Introduction

Kia ora and welcome to the second edition of *Cultural Safety in Aotearoa New Zealand*. It has been almost 20 years since cultural safety education became an integral part of the nursing and midwifery curriculum. A testament to the longevity of cultural safety has been its ability to remain relevant within the 21st century. Such relevance has culminated into the Nursing Council of New Zealand's (2011) *Guidelines for Cultural Safety, the Treaty of Waitangi and Māori Health in Nursing Education and Practice.*

This edition builds on the first edition of *Cultural Safety in Aotearoa New Zealand* whereby chapters have been reviewed due to feedback from the health and education sector. The end result has been the inclusion of chapters focused on whānau-centred practice, disability and competence. Chapter 2, written by professionals from the Nursing Council of New Zealand ('the Nursing Council') on competencies required for registered nurses' scope of practice, is of significance within this second edition. Direct passages from the Nursing Council's competencies are linked to real-life experiences so that students can become familiar with such requirements at an earlier stage within their respective programmes.

As with the first edition, the first three chapters set the scene with a discussion on the concepts within cultural safety and historical events that led to its inclusion by schools of nursing and midwifery. The foundations of cultural safety follow with six chapters focusing on concepts around culture, ethnicity, the Treaty of Waitangi, prejudice, ethics and research. The next eight chapters focus on fields of practice where practitioners have contributed their views on child/youth/family, mental health, midwifery, minority cultures, the aged, gender, Māori health initiatives and disability. I sincerely hope that this text will be useful for classroom and practice-based teaching and I welcome any feedback to improve the learning experience for students and health outcomes for all recipients of care in Aotearoa New Zealand.

Dianne Wepa

A note on the cover image

The manu tukutuku claims tino rangatiratanga and all that is involved in responsibility, governance, protection and relationship. The kākahu with broad tāniko band is based on the kaitaka cloak – a garment of mana of the highest prestige – something for all health professionals to be attuned to in their care of persons and the tapu of the body. The gold and silver leaf at the base talks about the sacred tie between humanity and land – the physical/whenua and the spiritual/waiora.

The tāniko on the kaitaka has been worked to talk about awareness; colours around the kaitaka and manu aute are healing/good health colours.

Gabrielle Belz

part 1

Setting the scene

1 Towards cultural safety

Irihapeti Ramsden

Learning objectives

Having studied this chapter, you will be able to:

- be familiar with the name of two models of Māori health;
- be able to describe the connection between colonisation, the Treaty of Waitangi and Māori health;
- understand the difference between nursing someone regardless of their uniqueness and being regardful of their difference;
- be able to critique the notion of multiculturalism within nursing;
- be able to describe cultural differences beyond ethnicity;
- be able to understand the origin of the term cultural safety;
- describe the importance of each of the following:
  - nurses' attitudes towards patients
  - recognition and understanding of the powerlessness of patients
  - the centrality of open-mindedness and self-awareness.

Key terms and concepts

- colonisation
- culturally safe health professional
- model for negotiated and equal partnership
- multiculturalism
- power of nurses
- Te wheke
- the Treaty of Waitangi
- Whare Tapa Whā

Introduction

This chapter explores the historical relationship between the health status of Māori, the Treaty of Waitangi and health services in Aotearoa New Zealand at the time when cultural safety developed. The clarification of these issues was necessary to enable me to work effectively in the teaching environment and introduce what was essentially new and revolutionary material to nursing and midwifery students. A chronological overview to the evolution of cultural safety following the immediate period after my initial teaching experiences in 1988 through to 2001 is presented. I wish to convey to the reader some essence of the sheer speed, over this thirteen-year period, at which cultural safety development has taken place within New Zealand nursing and midwifery professions.

Practice examples are given to assist the reader to recognise and understand the powerlessness of patients and the power of nurses.

Historical analysis

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

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

Durie (1994) states that there were hui throughout the country in the early part of the decade which accepted a model of health incorporating taha wairua (spiritual health), taha hinengaro (mental health), taha tinana (physical health)

and taha whānau (family health), and that this became widely accepted as the preferred Māori definition of health. Hui Whakaoranga also recommended that health and education institutions recognise culture as a positive resource. Spiritual and emotional factors as contributors to health and well-being were emphasised at the hui. Although Durie admits that the Whare Tapa Whā model is simple, 'even simplistic', it had immediate appeal for Māori and Pākehā alike. For example, the model was adopted widely by nursing schools and formed the basis for the philosophy of the inaugural curriculum of the Waiariki Polytechnic Nursing School at Rotorua which was set up in 1985. A further model appeared during this period which has enjoyed a level of acceptance, Te Wheke (Pere, 1991), which represents the tentacles of an octopus, each concerned with an aspect of health or illness or community and family.

The Treaty of Waitangi

The formal agreement between Māori hapū and the British Crown took the form of a treaty written in both Māori and English which was signed initially at Waitangi in the Bay of Islands in 1840. Later versions were signed at several other sites around the country.

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

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

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

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

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

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

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

Since the Treaty of Waitangi Act 1975, the Treaty has grown steadily in the public attention. Pushed largely by Māori urban activism to address the social and economic consequences of legislatively induced poverty (Durie, 1994), the establishment of the Waitangi Tribunal was seen as a significant outlet for Māori frustrations. Publicity given to the succession of cases and the landmark decisions that it made in respect of tribal claims against the

Crown enabled Treaty issues to assume an importance which they had not had over the previous 100 years. The Treaty became a focus for race relations activity, particularly in respect to property rights. Māori attempts to assert their arguments regarding these matters often caused vituperative comment from all levels of New Zealand society, ranging from radio talkback to the 1975 Court of Appeal decisions on the role and function of the Waitangi Tribunal.

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

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. The impression was given that Māori were activating simply for their own purposes and that other cultures needed patronising and defending. The idea that there were intact groups of people which could be called cultures was considered to be common sense and normal and was referred to in everyday conversation as though cultures were measurable and easily definable.

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

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

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

Learning and teaching: students as teachers

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

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

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

consider that change in their own attitude and self-knowledge was needed before any trust could be established.

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

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

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

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

> The idea of the nurse ignoring the way in which people measure and define their humanity is unrealistic and inappropriate . . . People are still prepared to die in order to maintain their cultural, religious and territorial integrity. It is not the place of the nursing service to attempt to deny the vital differences between people, however altruistic the rationale may be. (Ramsden, 1990, p. 1)

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

> Only one word needs to be altered in order to suitably change the old nursing philosophy to become appropriate for the end of the 20th century and onward