would remain confidential. Ground rules were also established, these included one person speaking at a time and showing respect for differing viewpoints. Participants were asked not to discuss experiences shared by the other participant or the identity of the other participant, outside the interview.

The interview commenced with general questions about their understanding of the Treaty of Waitangi and cultural safety, and education they had completed to support their cultural practice. Then they were asked to share a recent experience where they had used a cultural framework to care for a patient. The two vignettes were then used to explore how they would engage and develop a relationship with the patient, plan

care, identify the key features of care to meet holistic needs and required resources, and how they would assess care had been culturally safe. For the first eight participants interviewed, the semi-structured interview schedule was strictly followed. When asked to think of an experience where they had provided care from a cultural framework, most participants shared an experience of caring for a Māori patient and whānau. In general, participants required more prompting to articulate examples of caring for patients from other cultural backgrounds.

Participants were then asked to explore experiences where they felt they had made a positive difference to the care and health outcome for a Māori patient and a patient from another cultural background. The final questions asked participants to consider how their own training and cultural background influenced their cultural practice, how they assess care they provide for different patients is culturally safe, and what were the most important aspects of cultural care, in order to make a positive difference for Maori and other patients.

3.6 Data analysis

Following each interview I transcribed the recorded data, read through data to identify common themes, searching for words and descriptions repeated in several responses. Data were organized according to common patterns or themes to provide structure to conclusions based on the data. Concepts derived from the first pieces of data were compared to identify similarities and differences against other sets of data. These concepts were revised a number of times as other descriptions of themes appeared to be more suitable. A sequential approach to data collection and analysis allowed me to identify relevant concepts, follow through on subsequent questions and listen and observe in more sensitive ways (Creswell, 2009; Ratcliff, 1994; Thomas, 2003).

A general inductive approach was used to categorize and describe non-numerical data gained from paired and individual interviews. This included notes taken by the observer and researcher reflections. A general inductive approach enabled me to reduce and summarise raw data, identify frequency of phrases and ascertain how the data links to the research objectives (Creswell, 1998, 2009; Parahoo, 2006; Punch, 2006; Ratcliff, 1994; Thomas, 2003). Raw data (transcripts, observer notes, reflections) were organized and prepared for analysis following paired and individual interviews. From an initial reading through the transcripts, a number of themes

emerged and descriptions were interpreted to identify the meaning of themes and descriptions (Creswell, 2009). Analyzing data helped me to address codes on topics I expected to find based on literature, surprising codes not anticipated at beginning of study, unusual codes of conceptual interest to readers and codes that address a larger theoretical perspective in research. Rather than using a qualitative data analysis software programme, that I was not very familiar with, to store and organize data, I devised a table which identified each participant group with data recorded under emerging themes. Quotes and descriptions from transcripts were transposed into another document under each theme for the different groups of participants.

As indicated by Thomas (2006, p.238) “The primary purpose of the inductive approach is to allow research findings to emerge from the frequent, dominant or significant themes inherent in raw data, without the constraints imposed by structured methodologies”. A coding frame was developed and the transcripts coded by the researcher. As new codes emerged the coding frame was changed and transcripts re-read according to the new structure. The development of themes was discussed and refined with my academic supervisors. Data analysis was guided by the research objectives with findings arising directly from the analysis of the raw data, and not from a priori expectation. Thomas (2006, p.240) suggests, there are potentially five key features pertaining to the coding categories:

- Category label: a word or short phrase used to refer to category
- Category description: description of meaning of category including key characteristics, scope and limitations
- Text or data associated with category: examples of text coded into category that illustrate meanings, associations and perspectives associated with category
- Links: each category may have links or relationships with other categories. Links are likely to be based on commonalities in meanings between categories or assumed causal relationships
- The type of model in which the category is embedded: the category system may be subsequently incorporated in a model, theory or framework which will represent an end point of the inductive analysis.

The intended outcome of the above process was to create between three and eight categories that in the researcher’s view captured the key aspects of the themes identified in the raw data. Further, these themes were also assessed to be of most

importance in relation to the research objective. Four main themes and two sub-themes under each main theme were identified from the data.

3.7 Ethical considerations

Ethical approval was gained through the Northern Y Ethics Committee (Appendix VI) following Locality Assessment from Waikato DHB. A number of ethical considerations were considered prior to commencing this study. These included the safety of the participants, my position within the organisation and the potential for conflict between my role as researcher and current position (as Nurse Co-ordinator Professional Development and Recognition Programme [PDRP]), informed consent, and anonymity and confidentiality for the participants.

Safety of participants

I had to consider the safety of participants based on my experience of working with RNs on their professional development portfolios, and acknowledged that participants may initially feel uncomfortable sharing personal experiences of their cultural practice. I anticipated that the use of vignettes and skilled facilitation would assist participants to feel safe to share their practice. By using appreciative inquiry or a positive strengths based approach, I did not expect participants would be distressed or harmed by the research process. My concerns were not realised as all participants appeared to be confident and at ease articulating their cultural experiences.

Conflict between researcher and current position as employee

As Nurse Co-ordinator PDRP I assess, and teach others, to assess cultural practice in professional portfolios and have a comprehensive understanding of the expectations for cultural practice. I acknowledged that this could influence data analysis and interpretation of the findings. I ensured that the interview schedule and probing questions did not lead participants to respond in a certain way or frame responses within my 'bias'. Observing and recording interactions in paired and individual interviews may have introduced further bias. I actively engaged in critical self reflection about potential biases and predispositions, including not allowing my own personal views and perspectives to affect how data was interpreted, or how the research was conducted. When my personal views were identified by supervisors in early drafts of the presentation of findings, these were corrected. I have worked in

various roles within Waikato Hospital for over twenty five years and had originally thought that this may influence participant recruitment therefore participants were recruited through indirect methods. As the majority of the participants had known me in previous and current roles, this did not appear to be a concern for them.

Informed consent

Registered nurses who expressed an interest in participating in the research received information on: the purpose of the research; type of information required; why information was being sought; how they were expected to participate in the study; how it may directly or indirectly affect them; and how information would be used; to enable participants to give informed consent to participate in study. Consent was voluntary and without any pressure. There were some nurses who initially expressed interest in participating in the research but after receiving further information chose not to participate. Participants indicated their preference to be part of a focus group or individual interview. Potential participants were able to contact me for further clarification if desired although this did not happen.

Anonymity and confidentiality

All data collected was made anonymous by ensuring that if names were used during interviews these were not included in the transcripts. Consent forms are stored separately from interview data. The transcripts identified participants by initials only and I am the only person to have access to consent forms and EOI forms. Paired participants were asked not to discuss the interview discussion or identify the other participant. I assigned each person a pseudonym that reflected their ethnicity, ensuring that I did not use any actual names of participants. I also made sure that I did not include any specific details that may have made them identifiable. The observer in the interviews in pairs signed a confidentiality agreement to ensure anonymity and confidentiality of participants. No information that will identify individuals was be used in this report nor will be in any publications arising from this study.

3.8 Research rigour

Qualitative research has been criticized as lacking scientific rigour. These criticisms include the potential for researcher bias, the lack of generalisability, and lack of validity. Terms such as trustworthiness, authenticity and credibility are often referred

to for addressing the validity of qualitative research (Creswell & Miller, 2000; Lincoln & Guba, 1995). Creswell (2009, p.190) suggests that:

Qualitative validity means that the researcher checks for the accuracy of the findings by employing certain procedures, while qualitative reliability indicates that the researcher's approach is consistent across different researchers and different projects.

There are a number of procedures to check reliability of qualitative research. These include checking transcripts for obvious mistakes, making sure that the definitions of codes do not change during coding, and cross checking with other coders. Qualitative validity can be achieved by determining the accuracy of the findings from the perspectives of the researcher, the participants or the readers of an account. I had considered setting up a small advisory group from the focus groups, to present a summary of the main thematic analysis to check if this was a fair reflection of the information shared during focus groups. However, as paired rather than focus group interviews were undertaken and similar themes to individual interviews emerged, I decided this was not necessary. A number of strategies can be utilized to support this process, including triangulation of data sources, member checking by presenting themes and specific descriptions back to participants, the use of rich, thick description to illustrate findings, clarifying bias researcher may bring to research, and also presenting negative information to provide different perspectives (Creswell, 2009).

For the purposes of this research, trustworthiness of findings has been determined by ensuring that issues of credibility, transferability, dependability, confirmability, and adequacy have been addressed in relation to truthfulness.

I recognise there is not one truth of cultural practice but many truths. Therefore, it was important for me to represent an honest account of participant responses. During analysis I recognised that it was difficult to achieve total objectivity and used reflexivity to identify areas of potential personal bias and 'bracket' them so there is minimal influence on the research process (Ahern, 1999; Fischer, 2009; Gearing, 2004). "Reflexivity involves the realisation that researchers are part of the social world that they study" (Ahern, 1999, p.408). Reflexivity and bracketing assists researchers to understand the effects of their own experiences rather than eliminating them.

Bracketing typically refers to an investigator's identification of vested interests, personal experience, cultural factors, assumptions and hunches that could influence how he or she views the study's data (Fischer, 2009, p.583).

When writing up the findings it was important for me to not allow my personal assumptions and experiences to influence interpretation of the data. When concerns about this were pointed out by my supervisors, I addressed these to provide a more objective representation of the findings.

Credibility was achieved as participants confirmed vignettes reflected their reality of cultural practice. The vignettes were placed in a hospital setting so for some participants there was the need to adjust the vignettes during the interview, to be more reflective of a community setting. I chose not to pursue member checking to validate interpretation of data was reflective of their reality (Lincoln & Guba, 1985) as similar themes emerged from subsequent interviews.

Transferability may be attained by the degree to which findings are relevant and applicable in other practice environments (Lincoln & Guba, 1985). By giving accurate contextual information and including rich, thick descriptions from participants, it will be possible for comparisons to be made by readers.

Dependability may be determined when findings are similar if research was replicated. I have attempted to include information relating to each step of the research process and have included the interview schedule and vignettes to enable replication with different groups of participants. Sandelowski (1986) refers to this as using a decision trail while Lincoln & Guba (1985) refer to this process as an audit trail.

Confirmability is accomplished when credibility, transferability and dependability are ascertained (Sandelowski, 1986). This has been done by illustrating how the process of inquiry led to the interpretation of the data by use of a decision trail (Koch, 1994).

Adequacy is concerned with the question of whether the research process and outcomes were justifiable, relevant and meaningful (Hall & Stevens, 1991). Adequacy of the research, including data collection tools, was accomplished by data collection and analysis procedures being congruent with the approach adopted for this study.

I recognize that despite implementing strategies to ensure a high level of research rigour there were some limitations in relation to the research design. The research was reliant on participants responding to the vignettes in reference to their own practice and therefore, relied on their honesty and ability to articulate their practice.

The data presented and analyzed was provided by specific groups of nurses at Waikato DHB and therefore transferability of findings to all nurses/organisations is limited. The research does not include the patient/family/whānau perspective of cultural practice, but is based on nurses perception of their cultural practice, which has then been interpreted by a researcher.

3.9 Summary

This chapter provides the outline of the research process, the theoretical frameworks underpinning the research approach and justification of the approach. The participant selection process was described and the participants introduced. An outline of the data collection methods utilized and the data analysis process was presented. Finally ethical considerations were identified and strategies to promote rigour in the research process described.

The findings are presented in the next two chapters. First, findings related to caring for Māori patients are reported. Then, using a similar structure, caring for patients from other cultural backgrounds are outlined. Each chapter includes discussion of the findings. The findings and discussion are presented in this manner to clearly differentiate between the findings in relation to Māori as tangata whenua and obligations under the Treaty of Waitangi, and patients from other cultural backgrounds.

CHAPTER FOUR

Caring for Māori patients: Findings and discussion

4.1 Introduction

This chapter describes and discusses themes and sub-themes relating to participants' descriptions of how they cared for Māori patients. Whānau are also an integral part of the relationship because, as Durie (1998, p.72) states, "individuals are part of wider social systems" and that "family are the prime support system for Māori". The themes and sub-themes contextualize the findings and descriptions and quotes provided by participants (refer to tables 1-4 in Chapter Three) have been used to illustrate and explore in detail. Of course, the themes and sub-themes are not neat, discreet entities and therefore there is some over-lapping that occurs throughout the analysis. Key findings are discussed at the end of the chapter.

Four main themes emerged in relation to caring for patients in a culturally safe manner. These are: 1) establishing positive working relationships; 2) working positively to achieve outcomes; 3) supporting patient autonomy, empowering patients; and 4) awareness of and managing personal (nurses') stereotype and power. Two sub-themes became apparent under each main theme and are identified in Table 5. The term kawa whakaruruhau is used in this chapter to describe cultural safety within a Māori context.

Table 5 Main themes and sub-themes

Main themes	Establishing positive working relationships	Working positively to achieve outcomes	Supporting patient autonomy, empowering patients	Awareness of and managing personal (nurses') stereotype and power
Sub-themes	Communication skills	Models of patient care	Enabling informed choices and decisions	Challenging assumptions and stereotypes
	Developing relationships	Accessing resources	Culturally safe care	Sharing power

4.2 Establishing positive working relationships

The principles of the Treaty of Waitangi and kawa whakaruruhau form the basis of interactions between nurses and Māori patients of the services they provide (NCNZ, 2011). Establishing positive working relationships emerged as the most significant theme for engaging and interacting with patients. All participants consistently identified effective communication skills as being crucial to developing meaningful relationships in their accounts when caring for Māori patients and their whānau. Communication skills and developing relationships emerged as the sub-themes for establishing positive working relationships.

4.2.1 Communication skills

Communication skills in the context of caring for Māori patients, underpins kawa whakaruruhau and the principles of the Treaty of Waitangi, and emerged from the data as a sub-theme to support establishing positive working relationships with Māori patients. Participants from all groups identified the importance of communicating respectfully, connecting and engaging with Māori patients and their whānau as integral to establishing rapport and trust, and conveying key messages and information. Fundamental interpersonal skills outlined by participants included language, communication as a tool to show care and empathy, body language, health literacy, getting to know the patient as a person and finding out what they were most worried about. Some significant features of Māori nursing practice also emerged from data collected from Māori participants.

Participants identified a number of factors which contributed to their ability to engage and communicate effectively with Māori patients and whānau. These included growing up in rural communities with predominantly Māori populations, an ability to understand and speak some Māori language (this was not exclusive to Maori participants), and active listening. Andrea, a European nurse, who works across inpatient and outpatient settings, grew up in a small rural community alongside many Māori families. She completed a Māori language course and talked about the importance of being a good communicator.

It is all in the way that you have that conversation that pulls out the information that you need. [Andrea]

Language is also a pivotal component in aiding and enhancing communication within health care settings. This includes the ability to converse or understand patients who are not English speaking or prefer to use their first language. The majority of Māori participants testified to understanding Māori or speaking Māori while a number of European nurses and one IQN had undertaken Māori language programmes. They believed their ability to integrate Māori language into their conversations, was beneficial to communicate effectively with Māori patients and whānau. Although Rangī had some understanding of Māori, she was not a fluent speaker. She completed the Tihei Mauri Ora programme (Māori BN programme) and had previously worked in hospital settings but now works in the community. She said:

I remember a situation where a child [patient] could only korero Māori but no one had picked up on that. If you korero Māori to him he would korero but because nobody spoke to him in Māori there was no communication. When we became aware of this it was documented and signs in Māori were put up. It was really positive because it opened the door for other nurses to understand and it also made the parents happy. [Rangī]

A comprehensive nursing assessment is crucial to nursing practice as it provides all the relevant information to be able to plan and implement care to meet the individual needs of the patient (NCNZ, 2007, 2012a). This assessment should also include identifying specific communication needs. Situations like the one described above can be avoided when patient's preferred language is identified on admission and communication strategies put in place. For Māori speaking patients and whānau the integration of Māori words into conversations may help put patients at ease and build rapport. Being inclusive of whānau may also enhance rapport and trust and can enable nurses to care for the patient and whānau as a whole (Wilson, 2006).

Care and empathy are important aspects of communication and developing rapport and trust with patients (Reynolds & Scott, 2000; Watson, 1997). Through their communication skills participants demonstrated care and compassion in their interactions with Māori patients. Empathy and compassion in the Māori context can be aligned to aroha and manaaki. Barlow (1991) defines aroha as love, sympathy and charity, and manaaki as expressing love and hospitality towards people.

Participants' ability to be empathetic and compassionate was heightened as they engaged with and developed relationships with Māori patients and whānau, both in hospital and community settings. Jane, an experienced European nurse who has cared for Māori women and children in hospital and community settings recounted how:

A young woman came in from the community, my heart went out to her, it was like plucking her from one planet to another, bringing her into our service. She had been terribly abused, I don't know if anybody had ever shown her any kindness. But by just spending time with her, supporting her, showing her kindness, and praising her, she just blossomed. [*Jane*]

Listening and understanding the Māori patient's perspective was also considered critical for two way communication. Aroha, a recently qualified Māori nurse who completed her training through Tihei Mauri Ora (a Māori Bachelor of Nursing (BN) programme), expressed confidence in her knowledge and experiences of her Māori culture:

Being able to communicate and listen to them [patients] and make sure they are listening to you is about two way communication. Just being respectful, making sure they are comfortable and that things put in place run smoothly. I think communication and listening are huge and if you can't communicate then get someone who can. [*Aroha*]

From their descriptions it was apparent that the majority of participants adapted their interaction approaches to meet the differing needs of Māori patients and their whānau. Participants also acknowledged that not all Māori are the same, and therefore nurses had to learn different ways of engaging and communicating. Mana grew up in a Māori community and although she is not fluent in Māori, possesses a good understanding of the language. She completed the Tihei Mauri Ora BN programme and has worked in the hospital setting and now works in the community.

It was a busy shift and I was co-coordinating when one nurse said, a mum has barricaded herself in the room. I knew the mum was Māori so I went and knocked on the door, just said Kia ora, and she opened up the door. I don't know if there is that connection, I just went in and talked to her about the issues...I guess it is just the way you carry yourself, the more gentle approach, the body language and the way you make eye contact. She was on the chair, so getting down [physically], crouching, not being overbearing, and the tone of voice. I managed to talk her through things and see the heart of the problem and then managing that. The mum just didn't know how to communicate the issues. [*Mana*]

Greeting this patient in her own language, altering her tone and using body language enabled Mana to enter into this mother's world and listen to her concerns.

When there is difficulty engaging with Māori patients it is important for nurses to explore potential underlying reasons which may relate to the language used or the tone or manner of engagement. A number of participants talked about interpreting verbal and non verbal cues while engaging in conversations with Māori patients, and recognizing the need to find out what was really worrying the patient or whānau. Being able to accurately interpret these cues requires assessment and professional

judgment skills to be able to respond appropriately. Jenny gained her understanding of the Māori world personally through her Māori husband and children, and professionally through guides when working with Māori communities. She works across in-patient and out-patient settings and explained:

Someone has to talk to the elephant in the room, and asking, 'are you worried about anything? Are you concerned that this is something worse than the doctor has told you? Or is there anything worrying you?' Patients want someone to listen to their fears and who hears them, and also having a conversation that gives them permission to bring things up that they are most worried about. [*Jenny*]

Jenny's account illustrates the importance of picking up on cues that indicate the patient is worried about something and Jenny's confidence in approaching the patient to address 'the elephant in the room'. Showing willingness to listen and understand the patient demonstrates caring and compassion. These qualities underpin humanistic and relational nursing approaches (Christensen, 1990; Watson, 1997).

All Māori participants acknowledged their identity as Māori but different experiences and degrees of engagement in their culture emerged. Although Moana, a recently qualified nurse, had in the past denied her Māori identity, her ability to engage with Māori and care with empathy and compassion, was evident from her articulation of her practice when caring for Māori patients. For example, during her conversations with a kuia Moana was able to identify the underlying reason for her [the patient] not communicating with other nurses.

When I spoke to her, I came down to her level [physically] and she responded. I just started off having a general conversation, we talked about her family, and once we started, the floodgates just opened. Then we got on to her condition and it came out that she wasn't so scared of what was happening, she was scared about dying. She knew she was going to die and she had accepted that, but she didn't know what it meant....I shared some of the experiences of deaths I had seen, and how different people coped. That made her say, 'is that it'? And she felt really relieved. [*Moana*]

Taking the time to find out what the patient was most worried about, listening to her concerns and providing information to ease the concerns requires confidence and effective communication skills. These skills may not be limited to nursing experience but also include life experience.

Health literacy also plays a critical role in communication strategies aimed at aiding patients understanding of their health issues and accessing appropriate health services. Therefore, when there are concerns about understanding information or information has been mis-represented, this may require further exploration to identify

and address the issues (Clendon, 2012). The language nurses use, the manner and tone of the conversations and messages provided, as well as the approaches used, set the scene for developing relationships. Participants from each group described the relevance of communicating health information in language that is clearly understood by Māori patients, thereby enabling them to make informed decisions about care and treatment options. This included evaluating their understanding or mis-understanding of the information provided. For example:

We take photographs of the back of people's eyes and a rumour went round this small town that we stuck needles in people's eyes. It was partially fed by us because in the patient information sheet there was a diagram of an eye with a line through the eye. This was meant to be the beam of the camera looking into the eye. We wondered why more than half the people didn't turn up and then some brave soul told us what was going on. So getting the right information to patients so they understand the reality and don't imagine something worse is important. [*Jenny*]

Some of the New Zealand European participants who trained prior to 1990 described how their exposure to experiences of caring for Māori in a range of clinical settings and being guided by nurse and Māori mentors, had been influential in raising their cultural awareness and enhanced their practice and ability to communicate effectively with Māori. Some of the participants (Kate, Emma, Jenny and Andrea) had also grown up in communities with high Māori populations or had experienced aspects of Māori culture at various times. One participant worked with Māori through her involvement in a community project, and through the guidance of a Māori mentor, was introduced to a world she had not known existed in New Zealand. In her account she realized how different the lifestyle for Māori was when compared to her own life.

And so I did all these things that I had never done before in my entire life and that was the biggest wake up call I ever had. I was privileged as I went to a whole lot of things with her that European nurses would never have seen. I did the pokai round, went to tangi and all sorts of meetings around the region, and that was truly enlightening. I don't think people realize that there is a parallel culture in the region but people never see it, it's not obvious. That heavily influenced how I continue to practice. [*Jenny*]

Jenny's statement challenges Eurocentric attitudes where realities are considered from the dominant culture perspective. Viewing the world and making assumptions relating to values and human behaviour through a Eurocentric lens limits the ability of health practitioners to be effective cross-culturally (Naidoo, 1996). The idea that Māori and European see their worlds differently can be challenging, especially for European New Zealanders because Māori society is potentially invisible to them unless they are able to gain entry into that world. This was evident when kawa whakaruruhau was first introduced to nursing (Ramsden, 1990a, 1990b, 1993, 1994;

Wepa, 2005). Becoming aware of different realities for patients from 'other' cultures is a fundamental principle of cultural safety.

While for some New Zealand European nurses engaging with Māori was by their own accounts, a learning experience, all Māori nurses expressed confidence in their interpersonal skills, and their ability to connect and engage with Māori patients and whānau. They referred to their use of Māori processes, such as whakawhanaungatanga, as critical and they described being comfortable in sharing their own whakapapa, with patients and their whānau. Their acknowledgement of spirituality, tipuna and a sense of kinship with Māori patients were prominent features of the interviews.

I think our links with our tipuna guide us and are around us working for us. So I think that link and letting them knowing where you are from. You know that you are not just representing yourself but also whānau and I like to think of every person I come across that that is my brother, my aunty, my mum, so I nurse every person I like to think, as if they were a family member. [Mana]

The value on caring for Māori patients as if they were members of their own family was a comment made by a number of Māori participants but not by other participants. From a Māori worldview this may be seen as a mark of respect and acknowledgement of kinship and extended whānau as result of whakawhanaungatanga (Durie, 1998). However, this may be seen to be in conflict with the principles of cultural safety that discourages making assumptions about what may be important for patients based on the nurse's own background and experiences. This may also be considered a potential breach of professional boundaries (NCNZ, 2012). This remains a contestable discourse that requires further exploration and discussion.

Gaining an understanding of patient background and experiences and what has brought them to accessing specific health services, assists nurses to identify the individual needs and appropriate approaches for care provision. Participants from each group provided examples of taking the time to get to know their Māori patient as a person, and through conversations gaining some insight into and understanding of their health experience. Tony grew up in a farming community with a strong religious background and through his nursing has gained confidence in working with Māori from diverse backgrounds. He shared an experience of caring for a Māori woman and her husband:

By trying to take the time to get to know her, I think she appreciated the fact that I was interested in her as a person. I think that the fact that she opened up and seemed to trust me was huge. I was coming in at a time when this patient

was feeling very vulnerable, very unwell, and it was a privilege to look after her and her husband. She shared elements of her life and her family with me, which was a massive honour. She was talking a lot about her journey with me, as well as what was currently going on for her. [Tony]

Recognizing 'moments of trust' when patients share intimate personal details reinforces the trust that nurses gain as part of providing culturally safe care. The significance of these moments should not be underestimated as they can provide a gateway to a comprehensive understanding of what is important for individual patients.

Participants from each group identified that the most important feature of cultural practice was the ability to communicate effectively and engage with Māori patients and whānau to establish and maintain meaningful relationships.

4.2.2 Developing relationships

Developing positive nurse-patient relationships provides the foundation for building a therapeutic relationship (Reynolds & Scott, 2000). The common features of building relationships with Māori patients that emerged from the data were: getting to know the patient as a person at the beginning of the relationship, being able to connect and engage with the patient, acknowledging their fear, and building trust. These features were described by participants from all groups. Identifying the most appropriate approaches to use to initiate positive engagement with Māori patients and support them to make informed health decisions was considered crucial in establishing meaningful relationships. Working in partnership with the patient to enable them to make informed choices was also significant.

We had a relatively young Māori woman who came in, who let us know straight up front when diagnosed that she probably wouldn't have any treatment. I think her daughter was with her at the time, and the alert went up straight away for me. We would chat first off, and gradually I realized this young woman is at risk, and I knew it was important to develop rapport, not put pressure on her to have treatment, give her time, give her information, talk to the whānau and develop the relationship step by step and it's worked. She has missed many appointments but I would text her and gradually we are getting her through [her treatment]. [Andrea]

Throughout her interview, Andrea emphasized her role as being an enabling link for Māori patients to access her service. This, along with her perseverance in maintaining contact, was evident in relation to the above example. Her tenacity and dedication was aimed to ensure that this particular patient would not feel abandoned by the service or 'system', because of her decision not to have the recommended

treatment. If patients are not followed up they may not be given the opportunity to subsequently make a different choice and opt into treatment. This may also mean that establishing underlying factors that contributed to this situation remain unknown.

International Qualified Nurses (IQN) provided examples of engaging with Māori patients with care and empathy to build relationships. Mike immigrated to New Zealand from South Africa and although he initially struggled to understand his relationship as an immigrant with the Treaty of Waitangi, further reading and learning has assisted him to clarify this. In his example, Mike described how he initially engaged with a Māori woman during her treatment, established a therapeutic relationship, and worked with the woman, to ensure she received the recommended treatment. His description illustrates the process of *kawa whakaruruhau*. Through engaging with this patient Mike moved from judgment to empathy and a therapeutic relationship with this Māori woman. At the start he was judgmental regarding the woman. He had been informed that this patient had not been attending on time for her treatment and when he first met her, he noted her impoverished appearance. He acknowledged that prior to meeting her and from his first impression, he had made pre-judgments based on her being Māori. He explained to her the importance of her attending all of her treatments, and that if she did not attend, another patient could not be treated in her place. In conversation with her he gained insight into both the barriers she had accessing her treatment as well as her actual experiences of the treatment.

...she started describing 'the burn'. She talked about her experience of the treatment as 'the burn'. She couldn't see it, but she experienced this burning and hotness in her chest after the treatment. And part of her wandering around was to be with nature and be on her own, even if it was to walk around in the gardens and sit in the gardens, to interact with the earth. Then she described her own situation, and this confirmed the real impoverishment, there was no electricity, she was up in the "wop wops" as it's known, and she was having other difficulties. She knew she was probably terminal but she had a young daughter who was being truant at school, so she was trying to sort those things out. For one [forfeited] appointment she had to go and sort things out. [Mike]

As he learnt more about her circumstances, he came to appreciate her different 'reality', and the underlying reasons for her 'non-compliance', as first judged. By understanding what was important for this patient, he was then able to advocate for her. He also became aware of other dimensions of health that were crucial for her, including the need to connect with the natural environment. This enabled him to establish a caring, empathetic, and compassionate relationship that was maintained over time. From his own reflection, Mike was able to move from a position of

judgment to one of non-judgment and demonstrate kawa whakaruruhau in his practice.

In her description of 'the burn' and her experience, I couldn't help but feel for this person. I started developing a lump in my own throat just with the expression and the deep humanity, to hear that this was from her heart and not some made up story, this was just how she was. So her words were beating up on my own prejudice that I had walked in the room with.

When she had completed her treatment Mike met with her to explain the next phase of her on-going care and when he would see her again. When he spoke to those who had administered her treatment, he found that she had attended for her prescribed treatment as much as was possible in her circumstances. He then said:

But the amazing thing, and they had tears in their eyes, because she had gone around the whole hospital grounds, and anything that had a blossom she had picked, and put it into a little posy for those people who had caused 'the burn'. Because she recognized that they were there trying to help her, and she just left it there as her way of acknowledging that she appreciated what they had done. And I met with her a few times, but it was one of those things that really endeared me to reaching out to humanity in that her final statement to me when she left after that appointment, she said: "so okay you be my main man now", and flung her arms around me and gave me a huge hug, and she enveloped me. It just shows that if you open your mind to another person's humanity how you can get rid of whatever cultural prejudice or bias that might be sitting in your head.

During his interview, Mike talked about the importance of understanding 'what makes people tick' and getting to the 'essence of their humanity', and he recalled this experience as pivotal in the development of his cultural practice. His reference to humanity provides a deeper understanding of empathy and caring in relation to caring with knowledge, sincerity, and humility (Coulon, Mok, Krause, & Anderson, 1996). His description of the encounter embodies the process toward achieving kawa whakaruruhau, from cultural awareness through cultural sensitivity, to culturally safe nursing practice; and to see the patient 'as a fellow human', not judging the patient. Central to this is the ability to develop rapport and trust to establish an effective and empowering relationship with Māori patients and their whānau.

The development of interpersonal skills strengthens the ability to communicate with Māori patients and whānau, connect and engage with them in meaningful ways, and build relationships. These abilities lay the foundation to be able to work in negotiated partnerships with patients and whānau, to assist assessment and provision of care that builds on the strengths of the patient and whānau (Wilson, 2006).

4.3 Working positively to achieve outcomes

The second theme is working positively with Māori to achieve outcomes. The principles of kawa whakaruruhau are embedded in the Treaty principles. Tino rangatiratanga is enhanced when patients have knowledge and understanding to self-manage, and self-control their health (NCNZ, 2011). The nursing workforce can, by the way they work with Māori patients, protect health as taonga, by recognizing the values and beliefs held by Māori, and provide a responsive and supportive environment to meet their needs. Nursing has a key role in ensuring that Māori have the same access and opportunities as non-Māori and equity in health outcomes (Durie, 2001b; NCNZ, 2011; Ramsden, 1993, 2000; Wepa, 2005; Wilson, 2006, 2008). Models of patient care and accessing resources emerged as sub-themes.

4.3.1 Models of patient care

Māori concepts of health acknowledge that there are many dimensions to health, and that culture plays an important role in health and wellbeing. The western emphasis on disease and physical illness conflicts with Māori beliefs of health, which extend beyond the physical dimension of health (Durie, 1998). As part of kawa whakaruruhau education, Māori models of health and wellbeing are introduced to support nurses to work with Māori patients and whānau, in a culturally appropriate manner. The most well known and accepted models are, Te whare tapa whā (Durie, 1998) and Te wheke (Pere, 1991). These models provide culturally appropriate holistic models to assess and meet the health needs of Māori patients and whānau. In the following example, Tony shared his experience of using a Māori model of care to guide his practice:

I use Te Wheke mainly with Māori patients, but it applies to all patients really. I have adapted it to incorporate people of all cultures. When I think of culture, I also try to get an idea of any spiritual components that we need to be aware of, or religious components. We were taught that if you were treating just the physical, you are neglecting or missing key ingredientsbut if you can incorporate those beliefs and practices for that person, into their plan of care, it can basically help them get through their recovery. [Tony]

Respondents identified a number of models of patient care that have guided their practice, when caring for Māori patients and their whānau. Along with Māori models of health they included holistic care and individualized care, as generic concepts of patient care. Identification of cultural, spiritual, emotional and whānau needs, and integrating these into the plan of care, supported participants to deliver culturally appropriate care to Māori patients and whānau. Kawa whakaruruhau promotes the

notion of diversity within the Māori population. When it is the individual patient, not the ethnicity that is the focus of care, there is the potential to identify a broader range of needs, not only those relevant to a particular ethnic group, and also acknowledges diversity within cultural groups. Māori and IQN participants relied more on holistic and individualized notions of care, whereas European nurses qualified after 1990 provided care based on a cultural framework and Māori models of care. On the other hand, European participants who trained prior to 1990 talked in terms of continuing to use the holistic and individualized concepts of care they were taught in their training. Holistic practitioners view the patient as a whole not as a set of symptoms or a disease. Alongside the physical they consider the mental, emotional and spiritual elements that contribute to health and wellbeing (Lowenberg, 1992). A holistic approach to care for Māori includes the role of whānau. An individualistic approach also has the potential to exclude the family. Emma experienced Maori culture during her childhood and worked in hospital and community settings with Māori.

I trained 30 plus years ago and different cultures were not recognized specifically. The basis of our training was the individual in front of youwhat do they need, how do you respect their needs, how do you address their needs. [Emma]

In his recounting of 'the burn' Mike acknowledged how important it was for his patient to connect with the earth and nature as part of her healing process. Once he understood this, he was then able to engage with and work with her in a more meaningful way. Connection to the earth and the environment are inherent in Māori models of health and wellbeing.

With Māori there is a connection with the earth. A connection to the physical earth and being part of the earth is very important in their culture, recognizing those types of differences and just reading and becoming more aware of the differences and also the similarities makes it so much easier to engage and to find a connection and in finding connection we find partnership. [Mike]

Although many participants referred to using a holistic or individualistic approach to care all participants recognized the significance of including whānau in all aspects of the patient's health experience and recovery. However, whānau dynamics and expectations can bring challenges for nurses. How they respond to these challenges, access appropriate resources and integrate cultural processes is crucial for working in partnership with whānau. Emma talked about her experience of navigating challenging whānau dynamics, and developing strategies to meet their complex needs, when describing an encounter with a patient. In this whānau the brother had the power of attorney to make health decisions for his mother and he discounted his sisters' disagreement with his decisions. The conflict between the brother and sisters,

proved challenging for nurses. They could see how exhausted the daughters were from providing constant support and care for their mother. They sought cultural advice on how to approach the situation. Emma went on to say:

...I wasn't quite sure how to approach this. So I spoke to the Kaitiaki, at the hospital, and said I have a gut feeling that [the brother] needs someone, who he respects, to talk to him, as he doesn't appear to be concerned about his sisters' worries. I asked the kaitiaki if we could identify a kaumātua, or somebody who he would value their opinion, and tackle it from that way....The kaitiaki was fantastic and we did find someone that he would listen to, and she hasn't been back in. We relied on her daughters' responses for knowing their mum, and understanding what their mum would want. Family involvement was huge, with the daughters providing a high level of care for her....they had waiata.... when the whānau were there, and the mokopuna to be there all the time....Getting her into her community made her much more accessible, to the people she needed to be with. [Emma]

This example illustrates how a New Zealand European nurse took into consideration whānau and cultural aspects of care in addition to the physical aspects of care. Although the patient was physically able to be discharged, whānau concerns needed first to be addressed, but in this case the whānau could not do so without support that the nurse accessed, showing that to provide complete care nurses may need to go outside their own cultural familiarity.

Using a culturally appropriate framework, participants acknowledged the significance of whānau for Māori patients they cared for and their spiritual links, particularly near the end of life. Identification of patient and whānau needs for health and wellbeing, contributes to the process of supporting patients and whānau, to access appropriate resources to meet their needs. In the following example, Kelly an experienced nurse working in an acute care setting, described an experience of enabling a patient to connect with a whānau member in another part of the hospital.

She was from out of town and so I talked to her a lot....and got from her that she had an extended family member in the hospital, and somehow this person was an integral part of their whānau. She knew he was somewhere in the hospital, and not doing well, and she would like to try and see him. So I found out his name, and tracked him down in the hospital, and the outlook was not good. He was from the East Coast, and their chances of seeing him again, were very remote anyway. I tracked him down, put her in a wheelchair, and took her to the ward. I gave her about an hour there with her whānau [member], and they were so delighted to see each other. He was not expected to live, so that time with him was important. Meanwhile, I rang the marae to organize for someone to come to pick her and her husband up, and take them back to the marae. [Kelly]

In this example Kelly, another New Zealand European nurse, practiced in a culturally safe way with this patient in taking time to get to know her (relationship building),

talking with her (communication), having further understanding of issues of concern to the patient (listening), acknowledging the significance of whānau (even, if for Europeans, 'distant' relatives) in her actions, and finally making the effort to organize an acceptable and appropriate form of transport home.

A range of models of care were cited by participants. These included holistic and individualized nursing care approaches as well as Māori models of health with the inclusion of whānau. Whichever model of care nurses use will influence the assessment and strategizing around how care will be planned, delivered and evaluated. Therefore, to meet the needs of Māori patients and whānau the most appropriate model should encompass the dimensions of health that are most significant for the patient and whānau.

4.3.2 Accessing resources

As well as understanding the Māori worldview of health and wellbeing, access to health services may be a significant factor in improving health outcomes for Māori. Although there was some recognition of health disparities for Māori accessing Māori appropriate resources and supports did not emerge in participant accounts.

Through their experiences of caring for Māori, Andrea and Kelly gained some insight into Māori experiences of health services. Andrea recognized that Māori women responded differently to treatment options and timing of treatment, and had other processes to work through with whānau, before making a decision about treatment. Wilson (2006, p.xii) identified a key strategy as "facilitating access and use of health services by creating an environment conducive to enabling informed choice". Recognizing the importance of collective decision making for some Māori enables nurses to present patients with a range of options to support the decision making process, within culturally acceptable timeframes. The following account illustrates awareness of decision making processes for Māori:

We are very quick to say that Māori women do worse, and it's because they present late. But sometimes I wonder if it is actually part of their culture. Some women would say, I need to have surgery next week, but a Māori woman might say, look I need to go and talk to my whānau about this. They might live in Gisborne, and then you have to wait two weeks, for them to go down, then they come back, and they might come to the doctor. So there's no rush for them [Māori women], it's more important to do that. I don't know if I've ever seen that in any of the literature. It's our expectation that they [patients] complete the treatment, there are best recommended timeframes, but if they are going to complete the treatment over a longer timeframe, at least it's going to benefit them. [Andrea]

Identifying personal preferences and individual values and beliefs as part of a comprehensive nursing assessment assists nurses to identify relevant resources and integrate these into the planning and delivery of care. These are important features of culturally safe practice. Nurses are also required to have good knowledge of the services available in the community to meet the holistic needs of Māori and whānau (NCNZ, 2007). In the following example, Kelly described the steps she took to prevent a troubled youth 'falling through the cracks'. Although Kelly appeared in her account to lack an in-depth understanding of kawa whakaruruhau as a framework, the descriptions of her practice revealed she practiced from a holistic framework aligning to the principles of kawa whakaruruhau and the Treaty of Waitangi. While this youth initially did not engage in conversation with her, Kelly continued to show an interest in him, and show him that she was not judging his behaviour. She saw his potential and identified the need to link him to other services and support in the community.

I said to the policeman who had brought him in, look I'm really worried about this young man. He is a lovely young man and he's going to fall through the cracks, he's going to end up in prison. What can I do, where can I go to get some support for him, out in the community, so we can make sure he is well supported and safe? And he said, look give me all the information, we have a big brother group going within the community, and one of the cops will go round, and just adopt him as a big brother. Help him to go back to school, get him on the straight and narrow, or just to be there, as a support for him. So I went and talked to him [youth], said what I had done, this is what's going to happen. He was quite receptive to it, he wasn't angry or anything else, but I was really pleased that I went that extra bit. That's the whole holistic thing, it's looking outside the family, and looking somewhere where I knew, there would be some follow-up. [Kelly]

Kelly's knowledge of resources and her ability to explore other options for this youth enabled her to link him into additional services in the community to promote a potentially better future. This action therefore endeavoured to address other social determinants of health.

Māori nurse participants engaged with Māori patients and their whānau through kinship ties, a sense of connectedness, and being of the same social and cultural background, an understanding of each other. A real sense of wanting to provide the best care from a Māori health framework and improve health outcomes was evident from all Māori participants. They also better appreciated the barriers to health access for Māori, as well as existing health disparities.

Pare is an experienced nurse who works in an acute care setting. She grew up and is comfortable in the Māori world and has some understanding of the language. During

her interview she shared that she feels most comfortable engaging with Māori and is able to integrate Māori processes into the plan and delivery of care.

I guess for me, it is the access to services they need, to get the right information, to access those services, whether it is financial, social issues, or access for whānau to be able to support their spiritual and emotional needs. I believe that we are good at doing physical care for patients but the spiritual and emotional needs for the patient not so well. The organisation is very good at providing facilities for Māori to stay overnight on wards, lazi-boys, whānau room....Also being able to access a Māori chaplain to support the spiritual needs of the patient and I guess physical has been taken care of. It is those other dimensions of health that need to be met. [Pare]

Although Māori nurse participants acknowledged progress had been made in some areas, some expressed concern about the continued gaps in health care provision, and continuing marginalization of Māori in the health system. This is illustrated by the following example:

So it seems to be really culturally safe around the dying we need to look after the living a bit better. There are all the tikanga and processes around the dead but not around the living. [Rang]

In some respects IQN participants appeared to have a better awareness of health disparities for Māori and barriers to access than European nurses trained after 1990. The least aware nurses are those who participated in cultural safety modules and this raises questions about the effectiveness of cultural safety in nurse education. The increased awareness of health disparities of IQN participants possibly illustrates the sharpness of an outsider's perspective, unsullied by familiarity. South African participants were aware of disparities within the New Zealand context, but interestingly did not refer to those experienced in South Africa. In South Africa the 'Blacks' and 'Coloreds' are significantly disadvantaged when compared to their White and Asian counterparts in regard to health care (Kon & Lackan, 2008). These disparities are closely linked to economical inequality and discrimination (Charasse-Pouélé & Fournier, 2006). Awareness of health disparities by IQN is illustrated in the following accounts from Mike and Nirmela. For Mike the reality of the socio-economic disadvantage for some Māori became evident in his experience of caring for his aforementioned patient with 'the burn', who lived in rural isolation with no electricity.

I think it has heightened [my] awareness of how differently people live. It is just that recognition that seeing that difference, and also just recognizing that it is that Māori aren't only poor. [Mike]

Participants working in the community, rather than a hospital setting, gain a different perspective of health disparities. When participants visited some Māori patients in their home, they were confronted by peoples' real circumstances, including poor

housing, overcrowding, lack of heating, and poverty. Nirmela immigrated to New Zealand from South Africa, English was her first language. When Nirmela worked in a primary practice environment and cared for Māori in their home, she became acutely aware of the barriers that existed for some Māori. For her, this was a very different experience from caring for Māori in an in-patient setting.

The Māori patients were the ones who were not coming into the practice, and have high clinical indicators. So you needed to go and find out why...A lot of it was to do with their culture, their socio-economic background, they didn't have the money. They come and sit in the doctor's room, he looks at the computer, doesn't look at them, and it is five minutes of their time, and money wasted. So....see[ing] if they wanted to come in or they wanted me in their house.
[Nirmela]

It is apparent from the participants' experiences that although some progress has been made towards improving access to culturally appropriate services for Māori, barriers to access remain. Although an aim of kawa whakaruruhau is to reduce health disparities and improve health outcomes for Māori, there is little evidence from the literature to support this outcome being achieved.

4.4 Supporting patient autonomy, empowering patients

Nursing practice is “about relating and responding effectively to people with diverse needs in a way that the people who use the service can define as safe” (NCNZ, 2011, p.9). Patient autonomy aligns with Principle One of the Treaty of Waitangi, tino rangatiratanga, where Māori are enabled to have self-determination or autonomy and authority over their health. Two sub-themes, enabling informed choices and decisions, and culturally safe care, support the notions of patient autonomy and empowerment.

4.4.1 Enabling informed choices and decisions

The central tenet of kawa whakaruruhau is the empowerment of Māori to have self-determination over their health care decisions. Improving the health literacy of patients enables them to “access, use and understand essential health information and services to make informed health decision” (Clendon, 2012, p.25). Therefore, it is important that Māori patients and their whānau understand recommended treatments and potential consequences if they do not follow these.

Each group of participants acknowledged the role of and importance of whānau in decision making processes. For example, participants provided examples where patients and whānau made decision not to participate in research, or not to continue with recommended treatments. Nurses as patient advocates have an integral place in improving patient and whānau health literacy to enable informed decision making. This includes being respectful of choices that nurses may believe are inappropriate, such as outlined in the following example:

Fifteen whānau sitting there and they were all firing questions, and I thought, I know they are going to say no because they were concerned. There was no way they were going to let her be part of any study....they were concerned, and I was about to give them all the information about the surgery she was going to have. So I answered all their questions about the surgery. [Kate]

When describing this experience, Kate said that when patients and whānau declined the opportunity to take part in research [clinical trials], it could be considered as empowering because patients and whānau have the confidence to make their own decisions. She believed that empowering patients and whānau to make their own choices and not feel coerced into agreement was an important aspect of her nursing practice.

For participants, developing a meaningful relationship with Māori patients and whānau was integral to the informed consent process and meeting patient needs. Decisions that mean patients have taken responsibility for their health may not be evident initially, but for nurses who cared for patients over longer timeframes, they may be rewarded by seeing the positive changes in health. Nirmela described an example of her first interaction with a female Māori patient with poorly controlled chronic illness and the changes the patient made when provided with the relevant information to self manage her health more effectively. On the first visit Nirmela met with some resistance, but over time, was able to engage and build her relationship, and establish some common ground.

At the end of my journey with this lady, her clinical condition had improved, and she had stopped smoking. She had come into the surgery without me knowing, and was seeing the practice nurse for nicotine replacement therapy (NRT), and she wanted to surprise me that she had stopped smoking.... She was taking her tablets, she got her lipid levels down, and she had sorted out some of her personal stuff....I think being in the community helps you to look more widely, I did not put her in a box that she was a diabetic lady, and we needed to stabilize her diabetes, get her to take her tablets, I looked beyond that. By supporting her and acknowledging her for who she was, she came around on her own, and learnt to take more responsibility for her own self management. [Nirmela]

Despite previous poor or negative interactions with health services, one positive experience can make a difference in how the patient and whānau take responsibility for managing their health. Robyn, a European nurse trained after 1990, described how her experience of working with a young Maori woman, enabled the patient to take control of her chronic illness and improve her health outcomes. This young woman had a family history of diabetes and through conversations Robyn became aware of some of the challenges for this patient, and considered that it was her professional responsibility to provide the patient with information to promote better self care. She was also able to identify culturally appropriate services the patient could access on discharge.

I had to step up and be the resource for her, give her information, and support and guide her on the next step to self care. I asked her if she had thought of any other agencies to support her management in the community. She mentioned a Māori based provider that she was interested in, and had had a positive interaction with. She had her partner with her and he was very concerned about her health, so the three of us discussed this together. I used prompting questions and suggestions they both seemed very keen to take up the idea of pursuing the Māori provider, when they went home. [Robyn]

From establishing trust and building the nurse-patient relationship and taking the time to get to know this patient, Robyn was able to improve the patient's health literacy and offer her choices for on-going care in the community. Robyn's responses to the needs of this patient had the potential to improve the health outcomes for this patient. Nurses are well placed to be advocates when patients do not understand the full extent of what they are consenting to. Sara is an experienced nurse who immigrated from South Africa and works in the hospital setting. She has completed a Māori language course and has a keen interest in learning more about Māori culture. In the following example Sara identified that a patient did not fully understand that he had given consent for an amputation of his leg, not just a toe. The patient became increasingly unwell overnight and the decision had to be made with urgency. This meant whānau were unable to participate in the decision making or seek clarification from the doctor.

The surgeon...told the patient we do not have a choice, we have to amputate your leg. And I could see by his face he did not get it, but he said fine. Just before he signed I asked him, do you really know what the doctor has told you. And the doctor was really impatient with me, and he said, 'I can get him on the theatre table in half an hour, why are you stalling'? And I said I don't think the patient understands what you are saying, can you please explain to him what you are going to do. And he said, sir I am going to chop your leg off above your knee. And the patient said, 'oh I thought you were only going to take my toe off'. [Sara]

This example is quite a contrast to Kate's description of the woman and whānau discussing the possibility of participating in a clinical trial, where the patient and whānau were empowered to make a collective decision. Sara's description illustrates the importance of informed decision making to enable self-determination. This was reflected in other examples across all participant groups.

4.4.2 Culturally safe care

Kawa whakaruruhau acknowledges the role of the patient in determining that the care received has been culturally safe and has met the patient's cultural needs. Participants overall found answering the question on how they assessed with the patient that their care had been culturally safe, quite challenging. Some participants appeared confident asking patients and their whānau if they had met all their needs or if there was anything else they needed which was important for them. Participants working in the community and out-patient settings indicated that if patients felt unsafe accessing their services they often voted with their feet by not attending appointments or were not home when nurses visited. The majority of participants relied on their ability to assess non verbal communication, body language, and engagement of the patient in the management of their health, to determine if their care was culturally safe. This is illustrated in the following example:

You pick up on a lot of verbal prompts from the patients and the patient's family, often it is a feeling you know when things are going well. [Tony]

These are subjective rather than objective measures and rely entirely on an individual nurse's interpersonal and assessment skills. No common frameworks emerged from participants and assessment strategies tended to be generic, rather than specific for Māori. One IQN participant acknowledged that her ability to assess accurately can be affected by other factors.

I can read the signals wrong because I am tired, maybe I am overloaded, maybe I am thinking about other things in my personal life, not pushing them far enough back. [Sara]

There appeared to be no significant differences between the different participant groups in how they determined that their care was culturally safe. Their confidence in assessing whether patient needs had been met appeared related to levels of experience and confidence in communication. They were also open to being told that they had not met all patient needs and to then adapt their care accordingly.

I guess it is subjective in a way and we are reliant on patient cues. You know that they are comfortable with you because they say that's not the right thing to do. Otherwise they might just be quiet if they are not comfortable. [Andrea]

Easy to tell when you are not being culturally safe, Māori will often tell you. It is easy to tell if they are not happy with what you have done or how you have done it. It is important to be familiar with obvious protocols. If you have been culturally safe that patient doesn't complain and engages well in conversations and care....When patients start to proactively manage their own health this is a good indication that they are taking on board the different messages being given. When you start to see patients making changes in their lifestyle resulting in clinical changes, this is good outcome. You know you are accepted when you are included and part of rituals that are important for people from different cultures. [*Nirmela*]

Providing culturally safe care within a Māori context as determined by the patient requires nurses to be aware of their own beliefs and stereotypes of Māori and how these impact on their practice when caring for Māori patients and whānau (NCNZ, 2011). When Māori patients have the confidence to tell nurses care is not acceptable this could be a sign of a nurse practicing in a safe manner.

4.5 Awareness of and managing personal (nurses') stereotype and power

Kawa whakaruruhau acknowledges the diversity of Māori, the importance of not making assumptions, and not marginalizing Māori based on concepts of stereotyped behaviour. Key principles of kawa whakaruruhau include understanding the power relationship between health providers and people using the services, and empowering the users of the service. Cultural safety provides a framework for nurses to reflect on their own culture to understand how their own attitudes and beliefs may impact on others (NCNZ, 2011a). Their beliefs about Māori may consciously or unconsciously influence their ability to engage and connect with Māori patients and whānau, sometimes negatively. Challenging assumptions and stereotypes and sharing power emerged as sub-themes.

4.5.1 Challenging assumptions and stereotypes

Many participants talked about the importance of not making assumptions about Māori and taking the time to get to know patients as individuals. Some participants acknowledged that initially they viewed some Māori patients as non-compliant, in some cases because of stereotyping. However, when they took the time to get to know the patient and their health and social realities, they were able to change their initial judgmental attitude to one of care and compassion, and a greater willingness to work with and adapt care, that more appropriately met the needs of the patient. This

was represented in Mike's account of 'the burn' as he shared the learning he had gained from this experience.

I think our uniqueness as individuals and human beings first, before looking at differences, and that knowledge that there will be differences, and to be able to incorporate them, or utilise the differences positively. If someone is different, poor, or smokes and eats badly, should that negatively impact me, and the way I treat them? So I have to get rid of my own prejudices, to look at them as needing health care, and it is also finding out from Māori, what Māori want...It doesn't mean that just because they look Māori, they culturally identify as having traditional beliefs. [Mike]

Some participants acknowledged that just because a patient appeared to be Māori, it was important that they did not assume they would want to be cared for in a particular way, but took the time to establish what was important for them.

Work your way towards finding out how much of their own culture they engage with. You have to be very careful to work your way to that because they [Māori patients] won't often spell it out that they say 'I am very engaged in my own culture, I have beliefs and norms that are important to me'. So it is not a matter of saying, 'how can we meet your cultural needs', to say it in that way, but exploring it, not just asking the question. [Jane]

For some participants, practicing in a culturally safe manner involved responding to other nurses' stereotypes and assumptions to ensure Maori patients were not put at risk. These stereotypes may be based on a patient's ethnicity as Māori, where they live, or non-attendance for appointments. When assumptions are made, inappropriate responses may be initiated that patients may determine as culturally unsafe. This point was highlighted in the following description:

The practice nurse...had obviously looked at the address and made assumptions, because the mother's name was different to the husband, that this girl was probably a single parent, poor, Māori, and didn't know what to do. She [the practice nurse] was talking in an irritating manner and I [told her] this young woman is a professional at the top of her field, and the reason she is not coming to your appointment is because she is extremely busy, and she already comes to the clinic to see me....This girl is a highly intelligent, well qualified, middle class young woman. I had to head the practice nurse off at the pass, because she could say some things to that young woman that would be highly offensive, and put her off her going back to the surgery. [Jenny]

An important component of kawa whakaruruhau relates to nurses gaining an understanding of different cultural values and beliefs that Māori may hold and the importance of doing things in an appropriate way or tikanga. This is underpinned by the principles of the Treaty of Waitangi. Māori nurses brought up within Māori culture and who view health from a holistic perspective, play a crucial role in supporting other colleagues to understand the implications of how Māori patients may present. This is

particularly relevant when the spiritual dimension of health may be confused as mental illness.

A doctor from another country, and another culture, came in to me and said, 'can you go and see this Māori patient?' He said he had put him under the Mental Health (MH) Act.... the patient wants to kill himself and he was hearing voices. So I went up and said to this chap, the doctor had put him under the MH Act as he was hearing voices, what was this all about....And he said when he was really crook at the other hospital, he heard his tipuna calling him, and he was uncooperative with the registrar so he couldn't do a proper assessment. So those things put him under the MH Act....He was not psychotic, he was not hallucinating, it was just the way everything was interpreted. This chap was complaining about pain and wanted to be with his wife, he was frightened, he had analgesia charted as required, but no one had given it to him. [Kuini]

In this account Kuini used her understanding of the significance of the emotional and spiritual dimensions of health for this patient to assess that he was not a risk to his own health but that what he was expressing was related to inadequate pain relief. Stereotyping and making assumptions about Māori patients and whānau may result in the wrong course of action being followed, to the detriment of the patient.

4.5.2 Sharing power

Kawa whakaruruhau provides the foundation for nurses to understand the power they hold. When people access health services, they enter into a relationship with nurses as a patient. The notion of power dynamics in the nurse-patient relationship was alluded to by many participants. In the following example Sara acknowledged the importance of working with patients and empowering them to play an active role in the discussion.

I realized how powerful you can be as a nurse, and how much you can abuse that, how much you can use it for good, but also for bad, which I still sometimes see in our practice...the most important thing is not to be prescribing, it is a negotiation, it is all about discussion. [Sara]

Participants described practices where patients were empowered, as well as their observations of the practice of colleagues where patients were disempowered. In contrast to a hospital setting where the nurse welcomes the patient into the hospital environment, power dynamics may differ in the community because patients are able to determine who they will allow to enter their home. For example:

Working in the hospital setting, I learnt very quickly that we have power as nurses....But when I worked in the community, I learnt very quickly that it is a privilege to make it in their doorway....To me it is about respect and it is about who has the power, and it is about how you use that power....and it is that humbleness of listening. I have seen how power can be quite dangerous to a

patient when they are not compliant, especially from the health professional.
[Rangi]

The definition of cultural safety identifies “unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual” (NCNZ, 2011a, p.7). Therefore, practice which reflects this places patients at cultural risk. The perception of cultural risk, although identified across all participant groups, was expressed most strongly by Māori nurses in a number of ways. These included their own experiences of accessing health services, being exposed to attitudes of colleagues, and observing the actions of colleagues caring for Māori patients and whānau. From the accounts provided specifically by Māori participants, they observed situations where in their opinion, Māori patients had been placed at cultural risk by other nurses. Māori nurses, due to their knowledge and understanding of cultural values and beliefs, may identify situations where they believe the most culturally appropriate response for a Māori patient and whānau is contrary to other nurses. This may place Māori nurses at cultural risk also, as their decisions may conflict or be misunderstood by their colleagues.

I was assessing a young woman who had a stroke, she was very ‘traditional Māori’, her mum was fussing around trying to be a mum, but very worried. Then a [IQN] nurse said to me, ‘why do you want to take her up? Just fob her off and get her out’. And I said no, I am going up with this family, I don’t care what you say. He said ‘how come she can’t go to CT?’ and I said I will take them up. He didn’t understand, he just looked at me and asked why I wanted to do that. I said because this family needs it, so I am going to escort this family. I did not feel it was appropriate to just do the hand over on the phone, and considering her condition was a GCS 11 (General Conscious State 11), I think it was very important that she was handed over personally. [Moana]

In this situation Moana kept the patient at the centre of her care and despite the lack of understanding displayed by her senior colleague, did what she considered was most appropriate for this Māori patient and whānau. For Moana this was about providing culturally safe care.

Observing the behaviour and attitudes of other nurses, such as when Māori nurses are visiting relatives in hospital, can also place them in difficult situations. Some Māori participants expressed a sense of powerless to intervene when they observed Māori patients being placed at cultural risk. This is illustrated in the following accounts:

My mum spent some time here and to be on the other side of the fence, to sit beside the bed and watch the carry-on was sad and heart breaking and disturbing. And to watch this one patient, she was Māori. But to slowly see her through the days, to watch this woman’s integrity and countenance fall apart, because she didn’t feel she was being listened to, and seen as an annoying

patient. It just broke my heart, she had a Pakeha husband and he was trying to advocate for her and kept getting slammed. So no matter which seat you sit in, it is unfortunately the power that we hold can make, or break people. Just from simple things such as, not listening, not taking the time, and not seeing what is really behind a person's issues. [*Mana*]

Aroha was brought up within her Māori culture and completed her nursing through the Tihei Mauri Ora BN programme. She described a situation where she felt a patient's care could have been compromised due to the attitude of another nurse. It is unclear if the nurse's attitude was due to the fact that the patient was Māori or that he was addicted to drugs. The outcome was that the patient who was on a methadone programme, told Aroha that other nurses chose not to give him his medication on time although he knew this was important for its therapeutic effectiveness. Because Aroha was aware of the co-ordinator's attitude towards the patient, she did not seek assistance to put this patient's discharge plan in place, but used other approaches to enable the patient to transition smoothly into the community.

I rang the pharmacist, our pharmacist, his pharmacist, and his probation officer, to let them know he was being discharged. I got that all in place, then I went to him and said, there you go, it's all done. And he said 'is it?', and I said yes, I have rung them and told them you are being discharged today, at this time and you have had this dose, and that you would be picking up your weekend dose this afternoon. And he goes, you are awesome, the others wouldn't have done that. And I said they might have, and he said 'no, they wouldn't. They always give you dose late you are the only one who gives it to me on time'. [*Aroha*]

This example illustrates how nurses may use their power in subtle and covert ways, either consciously or unconsciously. If there is a conscious intent to diminish or demean the wellbeing of a patient this is culturally unsafe practice. On the other hand, if the intention is unconscious, nurses need to reflect on their prejudices and biases to become more culturally aware and progress towards cultural safety. The issues raised by Aroha, in this example, builds on Kelly's acknowledgement that the quality of care may differ significantly between individual nurses. However, in Aroha's example, these differences were identified by the patient as well.

A recently trained Māori participant talked about her sense of powerlessness in advocating for a patient with her nursing colleagues. She had assessed that a Maori patient in end-stage Parkinson's disease was in significant pain and required more effective pain management. She sought assistance from a colleague as she was unfamiliar with Patient Controlled Analgesia (PCA), but the colleague told her to 'ignore his pain because he was faking it'. The patient continued to complain of pain, so she accessed the out-of-hours resource nurse to guide her to initiate PCA. When

she returned to work the following day she found that the patient had not been encouraged to use the PCA and he was still in pain.

The patient said to me, 'I am glad someone listened to me'. He was in pain, he couldn't sleep and because he was doing big gigantic jerking movements, they thought he was putting it on, that he just wanted drugs. But he was not drug-seeking. I remember being told by the Pain Team that pain is what the person says it is, we cannot assess that it is different, so I remembered that. And so he died four days later, and a nurse came down to tell me he had died, and I looked at those girls and they knew how I felt about them not easing his pain. I will never forget how that man pleaded, and he was begging, rolling on the floor crying, and nobody else listened to him. And so I hate myself for that, I got him stuff but I felt I never did enough, I always felt that I should have stood up and said what are you doing, come with me now but I didn't. And then he died. It has taught me not to second guess myself, to trust myself because I have good instincts, and to work with my patients. And he was part Māori too and they do get overlooked, I do admit that. Because nurses stereotype Māori and they say, 'oh this Treaty, they have got to let it go'. One person said to me, 'the Treaty no longer has an impact on their health'. And once upon a time I might have believed that, but no longer, it has a huge impact on health. [*Moana*]

As this example showed, when nurses don't listen to patients and instead allow their own attitudes and prejudices to influence approaches to care, this can be perceived as culturally unsafe practice. While participants from a range of backgrounds articulated many examples of providing culturally safe care for Māori patients and whānau, they also highlighted situations when some nursing colleagues did not.

Participants in general highlighted the importance of not making assumptions based on the patient's ethnicity as Māori. However some participants described experiences where other nurses stereotyped and made assumptions about Māori patients and how they intervened to mitigate risk. Although the perception of cultural risk for Maori patients was identified across all participant groups, it was identified most strongly by Māori nurses in a number of ways: their own experiences of accessing health services or being with a loved one accessing health services; being exposed to attitudes of staff; and observing actions of colleagues caring for Māori patients and whānau.

4.6 Discussion of findings related to caring for Māori patients

This study provides a new approach to exploring nurses' articulation of their cultural practice when caring for patients from diverse cultural backgrounds, in this chapter specifically Māori patients and whānau. This section of the chapter discusses the

findings of the study in relation to the research question and objectives and the main themes identified from the findings.

The 'Guidelines for Cultural Safety, the Treaty of Waitangi and Māori Health in Nursing Education and Practice' (2011a) set out the theoretical foundation and outcomes to be integrated into clinical practice, although the guidelines are not explicit about how the theory is applied to clinical practice. The principles of the Treaty of Waitangi and kawa whakaruruhau provide frameworks for nurses to engage with and develop relationships with Māori patients and whānau (NCNZ, 2011a). The Nursing Council competencies for the registered nurse scope of practice (2007) provide the measures against which nurses' practice is monitored. Individual nurses take responsibility for meeting the on-going requirements for continuing competence. The themes and sub-themes identified from the data in this study align with the Nursing Council competencies (2007) and the Code of Conduct (2012a) and professional nursing models of care (Christensen, 1990; Watson, 1997).

When caring for Māori patients and whānau, the majority of participants in my study used the principles of the Treaty of Waitangi to guide their cultural practice rather than kawa whakaruruhau/cultural safety. This reflects the demographics of the participants as not all participants had undertaken cultural safety education or other cultural training. Despite varying degrees of cultural education, all participants appeared to be confident relaying examples that reflected aspects of participation, partnership and protection and kawa whakaruruhau. These findings support a social constructivism worldview that multiple factors contribute to the development of culturally safe practice. In this study these factors included participation in cultural safety and/or Treaty of Waitangi education, personal backgrounds and experiences, professional experiences, mentors for cultural practice, and maturity. As nurses gain experience they become more confident in their ability to consider the holistic needs of patients and anticipate problems. These stages of practice development can be aligned with Benner's (1984) theory of novice to expert. Although these levels of practice are based on clinical skills, cultural practice can develop in tandem with other skills. As confidence grows with experience so too does the ability to communicate, critically reflect on practice and adapt care to meet the holistic and individual needs of patients (Sumner, 2010).

4.6.1 Establishing positive working relationships

The ability to communicate effectively, build trust and establish rapport are integral to establishing positive working relationships with Māori patients and whānau and addressing barriers to access for Māori (Corbett, Francis & Chapman, 2006; Jansen & Jansen, 2006; Ramsden, 2000; Shih & Honey, 2011; Wilson, 2006, 2008; Wilson & Barton, 2012). The ability to 'connect' and 'relate' well to Māori patients and whānau are key strategies to establish trust and enable informed choices and decisions (Wilson & Barton, 2012; Bolitho & Huntington, 2006; Theunissen, 2011; Wilson, 2006, 2008). From the findings, establishing positive working relationships emerged as the strongest theme when caring for Māori patients and whānau. Communication and developing relationships with patients and their whānau were represented as the most critical components of cultural practice in this current study. They are also integral elements of more generic nursing models of care (Christensen, 1990; Watson, 1997) and are reflected across the Nursing Council domains of practice (2007). The ability to communicate effectively and adapt communication strategies to meet the diverse needs of Māori patients and whānau was illustrated across all participant groups.

Māori nurses appeared confident in their identity as Māori and their interviews showed how they engaged and connected readily with Māori patients using culturally appropriate processes to establish kinship relationships. All but one Māori participant expressed feeling secure in their identity as Māori. They felt that their knowledge and understanding of Māori culture was beneficial when caring for Māori patients and whānau and enabled them to more easily communicate with these patients. They recognized the role of whanaungatanga as key to engaging and connecting with Māori patients and whānau and sharing their whakapapa to connect with patients through kinship ties. Participants used these processes as a mark of respect to establish meaningful relationships and build trust with Māori patients and their whānau. When these processes are followed the nurse may be considered as part of the extended whānau. However, as with their own whānau, in these situations Māori nurses must be cognizant of not breaching professional boundaries. The Professional Boundaries Guidelines (NCNZ, 2012b, p.11) acknowledges:

Some Māori nurses have a strong sense of accountability in working with and caring for whānau/hāpu/iwi (extended family/sub-tribe-tribe). Māori nurses need to be clear about their role as a professional and their role as a relative.

4.6.2 Working positively to achieve outcomes

In this study participants applied a range of models of care when caring for Māori patients and whānau. From the findings of the current study it became apparent that European nurses trained after 1990 tended to provide care using a cultural framework and Māori models of care. Māori models of intervention assisted practitioners to negotiate tensions in order to deliver more effective services. The integration of Māori models of health can assist nurses to assess, plan, deliver and evaluate nursing care that is responsive to the holistic needs of Māori patients and whānau. Te Whare Tapa Whā (Durie, 1998) and Te Wheke (Pere, 1991) are well known and utilized models. However other models such as Te Kapunga Putohe (The Restless Hands) (Barton & Wilson, 2008) and the Whanaungatanga model of care (Lyford & Cook, 2005) have also been developed as alternative models. These models reflect a holistic paradigm as they incorporate physical, emotional, spiritual and social dimensions of health, as well as relationships with the past [ancestry] and connectedness to the natural environment.

However, European participants trained prior to 1990, Māori and IQN participants in my study tended to focus on Māori patients from a holistic and individualistic perspective. This may reflect that the models of care taught as part of their nursing education continues to influence their practice today. Although these approaches to care focus primarily on the patient as an individual the participants included the whānau when caring for Māori patients. This may be a reflection of the quality of their relationships with Māori patients and whānau and their ability to work together to achieve positive outcomes. Data collected from IQN participants suggests that Treaty of Waitangi workshops provided a strong foundation for these overseas nurses to build their cultural practice when caring for Māori patients and whānau. This is supported by other literature where nurses gained confidence caring for Māori patients and whānau following cultural education (Manchester, 2012; Ren, 2009; Yorke, 2009).

Although many participants described using a holistic approach to care, they did not refer to specific models or theorists. According to the American Holistic Nurses Association (1998), holistic nursing practice places healing of the whole person at the centre of care. Holism focuses on the uniqueness of the individual and their underlying balance between the physical, mental, emotional and spiritual dimensions of health (Lowenberg, 1992). Participants in this study who used a generic holistic

framework, considered the patient's ethnicity as Māori as just one of many factors that included emotional, spiritual, whānau and physical needs. When whānau are included in a holistic approach there is synergy with Māori models of health that nurses may not be aware of. It was evident from the findings that knowledge of Maori models of health was limited. Therefore nurses would benefit from integrating knowledge about Māori models of health and holistic nursing into post-registration and post graduate education.

Although there was variability across the groups, participants in general recognized the presence of health disparities and endeavoured to improve access to health and other services to address these. Their emphasis on removing barriers to communication, attempts to improve health literacy and development of positive working relationships, can be considered strategies to improve access to health services and promote self management (Bolitho & Huntington, 2006; Jansen, 2009; Wilson, 2006, 2008). Participants working in the community appeared to be more aware of disparities as they were visiting patients in their home and were able to identify a wider range of needs. IQN participants recognized and identified health disparities in their accounts. This suggests that their attendance at Treaty of Waitangi workshops as part of their orientation to practice may have influenced this, as evident in other literature (Manchester, 2010; Ren, 2009; Yorke, 2009). One IQN participant acknowledged that when she left the DHB to work in the community it really opened her eyes to the disparities that existed for Māori. Participants who cared for patients on a long term basis were also more likely to be rewarded by seeing positive changes in health. However, access to Māori appropriate resources and support did not emerge strongly in participant accounts.

Wilson (2006, p.xii) identified that an important strategy to improve access to health services was to maintain the integrity of Māori patients and whānau "by respecting their worldview and incorporating their knowledge and healing practices". Māori participants appeared to be more aware of health disparities while at the same time identifying gaps in available resources as well as policies aimed at supporting culturally safe care. It became apparent from their accounts that a supportive or non-supportive workplace culture had a significant impact on their practice. This feature of Māori nursing practice was also identified by Simon (2006). Māori participants and other participants also encountered situations where they had to challenge the culturally unsafe practice of other nurses. The lack of on-going education and

emphasis on culturally safe practice has the potential to contribute to unsafe cultural practice.

Kawa whakaruruhau was introduced as a framework with the assumption that it would help to improve health outcomes for Māori. However, there has been little evaluation of the value and efficacy of cultural safety from the perspective of the recipient of care (Mortensen, 2010; Papps & Ramsden, 1996; Wilson, 2006, 2008). Although it was not the purpose of this study to measure the value and efficacy of cultural safety because not all participants had been exposed to cultural safety education, the findings indicate that nurses need to have more awareness and understanding of health disparities and their role in improving health outcomes.

4.6.3 Supporting patient autonomy, empowering patients

Self determination is the first principle of the Treaty of Waitangi and the underpinning philosophy of kawa whakaruruhau (NCNZ, 2011a). In order to be self determining patients need to fully understand health information to be able to make informed choices and decisions about their health. Nurses play an important role in improving the health literacy of Māori patients and whānau (Clendon, 2012). Although participants did not specifically refer to health literacy they recognized the importance of patients understanding information including options for care and consequences of decisions made, especially if they decided against recommended treatments.

Participants from each group recognized the important role of whānau in collective decision making. Emphasis on collective decision making and presenting options for care and treatment enabled Māori patients and whānau to have autonomy and self-determination over their own health (Durie, 1998). Participants acknowledged communication skills and developing meaningful relationships were integral to the informed consent process and meeting patient needs.

The NCNZ cultural safety guidelines (2011a) and competencies (2007) do not provide a framework for nurses to use so that patients can determine their care has been culturally safe. Understandably participants expressed difficulty in assessing whether care had been “appropriate and acceptable” as determined by the patient. How confident they felt doing this appeared to be related to a number of factors: their years of practice, the relationship they had developed with the patient and whānau, how they asked for feedback and their openness to hearing responses. For some

participants reflection on their cultural practice was a useful self assessment tool. Reflection on practice is promoted to assist nurses to become more self aware of their cultural practice and how this may influence nurse-patient relationships (Wood & Schwass, 1993).

Assessment skills, interpretation of body language and other cues and confidence in asking patients, were the main approaches identified. How cues and body language were interpreted was based on the experiences and knowledge of the individual practitioner. Benner's model (1984) outlines the progression of nursing practice from novice to expert. As nurses progress towards expert practice their assessments skills are more advanced and they are more able to anticipate and respond to changing situations more quickly. Therefore, participants appeared to be confident developing their own approach for their own practice and also when assessing the practice of colleagues. It may be beneficial for patients if nurses had a generic framework to use and adapt as they developed their cultural assessment skills. This would also provide consistency for nurses who have not undertaken cultural safety education. It would be appropriate to include Māori stakeholders in the process of developing a assessment tool.

4.6.4 Awareness of and managing personal (nurses') stereotype and power

Cultural safety education aims to produce a "nurse who can understand his or her own culture and the theory of power relations can be culturally safe in any context" (NCNZ, 2011, p.4). Key features of cultural safety include not making assumptions or stereotyping people based on their ethnicity or other cultural attributes. Despite twenty years of cultural safety education studies suggest that stereotyping and assumptions about Māori continue to influence current practice (Wilson & Barton, 2012; Ramsden, 2002; Richardson & MacGibbon, 2010; Wilson, 2006, 2008).

Participants in my study consistently stated that assumptions and stereotyping had no place in safe cultural practice. All participants provided accounts to demonstrate how they provided culturally safe care for Māori patients and whānau. However, some described experiences where other nurses' stereotyped and made assumptions about Māori patients and, in situations like this, how they intervened to mitigate risk. Some Māori participants also referred to experiences when Māori patients had been placed at risk when culturally safe care had not been provided. This included the behaviour of nurses towards Māori patients and whānau,

inadequate management of pain, and delaying medication. When observing nursing colleagues providing culturally unsafe care for Māori patients, some European participants felt able to address their concerns with colleagues. However, Māori participants appeared to be less comfortable doing this. Some European nurses also alluded to the idea that other nurses might not be as culturally responsive as they were.

The differences in power dynamics in nurse-patient relationships was described by many participants, particularly in relation to differences between hospital and home settings. The routines and policies of organisations may hinder nurses ability to provide culturally safe practice in the hospital setting, particularly in relation to visiting hours which can restrict whānau involvement in care and decision making (Richardson & MacGibbon, 2010). In home settings patients are more able to determine whether or not they will invite a nurse into their home or alternatively may choose to not be at home when the nurse visits. Communication skills and developing relationships play a key role in sharing power in nurse-patient encounters (Ramsden, 1993, 2000; Reynolds & Scott 2000; Richardson & MacGibbon, 2010; Wilson, 2006, 2008).

Māori participants in my study talked about how they had benefited from the introduction of kawa whakaruruhau, not only in terms of education options but also application to practice. Over half of the Māori participants said they had completed their nursing education through the Tihei Mauri Ora (TMO) nursing programme at the Waikato Institute of Technology (WINTER). TMO was introduced in 1993 specifically for students who identified as Māori and integrated both western and Māori worldviews of health and nursing knowledge, delivered within a Māori appropriate framework. Although the delivery was the “point of difference, learning outcomes are the same as for all other students” (Simon, 2006, p.206).

Through descriptions of their practice Māori participants demonstrated some key features of Māori nursing practice as identified by Simon (2006). These were: 1) cultural affirmation and identity, knowing whakapapa (ancestry) and feeling secure in their identity as Māori; 2) cultural awareness and understanding of the Māori world assisting them to provide culturally appropriate care; and 3) knowledge of Māori models of care to integrate into assessment, planning and implementation of care. These characteristics were also evident in accounts from Maori participants who had not completed the TMO programme. This suggests that there are many factors

influencing Māori nursing practice but that confidence in their identity as Māori and experience of the Māori world played a significant role in the development of their cultural practice when caring for Māori patients and whānau.

Although confident in caring for Māori, when Māori participants identified situations of actual or potential cultural risk, some expressed a sense of powerlessness to be able to advocate, to overcome risks. The behaviour and attitudes of nursing colleagues were identified as barriers. The resulting conflict and tension created implies marginalization of Māori nurses as well as patients.

4.7 Conclusion

The findings from this research indicate that participants were comfortable using the principles of the Treaty of Waitangi as a framework for providing culturally safe care for Māori patients and whānau. The focus of their practice was primarily on effective communication and developing trusting and meaningful relationships. They readily articulated examples that demonstrated application of the Treaty of Waitangi and kawa whakaruruhau. The primary approaches to care identified by participants were both holistic and individualistic with the inclusion of whānau and Māori models of care. There is synergy between these concepts of care although Māori models of care are the most appropriate as they include all the elements that Māori believe are important for health and wellbeing. Participants also provided accounts where they had observed colleagues being culturally unsafe and how they addressed this practice with their colleagues. The impact of kawa whakaruruhau on improving health outcomes is not evident in this study although there was evidence of building positive working relationships.

In their care of Māori patients and whānau, Māori participants showed that their knowledge and understanding of cultural practices, their integration of Maori language and processes to engage with Māori patients positioned them well to best meet their needs. However, their understanding of what was important for Māori at times put them in conflict with their nursing colleagues. Māori participants were more cognizant of health disparities and through their personal and professional experiences observed situations where culturally appropriate care had not been provided.

CHAPTER FIVE

Caring for patients from other cultural backgrounds: Findings and discussion

5.1 Introduction

This chapter presents findings on how participants cared for patients from cultural backgrounds other than their own (excluding Māori). In this chapter the cultural safety framework addresses the broader cultural context which includes age, gender, religious beliefs, sexual orientation, disability, education background, and ethnicity as part of the cultural context. The cultural safety approach also recognizes the diversity within each of these different cultural groups (NCNZ, 2011a, Ramsden 1993; Wood & Schwass, 1994).

The thematic construct is the same as identified in Chapter Four Table 5. The difference lies in the application (by nurses in practice) of cultural safety principles to those other than Māori.

5.2 Establishing positive working relationships

Cultural safety provides a framework for nurses to engage and establish positive relationships with patients from varied background and who possess diverse views and opinions. Cultural safety education provides nurses and students with the professional skills to acknowledge values and beliefs that differ to their own. When asked to share their experiences of caring for patients from culturally diverse backgrounds, participants primarily talked about patients from other ethnic groups. However, some participants also identified culture in terms of age, gender, sexual orientation, hearing impairment and religious beliefs. The sub-themes for establishing positive working relationships are communication and developing relationships.

5.2.1 Communication skills

Communication was identified by all participants as a key feature of cultural practice. In the case of patients from other cultural backgrounds, particularly those who do not have English as their first language, communication through a third person was critical. This is different to the approach identified when working with Māori patients and whānau. Advocacy was also highlighted as an important element of cultural practice for patients from other cultural backgrounds. Other aspects of interpersonal skills such as adapting communication strategies and care and empathy were described by participants, similar to those described in the previous chapter.

Participants from all groups acknowledged caring for patients from CALD backgrounds required additional resources and support to enable effective communication. For patients with English as a second language, communication required the assistance of someone to interpret, whether that was a family member, a staff member who spoke the language, or an authorized interpreter. Although it may be recommended to access an authorized interpreter, this was not always the case for participants due to patient preferences or the unavailability of interpreters. The importance of accessing gender appropriate interpreters was also considered by some participants as very important, often in recognition of what female refugees, for example, may have experienced prior to their arrival in New Zealand and cultural practices.

Interpreters play an important role in assisting nurses to communicate effectively and appropriately with patients. They help in the assessment of patients as well as provide insight into cultural practices and help to identify specific needs of patients and their families that enable nurses to respond to (Mortensen, 2010). Rangi, who graduated ten years previously, talked about an experience from her first year of practice. She recalled that from her cultural education she had learnt the importance of accessing interpreters for patients and families who did not understand or speak English. Therefore, when she cared for a child whose parents did not speak English, she sought assistance from an interpreter for this Somali family. Although this was met by resistance from a senior colleague, Rangi believed it was important in relation to patient care as well as helping the parents understand the situation. The reason for this resistance was not explored further but may have been related to cost, or others not recognizing the importance of interpreters at that time. Nurses also need to be cognizant of gender specific interpreters as well as understand how and who makes decisions in different cultures.

I learnt very quickly it is not necessarily the woman who makes decisions. When the interpreter came in to ask the questions to get permission for surgery, the men needed to be addressed first, and the interpreter [she] had be very mindful of that. I learnt very quickly there is a hierarchy to work through. [Rangi]

This account reflects the conflict nurses may experience when they endeavour to integrate their cultural theory into practice in the hospital context. When this practice is not role modeled by colleagues the significance of culturally safe practice may be undermined.

For nurses working in the community with refugee and immigrant groups, accessing interpreters was common practice and crucial for communicating effectively with these groups of patients. However patients may decline an interpreter in preference to a family member as they may not want someone from their close knit community knowing their personal information.

When he [the interpreter] told me I thought, what am I going to do now, and I asked them if there were any alternatives, and the lady said that she would ask somebody in the family. She did speak some English butthe treatment is very specific you almost have to be pedantic about it to make it work properly. What we do and say is very repetitive because the treatment goes on for such a long time. We managed but there were mistakes in her taking the treatment, and I never know to this day, if it was because the interpreting was done by somebody else. [Caitlin]

Utilizing family members to interpret may increase the risk of information not communicated correctly, information being filtered or the patient not fully understanding what is expected. Interpreters play a key role in improving the health literacy of patients who do not speak English.

Two participants, both trained prior to 1990, emphasized that for patients who spoke English but for whom English was their second language, it was still important to access interpreters to ensure they were able to understand information in their own language.

...even if they speak English very well and they can understand it, we have an interpreter. There's nothing like someone who can talk in their own language or they can read their own language, because people will revert to what they know best which is their own language....We had a patient who spoke Mandarin and we downloaded some information for him. Even though he spoke English he wanted to read it in his own language. When the nurse delivered it to him, she wanted to give it to him discreetly but he dropped what he was doing and ran round the counter and hugged her. [Jenny]

Providing information in the patient's own language can enhance understanding of their condition as well as the rationale for care. Participants stated that access to appropriate interpreters was limited and they had to identify other options for communication such as family members and staff. Health information in many different languages is often not readily available. Gaps in resources, along with knowledge of other cultural values and beliefs, are also acknowledged in the literature (De Souza, 2005; Mortensen, 2010, North, Lovell & Trlin, 2006). Interpreters helped participants to gain some insight into the cultural needs and rituals that may be important for patients from different cultural backgrounds.

One participant working in the community shared her priorities for successful engagement with linguistically diverse patients:

1) An interpreter of the most appropriate language because sometimes it is difficult with different dialects in other countries. As an outsider you are often ignorant of that and it takes a bit of sorting out at first. 2) The other thing is, allowing enough time as everything takes longer when using an interpreter with a newly migrated family. Nothing is straight forward....I know now the only way to have that proper full engagement early on in the relationship, is to get the right interpreter and allow enough time. [Caitlin]

Caitlin was the only participant to acknowledge that additional time was needed when communicating through an interpreter and that nurses need to plan for this. However, this may be more achievable in community settings as opposed to a hospital context where there are many competing pressures on time (Richardson & MacGibbon, 2010).

As in the previous chapter participants acknowledged that the manner in which they approached a patient initially and then in subsequent interactions were important in establishing rapport. They believed their first engagement with a patient set the scene for the quality of the relationship established.

Some of the other things I would think about would be the tone of things, because I know that some of our refugee families have had a very difficult time in the past, and have often been in situations where they have been very frightened. So I make a point of being as gentle as possible, and not demanding. I always try to start off leading the communication because they are wondering who I am, what do I want, why am I here. So I would start off leading it but as time goes on, I would like to let them take some of the lead, and that would include cultural things. [Caitlin]

The recognition of one's own 'ignorance' as an outsider and reliance on others to be able to communicate effectively when patients do not understand English, enables nurses to be culturally responsive to patient needs.

Some participants also identified that there were not the relevant resources available to support them to work easily with patients from different cultural backgrounds. They acknowledged the importance of patients being able to speak to someone from their own culture in their language was beneficial to their wellbeing and recovery.

I had to ring outside the hospital to get support for this patient, someone from his culture, and it is amazing how much that means to them because they talk in their own language and they are connected....He comes from the Islands, they are very spiritual and like to go to church, so I got the chaplain down [although she was Māori] ...she understood his spiritual needs. So he ended up going up to chapel in the hospital. When we used to have a clinical meeting, he would get dressed in his traditional clothing and I thought here is a guy who has values and beliefs, and he still does it when he is in here. [*Te Rina*]

Interpreters support effective communication with patients from CALD backgrounds. However, they also aid communication using sign language with patients who have a significant hearing impairment.

....it was ensuring her family was with her, her son used to come and he would use sign language, offering the interpreter service, asking her afterwards, did you understand, and maybe writing initially, using visual information, written information, asking her to repeat back to show she understood. The way I got round it was going to appointments with her. [*Andrea*]

Some participants acknowledged that when there were language barriers nurses played a critical role as advocates for these patients and their families. This included advocating for family to be present at the end of life situations even when this may not be supported by other team members. It was apparent from a number of participants that their insistence on meeting the cultural needs of patients and families from other cultural backgrounds put them in conflict with nursing colleagues.

I was caring for a Chinese family, the father was dying and the family wanted to stay with him. But he was in a 6 bedded room and it wasn't the practice that anybody could stay. I tried to get him into a single room so the family could stay, especially as the adult daughter could speak English and was able to interpret. She told me that in their culture, if a relative is dying, the family stays with the patient so that the spirit will go to the other world when the patient dies. As it was important for the family, we did eventually get a single room for him and the family stayed. It was very difficult to get him a single room, but I just kept pushing. I wasn't very popular but I was happy I was able to do this for the family. [*Julia*]

This is the second reference, in this chapter, to nurses making themselves unpopular by pushing for cultural and language related support. Being challenged by nursing colleagues when advocating for culturally safe care, emerged as an issue for participants, when caring for patients from other cultural backgrounds. This was also identified as a concern in the previous chapter. The attitudes of colleagues and lack of respect for the cultural values and beliefs of patients conflict with the principles of

cultural safety. This raises the question as to whether as a profession nurses are committed to promoting cultural safety as central to their practice. With the increasing cultural diversity of the New Zealand population nursing needs to respond with the same dedication it showed with the original introduction of cultural safety to now meeting the needs of CALD populations.

Participants identified a range of interpersonal strategies they integrated into their practice to promote effective communication. Interpreting body language and non-verbal cues were two elements identified. An awareness of how patients from diverse cultural backgrounds may respond in different situations, the relevance of eye contact and personal space and cross-cultural communication issues enables nurses to more accurately assess and respond to patient needs in a culturally safe manner.

We are very conscious as staff, that even though they [patients] speak English, their understanding of English is not as good as [their] speaking it. You see sometimes they can write quite well, but we need to be very sensitive as they may just nod that they understand when they don't. [Jane]

Participants identified a range of communication strategies they utilized to build rapport and show care and empathy. These included engaging in multiple conversations to get to know the patient as a person. Participants overall showed a desire to be respectful to find out from the patient what was important for them and adjust their communication approach where they needed to. This is similar to the findings when caring for Māori patients.

It's really about communicating because you are dealing with people in grief and under stress all the time, it's the unknown and the outcomes can be unknown. So it's important to look beyond because sometimes you have to because you know there are some underlying things. [Andrea]

Participants acknowledged the hospital environment was often scary for patients and relatives, particularly in emergency and end of life situations, and part of their role was supporting relatives through crisis events.

I think it helps them to be in the room where we are treating the patient, to give them explanations and try to explain who everyone in the room is, what everyone is doing, so they feel that they know what is happening and feel part of it, have a sense that everything is being done that can possibly be done. [Pare]

Mike described his approach to engaging with an older patient was to firstly acknowledge his autonomy and then find out more about the patient as a person, as well as overcome any communication difficulties.

We can pick up that he is independent, that he is independent thinking, so in planning his care you are going to have to look at how you are going to make

this care work, so he is able to maintain as much independence as possible. He also has a problem in that he is deaf so to acknowledge that deafness, and to be able to change the way you engage. To make sure that he can see you, that he can lip read, to speak more slowly and to be able to accommodate him, because of his hearing impairment. [Mike]

Participants from all groups articulated examples to demonstrate how they engaged and related to patients from other cultural backgrounds in order to respond to their needs. In many cases communication was established through an interpreter and communication strategies were adjusted to meet the diverse needs of patients. Some participants showed awareness of different cultural practices while others relied on interpreters and family members to identify specific cultural preferences. For all participants effective communication provided the foundation for developing relationships with patients.

Participants also discussed the importance of establishing working relationships (and rapport) in the face of linguistic and cultural differences. These differences could become barriers and participants outlined various strategies they developed and resources they used in such contexts.

5.2.2 Developing relationships

A number of features in relation to developing relationships with patients from other cultural backgrounds became evident from the data. These included fundamental attributes such as taking the time to get to know the patient, being able to communicate effectively and identifying what was most important for the patient. Other elements that emerged were the significance of gender specific care as well as having an understanding of the values and beliefs of different cultural groups. How participants approached patients to initiate the relationship, and being flexible in how they worked respectfully with patients, were also important features of practice shared by participants.

One participant described how she established her relationship with a patient by taking time over two shifts to get to know a young man who was reluctant to share personal information and had not had any visitors. As she gained his trust she was able to ask him if there was anyone she could call:

I phoned him [patient's friend] and he was so relieved because they didn't know where he was. They had been looking for him for 3 weeks, they couldn't find him because he used to wander into the bush and stay there for a few weeks, and when he came out he was happy again. And then he phoned me

back and said his mother would like to talk to him and I said okay let me go and ask him. [Sara]

When sharing this example, Sara said that prior to coming to New Zealand she would have given the patient no option but to speak to his mother, but in this situation she sought his permission first, acknowledging that it was the patient's decision. IQN participants detailed how the emphasis on 'culture' had required them to examine their own values and beliefs and adapt their cultural practice to work safely in the New Zealand nursing context. This was initially through Treaty of Waitangi workshops but also their experiences of caring for patients from culturally diverse backgrounds as well as knowing they were required to adhere to the professional, ethical and legal requirements set out in the HPCA Act (2003) the Nursing Council of New Zealand (2007, 2011a, 2012) and the New Zealand Nurses Organisation (2010).

For another participant, developing relationships with patients from other cultural backgrounds, particularly refugees, not only involved language but also how to gain their trust. Having empathy for what these patients may have experienced prior to coming to New Zealand was an important feature of nursing practice.

Building up confidence and trust and mutually agreed things I try and do discussion around supports and cares that I have put in place as a way of gaining consent or permission. It is not always easy to write a care plan and ask somebody to sign it, because people [particularly refugees] do get a bit panicked when you ask them to sign something, so I would rather not do that until there has been full discussion and full elaboration and they have been given the opportunity to ask questions. So having that trust, building up trust by having proper engagement first, would be the best way I have found to be able to plan the care together. Because it is no good saying I am going to do this and this okay, because for one thing I don't know if it is okay or putting words into their mouth. And another thing, I think it is a bit disrespectful to assume everything, even if someone does seem to be new, vulnerable and needy. Need to make them feel safe. [Caitlin]

Patients from other ethnic groups may have a different worldview of health to western ideals that may influence the establishment and maintenance of therapeutic relationships. The stigma associated with some health issues may be significant for some ethnic groups. One participant, Kuini, described an experience of caring for an Asian woman following the birth of her baby. This woman was extremely anxious and stated that she did not want to live. Professionally Kuini knew that this woman could not be discharged home without someone being aware of her state of mind.

I said, I do need to talk to someone, who would you nominate? She couldn't give me anybody and I said, how do you feel about me contacting your husband? No, she didn't want that either, so I said I couldn't clear her to leave,

without having something firm in place. So I got the mobile phone...and I said I am going to ring your husband. I will sit here with you and you will hear what I am saying to him. So I rang him and he says that sounds like her...and I said are you happy for her to come home and will you make sure she comes to her appointment in Mental Health Services? He said he would and she accepted that, because she was in the same room and listening. [Kuini]

Kuini felt that she had made a difference for this patient by listening, acknowledging and affirming how the patient felt and how she wanted things done. Her awareness of the stigma associated with mental health for this patient influenced the approach she pursued with this patient. She also believed that using her professional judgment to make contact with the husband was important to minimize risk for her on discharge. Although the patient initially expressed that in her culture they did not talk about their feelings, in the end she was glad that her husband knew about her condition. This illustrates that at times when practicing within a cultural safety framework nurses' professional judgment and responsibility for patient safety may conflict with what patients want, at least initially. Such issues need to be worked through to a mutually satisfactory resolution.

The notion of gender specific care emerged from the accounts provided by female and male participants as potential barriers to developing therapeutic relationships. This related to the vulnerability of the patient as well as the nurse. The relevance of protecting personal privacy of female patients, particularly for Muslim women, was raised by a number of participants.

We were very careful to make sure the curtains were pulled, if they were open half an inch she was appalled, so we just became hypersensitive about her needs around privacy. If she was toileting or [we were] giving her a bed wash, we were very careful about doing a leg and keeping everything else covered up, do half a leg...very much asking before we did anything to her, so we didn't overstep something that was very important to her. [Sally]

When sharing this example Sally alluded to only female nurses caring for this patient. However, a male participant described a situation where he was assigned the care of a Somali Muslim woman who was going to be examined by a male doctor. He recognized the inappropriateness of this, as well as the cultural implications for the woman, and asked a female doctor to examine her, as well as a female nursing colleague to be with the patient.

I felt that although we could control what happened in the hospital, who knows what would have happened to that poor woman when she got home. She could have ended up getting assaulted or she could have ended up ostracized by her family because she unwillingly exposed herself for whatever circumstances. [Mike]

In this particular situation female colleagues appeared to be unaware of what they had exposed both the patient and their male colleague to. Male participants were aware of the vulnerability of female patients in their care and described actions they took to protect themselves and female patients. Protecting female patients' privacy was paramount as well as seeking permission to provide more intimate care and respecting their choice to be cared for by female nurses. They also had to consider the responses of family members and gain their trust. The male participants expressed that over time they had developed their own strategies to protect themselves and their female patients. This is in line with findings of studies exploring issues for male nurses when caring for female patients (Evans, 2002; Keogh, 2006).

A number of female participants also identified that some males appeared more comfortable being cared for by males and this was challenging, especially when establishing relationships with Pacific male patients. For example, they found Pacific males were often quiet, did not ask questions or make eye contact.

....he just wouldn't say much but in the end I did manage to get him to engage...a Tongan man, he wouldn't say anything at all...but he was becoming really unwell. His diabetes had resulted in renal failure so I managed to get hold of him just as he was entering into renal failure. I talked to the doctor to put some measures in place so that we could try and slow the progress of his renal failure, by adjusting his medication and stuff like that. My first thoughts were that it would be hard to work with him because he doesn't talk to me and I don't know if he understands. But he actually surprised me and he did really well. [*Nirmela*]

To demonstrate culturally safe practice nurses are required to "acknowledge the beliefs and practices of those who differ from them" (NCNZ, 2011a, p.4). Using the cultural safety framework nurses develop an awareness of the specific 'beliefs and practices' through communication skills and developing relationships. Jenny described the trajectory of her relationship with a young male patient over many years. When she had first met this client as a child, his mother told her that he was different and she thought he was gay. Jenny responded that this would not affect how she managed his condition. She had a long standing relationship with this young man but he reached a stage when he was not managing his condition well.

He came back one day because the GP sent him and he wasn't too happy. I knew he was gay and I said to him, do you have a partner? He said yes I do. And I said would you like to bring him along? And this kid just sat there and looked at me and he said you know I'm gay? And I said yes. We had this really funny conversation. So the next time he brings his boyfriend along. To cut a long story short, he is just doing fantastically well....he is completely engaged in his self management, comes to all his appointments and I'm sure it's because he feels totally accepted. [*Jenny*]

In acknowledging his sexual orientation and including the partner, Jenny demonstrated acceptance of his values and beliefs. In this way she was able to work with the patient and his partner to establish a positive working relationship.

Relationships may be developed by direct contact or phone contact, they may occur over short or long periods of time. The quality of the relationship is often dependent on the interpersonal skills of the individual nurse. One participant worked across the region and with some patients, her only contact was over the phone. With those patients she felt she struggled to gain good rapport with them and acknowledged that this may be because they did not have face-to-face contact. She believed that the approach she used over the phone or face-to-face helped her to establish caring relationships with her young patients.

....the language you use and the genuineness that you come from. I tell them straight up that I am there for them....and I am there for the journey, so whatever decisions you make I will totally be behind them. If there are some decisions you make that are sounding a bit off, I will just spend a bit of time with you to see where that decision came from, to find out if you are annoyed, angry or don't want to continue treatment. So stripping it back, seeing where that decision came from, and guiding them and giving them the information and resources to make an informed decision. So it is like getting buy in, finding out what makes them tick, is it music or pig hunting. You have to get in the door whether that door is physical or psychological. [Mana]

When nurses only have phone contact with patients they have to become skilled in picking up on subtle nuances in patient responses to understand the patient and meet their needs.

5.3 Working positively to achieve outcomes

Cultural safety is underpinned by recognition of the diversity of worldviews both within and between cultural groups. To work positively with patients from other cultural backgrounds requires nurses to have good communication skills to engage and connect with people to provide the foundation to establish and develop trusting and caring relationships. In situations where English is a second language, this requires the support and guidance of others from the same culture, including interpreters. These support people can assist nurses to have some insight into the values and beliefs of individual patients and the most appropriate model of care to provide culturally safe care and achieve outcomes. Under the theme of working positively with patients from different cultural backgrounds, models of patient care and culturally safe care came to light as sub-themes.

5.3.1 Models of patient care

As in the previous chapter holistic and individual approaches to care were identified by participants as the primary models when caring for patients from other cultural backgrounds. No alternative models of patient care relating to specific ethnic or other cultural groups were identified. Analysis of the findings suggests that participants were inadvertently integrating principles of cultural safety as a model of care but appeared unaware that they were doing this. Features of cultural competence became apparent when participants showed awareness of different cultural practices and used these as a foundation for their care. Participants across all groups identified the importance of understanding what was important for patients from a different culture to their own.

You have to be aware of people's differences, beliefs when it comes down to it....what is important for them and work with that....it is about patients and what is important for them and meets their needs. [*Sally*]

Participants across all groups described their experiences of caring for patients from other ethnic groups and how they adapted care to meet their different needs. One participant, while realizing the relevance of particular cultural beliefs, also identified the importance of understanding how a patient's professional status may affect their experience of health care. She described the challenges for a man from a Middle Eastern background who was a health professional and the influence this had on how she practiced.

As a health professional I think he presented problems for people who were caring for him because he had quite strong ideas of what he wanted and what he didn't want....Sometimes as nurses we expect patients to behave in a particular way or we are more comfortable when they behave in a way we are familiar with.... And I had a lot of empathy for him when I thought how challenging it might be for him, given his background, to be in the health situation he was currently in. And I tried to accommodate his needs, I tried to really take on board what it would be like for him relinquishing so much in that situation. It's hard to know how much was due to his cultural background, or the culture of the hospital, the culture of his profession which in some ways he had to set aside. I saw this all as culture as the cultural and the personal are not able to be separated. I feel the emotional and psychological problems he was facing added to the physical challenges he had around his health, which were huge, and I felt that through my nursing care I tried to minimize some of the psychological problems and interpersonal problems he was facing and justifying his care choice. [*Robyn*]

Robyn identified multiple competing challenges in relation to 'culture' for this patient. These included his own cultural background, the impact of the culture of his profession, as well as the culture of the hospital and his status as a patient. She was the only participant who explicitly acknowledged the impact of the culture of the

organisation and institutional power in relation to providing culturally safe care. Robyn qualified after 1990 and throughout her interview was able to describe how she integrated the principles of cultural safety into her practice.

Although participants sometimes acknowledged the role of family, it was not as overtly apparent as it was when they talked about caring for Māori patients. However, participants were aware of the role of family for patients from other cultural backgrounds, especially the importance of their presence at the bedside as well as being involved in planning care and identifying specific cultural needs, including specific dietary requirements.

We recently had an Indian gentleman who didn't speak English, we were able to put him in a single room so his family could stay, and they could help interpreting. We were able to ascertain he didn't enjoy our food, so they were able to bring their own food in so he would start to eat. We discussed with the family if he had different needs, if there was anything we could do differently and actually they were quite happy about the way we went about it. [Sally]

Organisational policies can support or hinder health practitioners being able to provide culturally safe and culturally competent care. The restriction on visiting hours is one example of how routines can be privileged over cultural care (Richardson & MacGibbon, 2010). In the above situation family were able to stay and act as interpreters for the patient as well as assist with nursing care. Family also had a critical role in guiding staff through appropriate cultural practices to ensure care provided was culturally safe.

Awareness of culturally specific practices enables nurses to respond appropriately to meet cultural needs when patients may not feel comfortable sharing cultural information. Participants conveyed the importance of adapting care to fit religious values and beliefs. A participant described a situation where she was called in to provide further education for a Somali man admitted following a diagnosis of diabetes and who required insulin injections. When she arrived the patient was very angry initially and difficult to engage with. Then from her personal experience she recalled that Ramadan was coming up and wondered if this was the cause of his anger.

I said are you concerned about this because of Ramadan coming and you need to fast? And it was like flicking a switch, he had felt unable to say that to anybody, and the doctors and the nursing staff had gone on and on at him about having regular meals with carbohydrate. Having to have all these insulin injections, he was a devout Muslim, and he was just so distraught that he would not be able to participate in Ramadan with his wife and children. He said 'I can't do this' and I said, actually, we can adjust your insulin so you can participate in Ramadan. And it was like the most glorious thing to see this

man's face, it was just so lovely and then he started to tell me what had been going on. [*Jenny*]

In this situation, having some knowledge of different cultural and religious values and beliefs and asking the right questions was beneficial for the patient and the nurse. This can also be valuable in assisting patients to continue their treatment while still adhering to their own cultural practices.

When caring for elderly patients a holistic approach to assessment was required to find out about their other interests and gain a better understanding of how to meet their needs.

What does he enjoy doing, does he enjoy music, does he enjoy listening to the sport, does he enjoy reading, just to find out a little bit more about him so you can match services to some of the things that he would like. [*Mike*]

Recognizing how differently generations respond to health crises was seen as important to understand the implications for care.

Need to recognize that the elderly don't have a complaining culture....recognize that their way of thinking about life is that they will take it on the nose they have this stoic resilience and don't complain. And also their religious persuasion, I get Brownie Points if I suffer! [*Mike*]

One participant described how she worked with elderly patients to meet their needs. She recalled an elderly patient whom she had been told had 'difficult behaviour'. She did not accept this judgment at face value but to the contrary, found this patient to be the opposite of what she had been told. She did find out that the patient had had extra fluid and needed to keep going to the toilet. The patient felt like she was being an inconvenience but she did not want to wet the bed. The nurse reassured her that she was not an inconvenience and that it was her job to assist her. She also identified the importance of working with the family, understanding how they were feeling, what was worrying them and how they could work together to meet their mother's needs and maintain her dignity.

...and from there we developed the relationship and her family came to respect me....They had been through a lot and they had come from overseas, one minute mum was okay and walking around and the next minute she was nearly dying on them. They were tired, they had done round the clock with her, and they were doing the cares too and just needed someone to listen, so I listened to them. I don't just focus on the patient but also on the whole family. The biggest thing for the elderly is respect for age and respect that they were going to take time because they can't move fast. It is about maintaining her dignity, giving her independence....The daughter was considered difficult but all that she wanted was to know what was going on, and everybody kept fobbing her off. All they needed to do was to explain that your mum is having this because of this, she is staying a little bit longer because we just want to check her, we want to make sure that she is okay we don't want her to get out there and have to come back in... [*Moana*]

Labelling patients as 'difficult' can increase the potential for stereotyping and making assumptions. It is important for nurses to look beyond the superficial and explore what might be the underlying reasons for particular behaviours in order to address concerns.

An awareness and understanding of refugee and immigrant experiences is important in helping to assist these population groups to adjust to the culture of a new country while still acknowledging the importance of their own cultural practices. One participant spoke about the range of needs she had to address and meet with refugees in the community, as they adapted to the way of life in New Zealand.

I guess the ones who spring to mind are refugees because of the huge impact it has on their lives, the huge amount of differences they find when they come here, and the massive changes they have to make emotionally and culturally. Language was the most obvious difference, along with the climate, the education system, the benefit system, the housing, everything. Every system that exists they have to readjust to, navigate their way through, and they need a lot of help. Some are more resilient than others, but generally they are very resilient, incredibly so, and they don't complain. [Caitlin]

Nurses need to use a model of care that they can adapt to meet the diverse needs of the patients they will encounter in practice. Cultural safety provides a flexible and adaptable framework that enables nurses to work together with patients to identify all their needs and plan care that is responsive to their holistic needs. Similar approaches to care were identified when caring for Māori patients with the exception of using Māori models of care and the consistent inclusion of whānau.

5.3.2 Accessing resources

Knowing the resources available in the hospital and the community enables nurses to link patients from different cultural backgrounds with appropriate services and resources. The main resources participants identified were interpreters, dietary and spiritual support. It was evident from the data that there was a range of knowledge and understanding of the needs of patients from CALD populations, although some participants stated they needed to find out more information about different cultural values and beliefs. Lack of access to appropriate education for nurses was considered a barrier. A number of participants acknowledged that accessing appropriate resources to meet patients' cultural and religious needs was not easily achievable at times, including availability of interpreters.

We are getting quite a multicultural population through our hospital. We have to be open-minded and not make judgments, give other people the same care, access to health care, and do that in a way that they understand, that's the challenge. Getting the message across is a challenge and I know we have

interpreting services, but they can't deliver all the time. I guess for me it is the access to services they need, whether it is financial, social issues and access for family to be able to come and share with patients, meeting their spiritual and emotional needs. I believe that we are good at doing physical care for patients but the spiritual and emotional needs for the patient not so well. [Pare]

5.4 Supporting patient autonomy, empowering patients

The central principle of cultural safety is the empowerment of all patients to have autonomy over their health choices and decisions. Supporting patients from other cultural backgrounds to achieve autonomy requires nurses to have effective communication skills to establish and develop trusting relationships. In order to meet patient needs and access resources patients must be health literate to be able to make informed choices and decisions about their health care and treatment, and determine that care provided has been culturally safe. Earlier in the chapter participants recognized the importance of accessing gender appropriate interpreters and being aware of how decisions are made by patients and families from CALD backgrounds so that they can support patients to make informed choices and decisions. It is assumed that all patients want to have autonomy over their own decision making although patients from CALD backgrounds may have an alternative worldview of the decision making process which may be in conflict with western views.

5.4.1 Enabling informed choices and decisions

Enabling informed choices and decisions was identified as a sub-theme to support autonomy and empower patients. For patients from CALD backgrounds this often required interpreters to support the informed consent process. When patients understand the choices available, they are more likely to make the decisions that are right for them. An important aspect of decision making and patient autonomy is to ensure the patient fully understands the implications and consequences of their choices and decisions.

This young person who I am helping has been two years in his health journey with his condition and I said two days ago, do you know what that is, and he said no. So it is just taking the time to make sure they understand and have the knowledge because he didn't know he had to take the medicine to try and kick [in] his bone marrow function. So it is about explaining something so they understand...asking them what they got from my talk, what are you taking home with you. [Mana]

Situations may arise where culturally safe care is at odds with ethical practice as the cultural values and beliefs of CALD patients may conflict with western beliefs. Therefore, empowering patients to make informed decisions may be challenging when health professionals do not agree with the patient's decision. One male participant described an experience where a female patient, who was a Jehovah's Witness, following a significant bleed, refused to have a blood transfusion. She was a middle aged woman with teenage daughters, who was dying because of her decision. The husband and a church minister were also present supporting her decision. The participant had been called in to make sure the patient was fully aware of the consequences of her decision. As an experienced nurse he quickly identified that the nurses on the ward were experiencing an ethical dilemma in response to the patient's decision and were making inappropriate comments that may be overheard by the patient and her family. He asked all the nurses to leave the room as he could see the patient was getting very distressed. Although he personally did not agree with her decision, he respected her decision and knew that he had to make her comfortable, and be there for the family. This was an important distinction from other nurses.

....she had quite long nails and she started clawing at her skin, ripping the skin open on her chest. I knew the decision was a cultural and religious decision and even though it was really difficult for me, I didn't believe that the patient, daughters and family should suffer so I negotiated with the registrar to just to try to settle the patient a bit and asked if we could give some midazolam which they agreed to. Then she settled and stopped clawing at her own chest and died peacefully. [Mike]

Following her death, he debriefed with the staff, emphasizing the importance of respecting patients' choices. He also recognized how distressed some nurses were and support was arranged for them.

A western perspective of patient autonomy is one of many viewpoints and it is important for nurses to be aware that patient autonomy may be different for patients from different cultural backgrounds. Ensuring that patients from CALD backgrounds understand all the relevant information including options and consequences to support informed decision making is challenging for nurses when communicating through a third person.

5.4.2 Culturally safe care

Cultural safety places the onus for determining that the care provided has been culturally safe on the patient. Determining this through an intermediary for CALD

creates additional challenges. Participants did not identify any specific frameworks for assessing that care provided for patients from other cultural backgrounds was culturally safe. The strategies used to assess that their care was culturally safe were similar to those in Chapter Four. Participants were either confident to discuss this with patients or relied on their assessment skills.

We assessed we had met her needs by observing she was relaxed, not tense, happy for us to do these things. She was appreciative because when I came in and saw there was a whole bunch of men sitting around, I would just say I will just pull these curtains around you, and she would give me a smile to express that she was happy...She recognized that we weren't doing it for the other ladies. [Sally]

Participants acknowledged that their assessment was more subjective than objective and was often perceived as a feeling. Some participants identified that changes in a patient's behaviour towards them, was an indication that care may not have been appropriate.

If you are not getting it right they will just withdraw from the relationship, from the conversations. [Jenny]

Changes in the patient's willingness to engage in conversations and interact with nurses, was also identified as a gauge for measuring appropriateness of care provided.

It is through their behavior towards me, if I haven't met their needs then she is going to close up and not want to talk to me, and their body language changes. So the conversation doesn't get lengthy, it will just get short and sweet, if I haven't met her needs, she wouldn't be satisfied and then she wouldn't open up. [Moana]

The previous examples reflect the importance of developing relationships and how nurses working positively with patients relied on their intuitive assessment skills to detect that patients were satisfied or not with care provided. Some participants identified that when patients were comfortable they may tell them if something was not appropriate. Continued attendance for appointments was seen as a positive response from patients in the out-patient setting. Some participants were comfortable asking patients if they had been able to meet all their needs or if there was anything else that was important for them that they needed to be aware of.

It is about keeping open and mindful but also I ask if something is not quite going right, I ask if everything is okay for you, is there anything I am missing. If it is a culture I haven't worked with before I say for my learning can you teach me, is there anything I need to be mindful of? [Mana]

One participant suggested that when the patient and family become more engaged with and friendly towards the nurse, this can indicate that care has been culturally safe.

Their body language as they are leaning towards me, the family will come to me. When I am down the corridor they will wave and say hello how are you, how we greet each other in the morning. They will come with their questions and say I've had a think about what you said yesterday, can we do this or they feel that they can trust me. They come to me for guidance but also realizing that I will listen, do what they say, and they realize that they are most important here because I want the patient to get better...I am looking for signs, body language, the way they speak to you, the way they answer your questions, the way the family come to you and ask questions. [Sara]

Many participants felt challenged to describe how they assessed the care they provided for patients from other cultural backgrounds was culturally safe.

I think if you get good engagement, you get good rapport and you build a relationship where people trust you and it is mutual....I think if you have had a good outcome or a reasonable outcome and you are both intact at the end, you are still together with things and on the same level or aiming for the same outcome, and the communication lines are still as open as they were, just body language, any discomfort you can usually pick up on and if you pick up on something hopefully you can make amendments to it by doing something in a slightly different way. Generally I think it is a lot to do with intuition. [Caitlin]

It was evident from the findings that to be able to work with the patient and family to determine that care had been culturally safe required effective communication and a trusting relationship where patients were comfortable sharing what their cultural needs were and how their needs were met or not. The need to work through interpreters to achieve this for patients from CALD backgrounds also required nurses to build positive working relationships with the interpreters. Participants acknowledged there was also the sense that in many cases 'you may never know'.

5.5 Awareness of and managing personal (nurses') stereotype and power

Cultural safety education is designed to prepare nursing students to understand differences and diversity within different cultural groups and the nurse's role in empowering patients. This includes understanding implications for power relationships and how these may impact on the nurse-patient relationship. Being aware of how the nurses own biases and prejudices may influence how they work with patients from other cultural backgrounds is an essential process towards becoming culturally safe. Two sub-themes became evident from the data, they are: challenging assumptions and stereotypes and sharing power.

5.5.1 Challenging assumptions and stereotypes

As in the previous chapter, participants from each group acknowledged that it was not culturally appropriate to make assumptions or stereotype people based on their particular cultural beliefs. One participant commented that even if nurses make assumptions about people, they have to move beyond that to provide culturally safe care.

You need to be clear in your head and not judge them, just take them for who they are and work with what you have. [*Te Rina*]

To be culturally safe nurses must be open to different values and belief of patients from other cultural backgrounds and be flexible in their care delivery. Through their descriptions of their practice all participants demonstrated acceptance of difference and willingness to adapt their care to meet the differing needs of their patients. They also understood the importance of not imposing their own beliefs on others or make judgments. Earlier in the chapter some participants alluded to assumptions or labelling about elderly patients by colleagues and the risks of marginalizing them.

The lack of references to assumptions and stereotyping of patients from CALD backgrounds suggests that this may be attributed to limited knowledge of other cultural values and practices and the premise that assumptions and negative stereotypes have not yet been recognized or publicized.

5.5.2 Sharing power

Understanding the power dynamics in nurse-patient relationships is an integral component of cultural safety. Sharing power was expressed in a number of ways by participants, this included working in negotiated partnerships and assisting patients to have control, no matter how small.

The most important thing is not to be prescribing, it is a negotiation, it is all about discussion. It is his body, it is not mine, although sometimes I would feel that you put your body, your wholeness in my hand, but with the idea that we are sharing the experience. He is giving me his trust, but it still means I have to take into consideration what is happening in his life, what is happening outside the hospital, what living with his sickness is now, what he is experiencing [*Sara*]

I picked up the glass with the straw and I gave her a sip of water and she got quite agitated and after a while I clicked she wanted to hold the glass which was totally impossible but she wanted to be able to control how much she was having. So I managed to hook her little finger around the straw which didn't do anything really but it must have meant a huge amount to her because she had a drink and I put it down and looked at her and she mouthed thank you. It was

just that one little thing but she relaxed after that for a little while and went to sleep. [Kate]

Participants when describing their reliance on interpreters for developing relationships, providing culturally appropriate care, and assisting with the informed consent process, alluded to the power dynamics of the nurse-patient relationship.

5.6 Discussion of findings relating to patients from other cultural backgrounds

This chapter provides new insights into the care of patients from diverse cultural backgrounds as well as adding to existing evidence. This section discusses the findings related to patients from other cultural backgrounds and includes comparisons with findings from the previous chapter.

Findings from this study suggest that participants primarily equated culture to ethnicity as when asked to articulate an experience of caring for a patient from another cultural background, the majority of participants described caring for patients from different ethnic groups. Along with the ethnicity of patients participants also considered gender implications, dietary and religious needs. However, Māori nurses and IQN more frequently articulated cultural practice in relation to age, gender, stigma of mental illness, refugee experience and lifestyle choices.

Participants in this research provided many examples of caring for patients from different cultural backgrounds. According to the Nursing Council (2007) competency relating to culturally safe practice, because participants accessed interpreters and other cultural supports for patients including spiritual resources, showed awareness of other services or referred patients to financial and social services to meet holistic needs, they would be considered to have met the requirements. However, cultural safety is more than this it is about the nursing role in its totality and not just about meeting Nursing Council requirements. Holistic practice must include nurses being cognizant of cultural safety and thereby practicing appropriately. When sharing examples of caring for patients from other cultural backgrounds participants took measures to ensure patients understood their care and treatment alluding to improving health outcomes.

5.6.1 Establishing positive working relationships

The underpinning values of the Code of Conduct (NCNZ, 2012a, p.4) include respect and trust as the basis of establishing positive relationships.

Behaving towards that person in a way that values their worth, dignity and uniqueness....Nurses need to establish trusting relationships with health consumers to effectively provide care that involves trust, using personal information, emotional and physical support.

The key features identified by participants in each group to establish positive working relationships were access to interpreters, understanding of cross-cultural communication and awareness of diverse cultural values and beliefs. However, some participants identified they would benefit from further education. This has also been identified in a number of other studies (De Souza, 2005; North, Lovell & Trlin, 2006). As in the previous chapter effective communication was identified as the most important feature of cultural practice. However, the cultural diversity of patients makes engagement and relationship building much more complex. This is influenced by having to communicate through an interpreter and have an awareness of different worldviews. When caring for patients from CALD backgrounds the interpreter was often a family member or an authorized interpreter and dependant on patient or family choice. Interpreting by family members created concern for participants about the accuracy of information being relayed to the patient. However, nurses had to be respectful of patient choices and following appropriate cultural processes for communication.

The findings acknowledge that language is one element of communication and other factors needed to be considered to support effective communication. General communication strategies for patients who spoke and understood English well were the same as identified in the previous chapter suggesting that there are fundamental communication approaches that apply when working with all patients.

For patients from CALD backgrounds differences in cross-cultural communication should also be considered. Participants relied heavily on interpreters and the family to assist them with cross-cultural communication. However they did not detail how their body language could impact on their approaches to communication. This includes different cultural perceptions of time, personal space, eye contact and touch. Although these factors are not explicit in the cultural safety framework they are recognized in cultural competence (Durie, 2001) and Giger and Davidhizar's model of transcultural nursing (1999). By not acknowledging these in their communication

approaches this may reflect limited knowledge and understanding of issues relating to cross-cultural communication.

The findings suggest that for some nurses, they were better able to engage with migrants and refugees through a cultural safety framework than with Māori, particularly nurses trained after 1990. Their awareness of and integration of cultural practices also reflected cultural competence.

5.6.2 Working positively to achieve outcomes

Participants did not identify different models of care when caring for patients from other cultural backgrounds but relied on the same models as previously identified in Chapter Four with the exclusion of Māori models. Their ability to work positively with patients from CALD diverse backgrounds to achieve outcomes was reliant on the quality of the relationship they developed with their patients, often through an interpreter or family member. Participants used cultural safety as a framework to integrate cultural practices and the family when planning and delivering care. Although family were acknowledged as playing an important role in health care and decisions, this was not as strongly voiced as it was for Māori.

Access to services primarily centred on interpreters although financial, dietary, social and religious support was also mentioned. Health disparities were not identified for this group perhaps reflecting that there is limited understanding of health disparities for patients from other cultural backgrounds. Generally the emphasis of health disparities is on Māori although health disparities for Pacific people have also been highlighted, but not in this research.

The findings suggest that when using a cultural safety framework nurses are able to provide care to meet some of the needs of CALD populations while other studies indicate significant gaps (De Souza, 2005; Mortensen & MacGibbon, 2010).

5.6.3 Supporting patient autonomy, empowering patients

According to the NCNZ Code of Conduct (2012a) nurses work in partnership to provide patients with information that they are able to understand to enable them to make informed decisions about their on-going care and treatment. Within this partnership nurses value personal preferences, values and beliefs.

Interpreters played a key role in assisting informed decision making for non-English speaking patients to support patient autonomy and empower patients. Some participants recognized that for some patients the decision making process was determined by other cultural practices and had to adapt their approach accordingly. When participants identified barriers to accessing interpreters this then became a barrier to informed consent.

Participants used similar approaches as when working with Māori to determine that the care they provided was culturally safe. As in the previous chapter the majority of participants used their assessment skills and subjective measures to assess whether their care was culturally safe. This included observing behaviour of patients, willingness of patients to engage and interact with nurses, as well as engagement and friendliness of family towards nurses. Participants did not allude to any specific cultural barriers that could interfere with patients from CALD backgrounds providing feedback that care was culturally appropriate or not.

5.6.4 Awareness of and managing personal (nurses') stereotype and power

In their accounts of caring for patients from other cultural backgrounds participants did not specifically acknowledge the implications of power dynamics on nurse-patient relationships. However this can be readily linked to discussions referring to communication and decision making. This perhaps also links to references to gender specific care which may also impact on power dynamics in relationships with patients from CALD backgrounds. Participants generally talked about not making assumptions about patients based on their 'cultural background' as identified in the previous chapter.

Advocating for patients at times, created tension with colleagues who appeared to be less responsive to cultural needs. Colleagues did not seem to be aware that through this practice they were diminishing the cultural identity and wellbeing of individuals. The findings indicate that the role of the interpreter once again was pivotal in developing quality nurse-patient relationships. When access to interpreters was hindered patients were potentially disadvantaged.

5.7 Conclusion

When caring for patients from other cultural backgrounds participants primarily related culture to ethnicity. However, some also recognized age, gender, sexual orientation and disability, thus encompassing culture in the broader context of cultural safety. The availability of cultural resources, particularly interpreters, presented some challenges in practice to meet the individual and cultural needs of patients. Working in partnership with interpreters assisted nurses to gain some insight into the relevance of cultural values and beliefs

The findings suggest that participants were more confident about describing their practice when caring for Māori patients than patients from other cultural backgrounds. This may indicate better understanding of Māori cultural values and practices than those for CALD populations. This may also reflect the initial focus of cultural safety was kawa whakaruruhau and Treaty of Waitangi workshops with the emphasis on meeting the needs of Māori. Some participants also acknowledged their knowledge of specific cultural values and beliefs was limited and highlighted the importance of further education.

From the descriptions of practice and analysis of the findings it is not clear how well cultural safety meets the needs of patients from other cultural backgrounds or improves health outcomes. The apparent inconsistent application by participants' colleagues of culturally safe practice potentially puts patients at risk.

CHAPTER SIX

Conclusions, implications for practice and policy, limitations, future research and recommendations

This research has sought to gain an understanding of how nurses articulate their cultural practice within a New Zealand context when caring for Māori patients and patients from other cultural backgrounds. Examination of cultural practice for Māori patients was based on the principles of the Treaty of Waitangi and kawa whakaruruhau. Care for patients from other cultural backgrounds was evaluated against the broader concept of cultural safety. Determining whether there were different understandings of cultural practice between nurses from diverse backgrounds was an important focus of the study. How nurses assessed that their practice was culturally safe, as determined by the patient, was also explored.

Previous studies have examined cultural safety from different perspectives including: cultural safety as a theoretical framework; development and implementation of cultural safety in nursing; perceived outcomes of cultural safety; and application to practice (Clear, 2008; De Souza, 2005; Mortensen, 2010; Richardson, 2004; Richardson & Williams, 2007; Wilson, 2008). However, there is little evidence evaluating the effectiveness of cultural safety in meeting the cultural needs of Māori patients and whānau (Wilson, 2006, 2008; Wilson & Barton, 2012) and patients from other cultural backgrounds (De Souza, 2005, 2008; Lawrence & Kearns, 2005; Mortensen, 2008, 2010; North, Lovell & Trlin, 2008). These studies identified cultural expectations of Māori and other patients and how their needs were met and highlighted specific deficits in cultural care for Maori patients and patients from CALD backgrounds (Wilson & Barton, 2012; Corbett, Francis & Chapman, 2006; De Souza, 2005; Henry 2008; Mortensen, 2010; North, Lovell & Trlin, 2006; Shih & Honey 2011; Wilson, 2008). Understanding expectations of patients from diverse backgrounds when accessing health services offers nurses and other health practitioners' valuable insight into their experiences of health services.

The literature draws attention to cultural safety, cultural competence and transcultural care as different approaches to meeting the cultural needs of patients (Cooney, 1994; Coup, 1996; Durie, 2001a; Leininger, 1997; Ramsden, 1993; Wood & Schwass, 1993). Cultural safety places an emphasis on effective communication to determine what is important for the patient without making assumptions. The health experience of the patient is central to the concept. In contrast to cultural safety, cultural competence focuses on the knowledge and understanding of different cultural values and beliefs and experiences and the role of health practitioners improving health outcomes (Betancourt, et al., 2002; Durie, 2001a; Leishman, 2004). It has been suggested that cultural competence frameworks present a way of achieving knowledge and understanding of cultural norms and differences, communication skills and respect of the social world in which the patient lives (Leishman, 2004; Papadopoulos et al., 2004). On the other hand, transcultural models are considered to promote an ethnocentric approach to care which I believe conflicts with both cultural safety and cultural competence approaches (Cooney, 1994; Coup, 1996; Leininger, 1996, 1997).

Cultural safety and cultural competence are often presented as competing discourses (Betancourt, et al.; Durie, 2001a; Leishman, 2004; Mortensen, 2010). However, I propose that together they have the potential to equip health practitioners with the knowledge and understanding to more effectively meet the changing needs of an increasingly culturally diverse population. This on-going tension between these contrasting concepts and underpinning principles perhaps signals the need for further review of the nursing education curriculum to prepare nurses to care appropriately for an increasingly culturally diverse population of Aotearoa New Zealand.

6.1 Contribution of the research to understanding cultural safety in practice

There is limited evidence that examines the application of cultural safety in the practice setting (Mortensen, 2010; Richardson & MacGibbon, 2010; Richardson, et al., 2009). The findings from my research, adds to the existing evidence while also examining cultural practice through a number of different lenses. It was not the purpose of my study to evaluate the effectiveness of cultural safety education but to understand the range of influences which contribute to the development of cultural practice and how these differed between groups of participants. This study examined the cultural care described by participants when they cared for Māori patients and

patients from other cultural backgrounds, to identify similarities and differences between the participant groups. A new approach was to determine how nurses assessed that their care had been culturally safe, with the patient, and what framework was used. The results of this research reflect how nurses, from their own accounts, applied the principles of the Treaty of Waitangi and cultural safety while identifying some of the challenges to the provision of culturally safe care. The findings suggest that further development of the cultural safety framework may be warranted to more responsively meet the needs of Māori and the culturally diverse population in New Zealand.

Four main themes and eight sub-themes became apparent from the data as identified in Table 5. Analysis of the findings identified a number of commonalities and differences between the groups for both Māori patients and patients from other cultural backgrounds. The findings provide new insights into aspects of cultural practice and implications for practice and policy.

An important contribution of my findings are clearly articulated examples of cultural safety in practice (as described by nurses) relating to positive patient experiences. A positive patient experience is a more realistic outcome of cultural safety than reducing disparities in a population, in my view. The participant accounts detail how these nurses from different backgrounds, based on their ethnicity and time and place of training, articulated their cultural practice when caring for patients from diverse backgrounds. In their examples, particularly for patients from other cultural backgrounds, participants also integrated elements of cultural competence to their practice. It was evident from their descriptions that some participants were aware of some of the beliefs and cultural practices of other cultural groups. Examples reflected development of practice from cultural awareness to cultural safety. From these all participants demonstrated application of the principles of the Treaty of Waitangi, *kawa whakaruruhau*/cultural safety in practice to meet the Nursing Council (2007) competencies and associated indicators.

Theme one, establishing positive working relationships with the sub-themes communication skills and developing relationships, was the most significant feature of cultural practice when caring for both Māori patients and patients from other cultural backgrounds. Communication skills and developing relationships are fundamental elements of professional nursing practice and were identified as such by all participants. Language and other interpersonal strategies were described as

important factors which enhance communication. For patients who did not speak or understand English, interpreters played a key role in assisting nurses to communicate effectively, understand specific cultural practices, and adapt care accordingly. However, limited availability of interpreters and at times, lack of support from colleagues in accessing culturally appropriate resources, were identified as barriers. Some participants from each group demonstrated an awareness of different worldviews on health issues and particular cultural practices which guided their approach and care for patients. Overall, participants appeared more confident caring for Māori patients than those from linguistically diverse backgrounds. This may be related to a better understanding of Māori culture and language than the cultural values and beliefs of refugees and immigrants.

Differences between groups when caring for Māori patients

A number of differences in cultural practice between participant groups when caring for Māori were identified from the findings. These differences primarily related to influences on participants' development of cultural practice and application to practice.

1. New Zealand European nurses who qualified prior to 1990: In spite of not having encountered cultural safety education in their training, in their accounts this group appeared to have a culturally safe approach to working with Māori. In some cases this was related to life experiences of having lived closely with Māori communities, professional experiences working in Māori communities, and learning from Māori colleagues. For others, this perhaps reflected years of nursing practice and the experiences and maturity developed.
2. Māori nurses, as the in-group (emic), already know what is acceptable, know how to communicate, interpret, behave, and are well-able to articulate kawa whakaruruhau. For some Māori nurses their empathy went further, as they, too, had experienced cultural un-safety at the hands of non-Māori colleagues. Some articulated experiences where they felt their decisions may have been in conflict with colleagues. Although the perception of cultural risk for Māori patients was identified across all participant groups, it was identified most strongly by Māori nurses in a number of ways: their own experiences of accessing health services or been with a loved one accessing services; being exposed to attitudes of staff; and observing actions of colleagues caring for Māori patients and whānau.
3. IQNs also had not had cultural safety/competence components in education, but all had completed Treaty of Waitangi workshops since arriving in New

Zealand. With the benefit of the sharpness of perception in a less familiar society, all acknowledged disparities for Māori, and most learned to move past being judgmental to practicing safely.

4. Paradoxically, those New Zealand European nurses whose education incorporated cultural safety (trained after 1990), were of the four groups, least likely to acknowledge continued disparities, and less able to articulate how they practiced in a culturally safe manner with Māori patients and whānau.

Differences between groups when caring for patients from other cultural backgrounds

Differences in cultural practice between participant groups when caring for patients from other cultural groups were not as distinct as those for Māori. The differences were primarily related to differences in perceptions of 'culture'.

1. European nurses trained prior to 1990: The concept of culture for this group of nurses was aligned primarily to ethnicity. This fits with the common understanding of culture as ethnicity from when they trained. They acknowledged the importance of not making assumptions based on the ethnicity of the patient or the patient's level of engagement in their own culture.

2. European nurses qualified after 1990: Ethnicity and associated cultural values and beliefs were the primary focus of culture for this group. This group appeared to understand the power dynamics in the patient-nurse relationship and used a cultural safety framework to guide their care. However, this was not as strongly reflected in accounts of caring for Māori. As advocates these nurses were sometimes placed in situations where their decisions to meet the cultural needs of patients put them in conflict with colleagues.

3. Māori nurses: Key examples of culture described by this group of participants included ethnicity, age in terms of young and elderly patient, gender, as well as the stigma of mental illness, for specific patient groups. This group considered multiple indicators of culture together rather than one in isolation.

4. IQN: International Qualified Nurses provided examples related to ethnicity, refugee experience and lifestyle choices in a broad interpretation of culture. They recognized their 'ignorance' as an outsider, and were open to gaining better insight into cultural needs and values.

Other findings

Assessment of culturally safe care

Nurses are required to demonstrate culturally safe care as determined by the patient (NCNZ, 2007). The indicators for this competency identify what is required but does not identify an appropriate tool to support the assessment process. There was no significant difference between groups in how they determined that their care was culturally safe and neither did participants use a consistent approach in making their assessments, taking patient perspectives into consideration. Assessment appeared to be based on verbal and non-verbal cues, subjective rather than objective processes, and the behavior of patient towards them. The more experienced nurses appeared confident asking patients if all their needs had been met, or was there anything they could do differently. A number of participants believed that some patients would feel comfortable saying if care was inappropriate. These findings suggest that cultural safety education does not feature assessment skills to work with patients and determine care has been culturally safe.

Professional culture

Participants provided examples of a professional culture that is at times, unsafe. For example, when resources such as interpreters are limited and nursing colleagues are disrespectful in relation to the choices patients make. In some cases when nurses are practicing from a framework of cultural safety they come up against powerful negative forces in their own profession and organisation. Participant observation of colleagues practice suggests that there are nurses who are not providing culturally safe practice thereby putting patients at risk. Further, the findings highlight that cultural safety is inconsistently applied in practice. Findings from my study also indicate that despite education of health professionals and requirements to demonstrate culturally safe and culturally competent care, Māori continue to experience marginalization in the health system. This has also been identified in other studies (Wilson & Barton, 2012; Wilson, 2006, 2008).

Organisation power and policies

The 'power' and policies of organisations and limitations of time were raised as barriers to culturally safe care. Although this was not raised by many participants it reiterates the results of a previous study by Richardson and MacGibbon (2010) who identified a number of factors that created barriers to providing culturally safe care for

patients. These included: the primacy of biomedical models of care over nursing models of care; privileging of routines over cultural needs and personal preferences; lack of time spent with patients; and organizational systems that do not support implementation of culturally safe care for Māori patients and whānau. These barriers move beyond the scope of the individual practitioner and emphasize that consideration of a systems approach is required, in order to meet the needs of Māori patients and improve health outcomes. My study revealed similar findings. However, as the purpose of the research was not about barriers, these issues were not explored in more depth.

Gender specific care

The notion of gender specific care materialized as an unexpected finding from both male and female participants but demonstrated the awareness of participants to this issue and how they responded to provide culturally safe care. Gender specific care was not acknowledged in patient expectation literature reviewed but has been examined in relation to male nurse-female patient care (Evans, 2002; Keogh, 2006). With the increasing cultural diversity of the population patient preferences for gender specific care may increase. Further investigation of this is warranted in order to provide culturally safe care for patients from culturally diverse backgrounds.

Proposed cultural theoretical framework

From the findings it is possible to advance a theoretical framework model linked to the main themes. The Treaty of Waitangi provides a foundation for engaging with and developing relationships with Māori patients. Cultural safety provides a framework for nurses to understand power dynamics in nurse-patient relationships and work in partnership with patients from diverse backgrounds to meet their holistic and individual needs to improve health outcomes (NCNZ, 2011a; Ramsden, 1993, 1994, 2002; Wood & Schwass, 1993). Cultural safety places the onus on the patient to determine that care has been culturally safe while cultural competence relies on the practitioner to determine care is culturally appropriate. Cultural competence promotes health practitioners having an understanding of different worldviews to health and western medicine, and the social and cultural influences on health beliefs and behaviours. Within this framework the practitioner has a responsibility for providing care to improve health outcomes for patients from different cultural backgrounds (Betancourt, et al., 2002; Durie, 2001a; Leishman, 2004). Using the positives of cultural competence and cultural safety parameters as well as models of care and the

Treaty of Waitangi, would perhaps provide a stronger foundation from which to address disparities, health outcomes and importantly, promote a more tolerant and ‘culturally’ aware nurse. What table 6 shows is that these are all important to deal with the complexity of health care and the environment(s) in which it is practiced. Some challenges that may arise from this proposed theoretical framework include, whether this is a model that can work for Māori and other cultures, and if it is possible to privilege Māori using this model.

Table 6 Proposed cultural theoretical framework

Treaty of Waitangi	Cultural Safety	Theme 3 and 4	Disparities
	Cultural competence	Theme 2	Socio-economic determinants
	Nursing professional model of care	Theme 1	Health outcomes

6.2 Implications for practice and policy

The findings demonstrated that participants in this study were confident articulating cultural practice although from my experience this is not so for all nurses. The outcomes of this research will be of interest to a number of stakeholders. The findings have implications for practice for individual practitioners as well as policies at organizational and professional levels. I would argue that the most significant implications are for the profession in relation to the cultural safety framework, on-going cultural education and tangible outcomes of culturally safe practice.

Although participants were readily able to articulate their practice in relation to the principles of the Treaty of Waitangi and cultural safety, it has been my experience that nurses often find this difficult. Therefore, the examples of practice embedded in this study can assist student and registered nurses to better understand how to apply the principles of the Treaty of Waitangi and cultural safety to their own practice when caring for Māori patients and whānau and patients from other cultural backgrounds. I anticipate that nurses will be able to use the findings to identify areas for further

development of their cultural practice and that nurse educators in practice will integrate cultural components into professional development.

When cultural safety practices are supported at all levels within an organisation nurses are better equipped to meet the needs of patients. While cultural safety places responsibility for providing culturally safe care on the individual practitioner, barriers do exist within services and organisations. As mentioned above, the most significant barrier participants identified was access to interpreters. Other studies reinforce that systems within organisations hamper availability and access to appropriate cultural resources (Betancourt, et al., 2002; De Souza, 2005; Mortensen, 2008, 2010; North, Lovell, & Trlin, 2006). As patient advocates nurses can be involved in the development of policies to counter organizational shortcomings.

While the results of this research affirm cultural safety as an appropriate framework to enable nurses to meet the needs of patients they care for, they also indicate that further review of the cultural safety model is required to more effectively address the needs of Māori patients and patients from culturally diverse backgrounds. The limited evidence verifying outcomes from cultural safety and exploration of patient experiences suggest that further changes to the framework, curriculum, teaching strategies and application to practice are needed to more effectively meet the needs of Māori (Wilson & Barton, 2012; Mortensen, 2010; Ramsden, 2002; Wilson, 2006, 2008) and refugee and immigrant populations (De Souza, 2005; Mortensen & MacGibbon, 2010; North, Lovell & Trlin, 2006). Ramsden (2002) suggests that Māori health should be taught separate from cultural safety to overcome any confusion, while exploration of the power dynamics between the nurse and patient, and reflective skills could be integrated throughout the programme. This would require changes to teaching strategies.

It is apparent from the results of my research as well as previous studies I have reviewed that the needs of CALD populations have not been well served by cultural safety and therefore needs reviewing. An additional component for other cultural groups, including CALD populations, would help to address some of the knowledge deficits identified in other studies (Betancourt, et al., 2002; De Souza, 2005; Mortensen & MacGibbon, 2010; North, Lovell & Trlin, 2006). The underpinning principles of cultural competence should also be considered to determine how these may inform further development of cultural safety (Durie, 2001; Leishman, 2004; Papadopoulos et al., 2004). However, the focus of the review should not be for

nurses to become expert of other cultures as this may increase the risk of stereotyping and making assumptions about patient expectations. The emphasis needs to be on communicating effectively and understanding cross-cultural communication issues, and developing therapeutic relationships with a diverse range of patient groups in order to improve their outcomes. Through enhanced therapeutic relationships nurses would be more able to provide culturally appropriate and responsive care, and understand the influence of different worldviews on health and illness, as well as the role of extended family.

Participants from this study viewed culture primarily from an ethnicity perspective. This infers that further education is needed to encourage nurses to understand the implications of age, gender, education, religious beliefs, worldview, cultural values and beliefs, and refugee experience on the health needs of an individual in order to meet their holistic needs. This education should be incorporated through undergraduate education, post-registration and post graduate education to improve knowledge and skills in practice. This includes professional development by employers and professional groups.

6.3 Limitations of this study

Whilst this research reveals some new insights, it has several limitations. Firstly, the participants in this research do not fully reflect the cultural diversity of the Waikato DHB nursing workforce as Indian, Filipino and Asian nurses are not represented. Although findings from this study cannot be generalized across the workforce they provide some insight into the practice of some New Zealand European nurses trained prior to and after 1990, Māori nurses and a small group of Internationally Qualified Nurses. Previous studies have not specifically explored the cultural experiences of nurses from different cultural backgrounds as identified in this study. Therefore, the findings from this research present a unique point of view and augment existing knowledge. Further investigation of the cultural practice of Indian, Filipino and Asian nurses would add a valuable viewpoint to these research findings. Secondly, the participants were self selecting and appeared to be comfortable and confident articulating their experiences of caring for Māori patients and patients from culturally diverse backgrounds. Although the sample population has provided valuable insight into how nurses describe their cultural practice the findings cannot be generalized for all nurses at Waikato DHB. Finally, the interview questions may have limited the

responses participants were able to share and the findings are based on nurses' accounts of their practice as observation of actual practice was not done.

6.4 Implications for future research

The findings from this study and previous studies indicate that there are many implications for further research to evaluate the value and efficacy of cultural safety in meeting the diverse needs of Maori and other patients. Further investigation of the cultural practice of Indian, Filipino and Asian nurses in the care of Maori patients and patients from their own and other cultural backgrounds would enhance these research findings.

After investigating the experiences of whānau caring for relatives following a stroke, Corbett, Francis & Chapman (2006) recommended further cultural safety education for all staff as “appropriate care and support does not appear to be embedded in current clinical practice” (p.262). Wilson (2006, 2008) also highlights that further education is required in order to provide more culturally appropriate and responsive care for Māori patients. A number of other studies recommend further research to consider the effectiveness and outcomes of cultural safety for Māori patients and whānau (Wilson, 2006, 2008; Wilson & Barton, 2012). My findings support this recommendation.

What participants understood about the expectations patients from culturally diverse backgrounds had of them as health professionals was not described in this study nor was this a focus of my research. However, from a review of the literature and the findings from this study, further investigation of this is warranted. The results from other studies suggest that health professionals need better knowledge and understanding of cultural values and beliefs of refugee and migrant populations in order to provide safe and equitable care (De Souza, 2005, 2008; Lawrence & Kearns, 2005; Mortensen, 2008, 2010; North, Lovell & Trlin, 2008). This is reiterated by the findings in this thesis. In their care of CALD populations the issue of gender appropriate care may also need to be addressed in a more culturally appropriate manner to ensure the safety of both male and female patients. In some situations it is not appropriate for females to care for male patients. With the increasing cultural diverse populations this would be an area for further research.

To address some of the limitations of my study a larger study involving more nurses and patient groups, including an observational component and patient interviews

would provide a variety of perspectives. The inclusion of Indian, Filipino and Asian nurses would be more reflective of the demographics of the nursing workforce. As the recipients of care and the ones to determine if care has been provided in a culturally safe manner, the patient perspective would be a critical feature of this research. Patients would include Māori and patients from CALD backgrounds.

Richardson and MacGibbon (2010), highlight that cultural safety provides a framework for holistic care including physical, social, emotional and spiritual needs of patients. How nurses apply this framework in practice requires further investigation as the effectiveness of cultural safety for patients from CALD populations continues to be disputed (Mortensen, 2008, 2010; North, Lovell, & Trlin, 2006). The results from my study endorse further investigation of this.

6.4 Recommendations

1. A review of the Nursing Council cultural safety curriculum and cultural practice competencies is required to more strongly reflect application to practice and guide nurses more clearly on expectations for practice. A comprehensive review of the cultural safety framework involving educators and clinical practitioners is needed to further develop the framework to more effectively meet the needs of Māori and CALD populations. This review should also include input from Māori and patients from diverse cultural backgrounds. Integration of cultural competence to the cultural safety framework is also recommended.
2. It is apparent from this study that participants were challenged when asked how they assessed that they had provided culturally safe care. No consistent objective measures were identified as to how patients could determine their care was culturally safe without patients potentially feeling compromised or at risk of retribution. With the review of cultural safety it is recommended that evaluation tools are considered to enable patients to feel safe in determining whether their care has been culturally safe or not. Nurses should also be encouraged and supported to reflect critically on their cultural practice.
3. The teaching and implementation of cultural safety is not consistently applied across New Zealand. Individual institutions currently decide how cultural safety will be delivered as there is not a national curriculum. Differences in implementation can result in dissimilar outcomes that may not be in the best

interests of Māori or CALD populations. Therefore it is recommended that as part of a comprehensive review a national curriculum is considered.

4. Teaching strategies for cultural safety vary across institutions and experiences of student and registered nurses indicate that changes to these should be considered. It is recommended that current teaching strategies be evaluated and changes considered that can be used across undergraduate and post-graduate education and integrated into post-registration education in clinical practice.
5. It is recommended that the Nursing Council competencies 1.2 and 1.5 and associated indicators of practice are redeveloped to more clearly reflect the application of the principles of the Treaty of Waitangi and kawa whakaruruhau to meet the expectations of Māori patients, and the principles of cultural safety to meet the requirements of patients from culturally diverse backgrounds.
6. Nurses need to be better prepared to meet the anticipated needs of culturally and linguistically diverse populations. It would be beneficial for nurses to have better awareness of other worldviews of health, issues arising through cross cultural communication and values and beliefs and their relevance to health care and treatment. It is recommended that education opportunities are promoted to support nurses practicing in a variety of practice settings.

APPENDIX I CONSENT FORM



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CONSENT FORM FOCUS GROUP / INTERVIEW

Project Title: **Articulating cultural practice within a New Zealand nursing context**

FROM: (name of participant)
ADDRESS: (contact details of participant)

To: Researcher

Chris Baker, Masters in Health Science candidate, Population Health, University of Auckland.

- I have read and understand the information sheet dated June 2011 and I have had the opportunity to ask questions and to have them answered to my satisfaction.
- I agree to participate in an interview in relation to my opinions about and experience of articulating cultural practice within a New Zealand nursing context.
- I agree to the interview being audio recorded and transcribed. I understand the audio recording, the transcript of interview, paper records, the consent form and computer files will be stored for six years and subsequently destroyed.
- I understand that taking part in this study is voluntary (my choice), and that I may withdraw from the study at any time.
- I understand that I may withdraw information supplied by me in an individual interview up to [date].
- I understand that I will be unable to withdraw my information from a focus group once this is underway.
- I understand that I may refuse to answer any question(s).
- I agree that this information may be used as source material for written publications and oral presentations.
- I understand that no personal names or any other information which would serve to identify me as a participant will be included in any publication or presentation.

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

Participant Signature: _____

Date:

One signed copy of this document to be given to the participant and one signed copy to be held in safe keeping by the researcher at University of Auckland.
'This study has received ethical approval from the Northern Y Regional Ethics Committee, ethics reference number NTY/11/08/084.

APPENDIX II PARTICIPANT INFORMATION SHEET



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PARTICIPANT INFORMATION SHEET

Project Title: **Articulating cultural practice within a New Zealand nursing context**

Researcher: Chris Baker
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Research Supervisors:
Associate Professor Nicola North, School of Population Health, University of Auckland
Dr Philippa Miskelly, Waikato DHB / University of Auckland

Project Description and invitation

This research explores how registered nurses, from different backgrounds, describe their cultural practice within the New Zealand context. For the purpose of this research, cultural practice relates specifically to how nurses apply the principles of the Treaty of Waitangi and the principles of cultural safety to nursing practice. These principles are an integral part of nursing practice in the establishment and maintenance of therapeutic relationships with patients from different backgrounds. Although nurses do this in their everyday practice, and are expected to articulate their practice as a nursing competency, they often find it difficult to put into words exactly how they do this.

You are invited to take part in research exploring your experiences of articulating cultural practice within a New Zealand nursing context. Your participation would involve taking part in a focus group/individual face-to-face interview which will last approximately for 1 hour to 1 hour and 30 minutes. Interviews and focus groups will be conducted in private by Chris Baker in the Bryant Education Centre or meeting room in the Professional Development Unit, Percival Flats, 17 Ohaupo Road. An observer will be present during the focus group to record discussion in the event of problems with the audio recording device. During the focus group/interviews you will be asked to share your thoughts about cultural practice within clinical settings.

You do not have to take part in this research as participation is purely voluntary (your choice). Deciding not to take part will not be communicated to your employer or manager and so it is highly unlikely to negatively impact on your employment status with Waikato District Health Board nor your current position within the ward/unit you work for.

If you agree to participate, you will have the right to:

- Refuse to answer any question(s) and to withdraw from the study at any time
- Ask questions about the research during the course of the project
- Ask that certain information not be used

Project Procedures

You are invited to choose from two options of how you would like to participate in this study. A semi structured interview process using the same questions will be used for both options.

- Option 1 Focus group interview: focus groups will consist of nurses from similar backgrounds e.g. New Zealand trained nurses prior to 1992, New Zealand nurses trained after 1992, overseas trained nurses
- Option 2 Individual interview

All focus group and individual interviews will be audio taped, with participant consent and transcribed. A small advisory group from focus group participants will be set up and presented with a summary of the main thematic analysis and asked if this is a fair reflection of the discussion.

Participants interviewed individually will be asked to check their transcript for accuracy.

Participants will be invited to share refreshments at the end of the focus group / interview.

Confidentiality and anonymity

The focus group/interview will be audio-recorded (with your permission) and transcribed by the researcher. The observer present during the focus group will sign a confidentiality agreement to keep information heard confidential. Only the researcher and her supervisors will have access to the information you provide in the interviews and focus groups. The transcriptions will not reveal your name or other personal details that could identify you. No material which could personally identify you will be used in any reports about this study. All information will be treated as confidential and your anonymity in reports and publications will be protected (you will not be named). Pseudonyms will be used in reports, and you will be able to choose your own pseudonym if you would like to do this. However, it should be noted that while confidentiality is encouraged in focus groups it cannot be guaranteed.

To ensure patient privacy and confidentiality as per Health Information Privacy Code, participants will be asked that when they share examples of their practice when caring for specific patients that they focus on describing their nursing practice and do not disclose any patient details that will enable the patient to be identified. This includes not using names, dates, diagnosis or clinical details of patient, locality where patient lives, specific unique situation such as a high profile media case or practice setting where care was provided.

Data storage / retention / destruction / future use

The information will be stored on a password protected computer to enable analysis of the data. Once this has been completed the results will be incorporated into my Masters Thesis. Part of the research material may also be used in articles for publication.

The audio recordings and other information will be kept in a secure location which will only be accessible to the researcher. All information will be stored on computer for ten years and will only be accessible to the researcher via the use of passwords. The audio recordings once transcribed and saved will be deleted from the recorder. Any paper records from the study e.g. consent forms, will be stored in a secure location at the University of Auckland Tamaki Campus for ten years. Data collected will be stored electronically for ten years and utilized for preparing articles for publication.

This research has been approved by the Northern Y Regional Ethics Committee.

If you have any questions or concerns about your rights as a participant in this research study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability commissioner Act. Contact details are:

Telephone: (NZ wide) 0800-555-050

Free Fax: (NZ wide) 0800-2787-7678 (0800 2 SUPPORT)

Email: (NZ wide) advocacy@hdc.org.nz

WHY SHOULD THIS RESEARCH BE CONDUCTED?

The nursing workforce is made up of nurses from diverse backgrounds. These backgrounds include nurses who trained in New Zealand prior to 1992 when cultural safety was first introduced into the nursing training curriculum and those who trained in New Zealand after 1992 as well as nurses who trained overseas. Overseas trained nurses include those who have English as a second language. The research will also investigate if nurses from diverse backgrounds have a different understanding of cultural practice and how they practice in the New Zealand environment.

As part of Nursing Council of New Zealand requirements for continuing competence, nurses are required to provide care in a culturally safe manner, as determined by the patient. Cultural safety is a concept that is embedded in nursing education and practice and although it is understood by nurses, it is not a concept that is understood by patients and this is difficult for nurses to ask patients if their care has been culturally safe. How then do nurses assess their practice is culturally safe, as determined by the patient? Research participants will be asked to explore collectively or individually how they assess the effectiveness of their cultural care.

Participation in this research will enable nurses to explore and clarify their views on cultural practice and construct meanings around their practice. Nurses may feel more comfortable sharing their experience on an individual basis or as part of a focus group. A focus group interview will enable members of the group to collectively make sense of cultural practice and understand each other's reasons for holding a certain view. Participants may on hearing other people's views change their minds and agree with views they would not have considered had they not heard the views of others.

The results of this research will demonstrate to students and other nurses how to implement the principles of the Treaty of Waitangi and cultural safety into their practice and assist other nurses to recognize and describe their cultural practice. The findings will also contribute to the limited body of nursing knowledge on application of the principles of the Treaty of Waitangi and cultural safety in practice.

Contact Details and Approval Wording

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This study has received ethical approval from the Northern Y Regional Ethics Committee, ethics reference number NTY/11/08/084.

APPENDIX III CONFIDENTIALITY AGREEMENT



THE UNIVERSITY OF AUCKLAND
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HEALTH SCIENCES

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RESEARCH PROJECT

“ARTICULATING CULTURAL PRACTICE WITHIN A NEW ZEALAND NURSING CONTEXT”

RESEARCHER: Christine Baker

CONFIDENTIALITY AGREEMENT FOR OBSERVER OF FOCUS GROUPS

I have read the information sheet outlining this study. I have discussed with the researcher the nature of the research and I have had any questions that I have asked, answered to my satisfaction. My role as the research observer has been outlined to me by the researcher.

At all times the research information (written during focus group) will be inaccessible to other persons. The researcher has assured me she will debrief me following each focus group to address any issues that observing bring up for me.

Most importantly, I understand and agree to store the data securely while in my care and keep the information I hear in the course of the focus groups confidential to the researcher and myself.

Observer's full name: _____

Observer's signature: _____

Date: _____

Researcher's signature: _____

Date: _____

One signed copy of this document to be given to the observer and one signed copy to be held in safe keeping by the researcher at University of Auckland.

'This study has received ethical approval from the Northern Y Regional Ethics Committee ethics reference number NTY/11/08/084.

<p>1. Introductory questions</p>	<p>I am interested in exploring the Treaty of Waitangi and cultural safety as core components of nursing practice. Who do you think the Treaty of Waitangi applies to? Who do you think cultural safety applies to? How have you gained your knowledge and understanding of caring for patients in a culturally safe manner?</p>
<p>2. Transition question</p>	<p>In your recent practice, does a patient come to mind, where you thought of this patient from a cultural safety framework?</p>
<p>3. Key question Vignette 1- elderly man</p>	<p>The Nursing Council defines culture to include, age, gender, social and education background, disability, sexual orientation and ethnicity (non Maori). The Nursing Council requires nurses to practice nursing in a manner that the client determines as being culturally safe. Vignette 1 (elderly male)</p> <ul style="list-style-type: none"> • How would you engage with and develop a trusting relationship with this patient and his family? • How would you plan care with the patient and family to meet his needs? • What do you think are the key features of care you need to consider for this elderly man? • What resources would you access to meet his holistic needs? • In this situation, how would you assess that you had provided care in a culturally safe manner?
<p>4. Key question Vignette 2- Maori mother</p>	<p>The Nursing Council requires all nurses to demonstrate the ability to apply the principles of the Treaty of Waitangi to nursing practice. Vignette 2 (Maori woman)</p> <ul style="list-style-type: none"> • How would you engage with and develop a trusting relationship with this patient and her whanau? • How would you plan care with the patient and whanau to meet her holistic needs? • What do you think are the key features of care you need to consider for this Maori woman? • What resources would you access to meet her holistic needs? • In this situation, how would you assess that you had provided care in a culturally safe manner?
<p>5. Key question</p>	<p>Can you think of a time where you felt you made a positive difference to the care and health outcome for a patient?</p> <ul style="list-style-type: none"> • What cultural aspects of care did you take into consideration when caring for this patient? • How do you think you made a difference? • Why was that significant? • How did you assess that you had provided care in a culturally safe manner? <p>How has this experience influenced your cultural practice when caring for patients from other cultures?</p>
<p>6. Key question</p>	<p>Can you think of a time where you felt you made a positive difference in care and health outcome of a Maori patient and whanau?</p> <ul style="list-style-type: none"> • What cultural aspects of care did you take into consideration when

	<p>caring for this patient?</p> <ul style="list-style-type: none"> • How do you think you made a difference? • Why was that significant? • How did you assess that you had provided care in a culturally safe manner? • How has this experience influenced you cultural practice when caring for Maori patients and whanau?
7. Key question	How do you think your own training and cultural background influences the cultural care you provide to Maori and other patients?
8. Key question	The Nursing Council requires all nurses to provide culturally safe care, as determined by the patient. How do you assess that the care you provide for different patients is culturally safe?
9. Ending question	What do you think are the most important aspects of cultural care in order to make a positive difference to outcomes for Maori and other patients that you care for?
10. Final question	Is there anything else that anyone feels that we should have talked about but didn't?

APPENDIX V VIGNETTES

Vignette 1 (elderly male)

You are caring for an elderly man in his 70s, Jack, admitted for poor management of his diabetes. As result of his diabetes Jack has poor circulation and has developed an ulcer on his leg which is not healing well. His mobility has also been affected and he requires a walking frame to assist him. He is not coping well with loss of some of his independence and he has expressed this to you. Jack has a hearing impairment and has hearing aids. Jack is able to make his own decisions and has given his consent for his wife to be given information about his care.

Prior to admission Jack has been living in a retirement village with his wife (Iris) who is in her sixties. They are both very active in their community and have a wide social network of friends and attend church each Sunday. Their two children live in Hamilton and they visit Jack each day along with the teenage grand children. They are a loving and caring family who are concerned about Jack's condition and his increasing dependence on Iris and how she will cope when he is discharged.

Vignette 2 (Māori woman)

You are caring for a middle aged Māori woman who has recently been diagnosed with invasive breast cancer. Aroha is a single mother of three children under fifteen who lives in a rural south Waikato town with her parents. She has been admitted for a bilateral mastectomy and reconstructive surgery.

You meet her for the first time on admission when she was accompanied by her mother. She was very anxious, tearful and unsure about what is going to happen and what the future may hold for her.

APPENDIX VI ETHICS APPROVAL



Northern Y Regional Ethics Committee
c/- Ministry of Health
Level 3, Bridgewater Building
130 Giessem St
Hamilton 3204
Phone: (07) 9293612
Email: northern_y_ethicscommittee@moh.govt.nz

18 October 2011

Ms Christine Baker
Waikato DHB
Waikato Hospital
Pembroke Street, Hamilton

Dear Christine -

Ethics ref: NTY/11/08/084 (please quote in all correspondence)
Study title: Articulating cultural practice within a New Zealand nursing context
Investigators: Ms Christine Baker

This study was given ethical approval by the Northern Y Regional Ethics Committee on 18 October 2011.

Approved Documents

- Information sheet and Consent form version 2 dated September 2011
- Confidentiality agreement for observer of focus groups dated September 2011

This approval is valid until 30 December 2012, provided that Annual Progress Reports are submitted (see below).

Amendments and Protocol Deviations

All significant amendments to this proposal must receive prior approval from the Committee. Significant amendments include (but are not limited to) changes to:

- the researcher responsible for the conduct of the study at a study site
- the addition of an extra study site
- the design or duration of the study
- the method of recruitment
- information sheets and informed consent procedures.

Significant deviations from the approved protocol must be reported to the Committee as soon as possible.

Annual Progress Reports and Final Reports

The first Annual Progress Report for this study is due to the Committee by 18 October 2012. The Annual Report Form that should be used is available at www.ethicscommittees.health.govt.nz. Please note that if you do not provide a progress report by this date, ethical approval may be withdrawn.

A Final Report is also required at the conclusion of the study. The Final Report Form is also available at www.ethicscommittees.health.govt.nz

Statement of compliance

The committee is constituted in accordance with its Terms of Reference. It complies with the Operational Standard for Ethics Committees and the principles of international good clinical practice.

The committee is approved by the Health Research Council's Ethics Committee for the purposes of section 25(1)(c) of the Health Research Council Act 1990.

We wish you all the best with your study.

Yours sincerely



Amrita Kuruvilla
Northern Y Ethics Committee Administrator
Email: amrita_kuruvilla@moh.govt.nz

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