Nursing Praxis in New Zealand

CULTURAL SAFETY: DOES THE THEORY WORK IN PRACTICE FOR CULTURALLY AND LINGUISTICALLY DIVERSE GROUPS?

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Abstract

Culturally diverse refugee and migrant groups under-utilise health services in New Zealand and cultural barriers are cited as reasons for not using health services. According to the Nursing Council nurses are required to demonstrate competency in culturally safe practice, yet cultural safety is determined by the person receiving the care. This article critically examines the theoretical base of the cultural safety guidelines for nursing practice with respect to culturally and linguistically diverse (CALD) groups. Two key questions were posed: have the guidelines led to culturally safe nursing practice in health care for CALD groups, and have the guidelines contributed to provision of culturally acceptable health care for CALD groups? It is concluded that further theoretical consideration should be given to the conceptual basis for including CALD groups in the cultural safety model. The cultural competencies required for culturally safe nursing practice need to apply to the care of all culturally diverse groups present in New Zealand. Recommendations are made for strengthening the cultural safety model, and the registered nurse competencies for culturally safe practise.

Key Words: Cultural safety, Cultural and Linguistic Diversity (CALD), Asian, refugee and migrant groups.

Introduction

The 2006 Census revealed an increasingly diverse population in New Zealand in terms of ethnicity and demography (Friesen, 2008). Specifically ethnic diversity in the population has increased in the two decades following changes to the Refugee Settlement Policy and the Immigration Act in 1986/1987 (Bedford & Ho, 2008; Friesen; Ministry of Social Development (MSD), 2008). The most notable aspect of this change has been the growth of populations of Asian origin, although Middle Eastern, Latin American, African (MELAA) and other culturally diverse populations have also grown (MSD; Statistics New Zealand (SNZ), 2006).

Asian, Middle Eastern, Latin American and African groups in New Zealand have inequitable access to health care. New Zealand studies show disparities between the health of Asian and MELAA groups compared to other populations (Gala, 2008; Perumal, 2010; Scragg, 2010). With acculturation, patterns of poor health including: diabetes, obesity and cardiovascular disease, high smoking rates, poor oral health, mental health and sexual and reproductive health are occurring in Asian, Middle Eastern, Latin American and African populations (Gala; Perumal; Rasanathan, Ameratunga, & Tse, 2006; Scragg).

New Zealand studies have identified a lack of cultural knowledge and skills in the health workforce as a major barrier to provision of accessible, safe and equitable health services for Asian, refugee and culturally diverse migrant groups (Asian Public Health Project Team, 2003; Lawrence, 2007; Lawrence & Kearns, 2005; Lee, Kearns,

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& Friesen, 2010; Mortensen, 2008; North, Lovell, & Trlin, 2006). As well, New Zealand research with health care providers indicates that nurses and other health professionals are ill-prepared to provide culturally competent care for culturally and linguistically diverse (CALD) groups (Lawrence & Kearns; Mortensen; North et al.). This article presents a critical exploration of the theoretical basis of the cultural safety guidelines for nursing (and midwifery) education for the CALD groups served in order to answer two questions: (a) have the guidelines provided culturally safe nursing practice for CALD groups in healthcare? and (b) have the guidelines contributed to the provision of culturally acceptable health care for CALD groups?

Changing Demographics in New Zealand

Of any country in the Organisation for Economic Co-operation and Development (OECD) New Zealand has one of the highest proportions (22 per cent) of overseas born residents in the population (SNZ, 2006). By comparison, Australia alone has a higher rate of overseas born residents with 24 per cent; Canada has 17 per cent, and the United States 10 per cent (MSD, 2008). Rapid ethnic diversification within the population of New Zealand's main centres, in particular in the Auckland region, followed the changes made to New Zealand's immigration policy and to refugee policy in 1986/1987. The legislative changes to the Immigration Act 1987 removed, for the first time, specific source country preferences for immigrants from the United Kingdom and Northern Europe (Bedford, 2003). A review of refugee selection policy at the same time introduced an annual quota intake of 750 refugees, and replaced the selection of 'specific national, ethnic and religious groups' with 'worldwide categories' (Department of Labour, 1994, p. 25). The profile of refugees in need of resettlement from this time onwards increasingly has been characterised by new and diverse nationalities.

Since the early 1990s the demography of the Auckland region has changed significantly (MSD, 2008). The region has settled over 230 diverse ethnic groups (SNZ, 2006). Over 65 per cent of the 50,700 New Zealand adult non-English speakers live in the Auckland region. Almost three-quarters of the people who come to New Zealand from the Pacific Islands, and two-thirds of those who come from Asia, live in Auckland. Asian peoples are overall the second largest population group in the region, representing 21 per cent of Auckland's total (Friesen, 2008). Asian populations are made up of diverse ethnic sub-groups with Chinese being the largest (45 per cent), followed by Indian (27 per cent) and Korean groups (9 per cent) (Asian Public Health Project Team, 2003). Other Asian ethnic groups include Thai, Filipino, Japanese, Sri Lankan, Laotian, Cambodian, Vietnamese, Burmese, Bhutanese, Nepalese, Tibetan and Indonesian groups (Asian Public Health Project Team).

Refugees from over 43 different countries have been approved for residence through the Refugee Quota programme (Department of Labour, 2009). In the last five years, the largest source country has been Myanmar (Burma), followed by Afghanistan, Iraq and Bhutan. Other refugee source countries in the last two decades include: Iran, Sudan, Eritrea, Democratic Republic of Congo, Burundi, Republic of Congo, Colombia, Ethiopia, Somalia, Rwanda, China, Sri Lanka and Nepal. In particular there has been dramatic change in the health populations served by Auckland region District Health Boards where two-thirds of all Asian and MELAA populations reside (MSD, 2008). 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 populations served.

Nursing Council of New Zealand Cultural Safety Guidelines

This section explores the paradigms and principles underlying the Nursing Council of New Zealand's ('the Council') (2009) guidelines which form the basis for culturally safe practice for CALD groups in New Zealand. A historical overview of the background to the development of the guidelines, and, in particular, the perspectives taken on multicultural and transcultural approaches to nursing care are highlighted.

Background to the New Zealand Model.

The Council's (2009) *Guidelines for cultural safety, the Treaty of Waitangi, and Maori health in nursing education and practice* provide standards for the cultural care for all ethnic groups in New Zealand, but this model is far from clear about the conceptual base for the inclusion of the multi-ethnic populations served by the health sector.

In 1990 the Council amended the standards for nursing registration to incorporate cultural safety into curriculum assessment processes (Nursing Council of New Zealand (NCNZ), 1990a, 1990b). Applicants for registration for nursing and midwifery were required to demonstrate 'culturally safe' practice (NCNZ, 1990a, 1990b). In 1991, the Council commissioned Irihapeti Ramsden to write the guidelines for cultural safety in nursing and midwifery education. The subsequent document was approved by the Council in 1992 and distributed to all polytechnic nursing courses (Ramsden, 1992).

Historically, the cultural safety guidelines arose out of three nursing hui (a formal gathering similar to a conference) in 1988, 1989 and 1990 (Ramsden, 2005). The hui addressed nursing education from the perspective of the principles of the Treaty of Waitangi (an agreement signed between Maori, the indigenous peoples of New Zealand, and Queen Victoria in 1845) (Kawharu, 1989). The principles are partnership, participation, and protection. Also considered at these hui were recruitment and retention issues for Maori women in nursing (Ramsden, 1993; Ramsden, 2005). The cultural safety guidelines introduced in 1990 and approved in 1992, were subsequently reviewed and rewritten in 1996 (NCNZ, 1996; Ramsden, 1992). The 1996 *Guidelines for Cultural Safety in Nursing and Midwifery Education,* represented diagrammatically in Figure 1, placed cultural safety within the overall context of the Treaty of Waitangi.

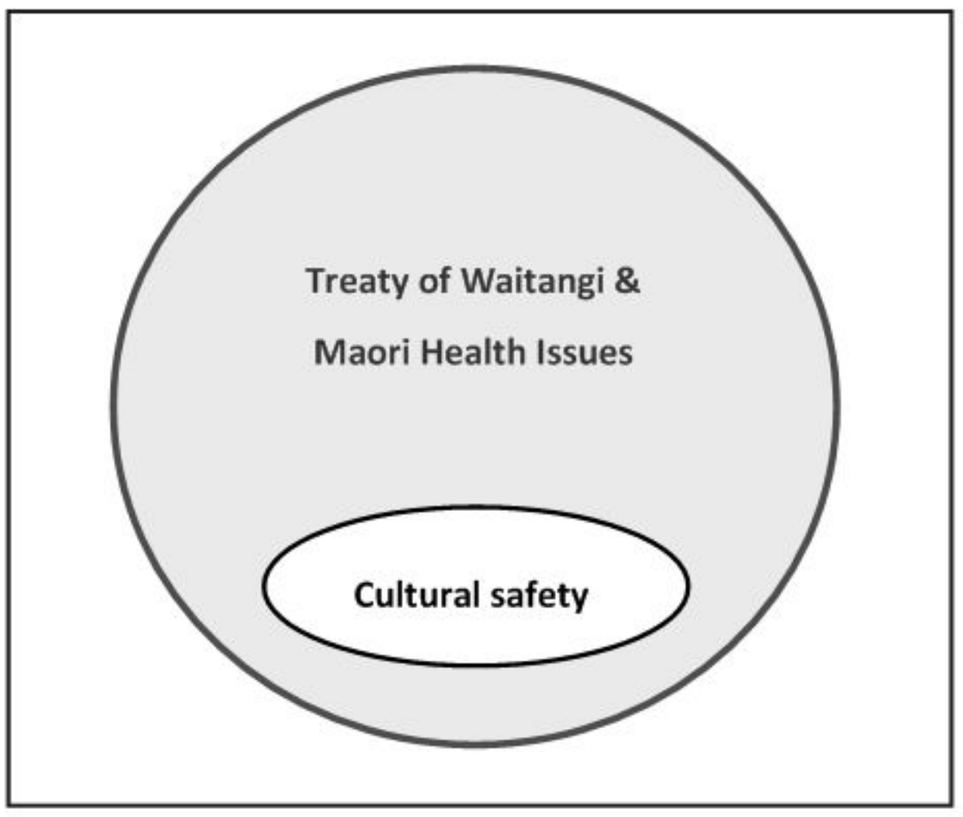

Figure 1. The 1996 interpretation of cultural safety
Note: Sourced from Nursing Council of New Zealand (2009, p. 2)

A further Council review in 2002 highlighted a number of important clarifications, namely, that equating the guidelines for cultural safety with the Treaty of Waitangi and Maori health had 'contributed to the confusion surrounding cultural safety, which is a broader concept' (NCNZ, p. 4). The 1996 guidelines were replaced with the *Guidelines for Cultural Safety, the Treaty of Waitangi, and Maori Health in Nursing and Midwifery Education and Practice* in 2002 (NCNZ, 2002). The 2002 model, represented in Figure 2, separates cultural safety conceptually from the Treaty of Waitangi and Maori health (p. 5). Subsequently there have been minor amendments in the 2005 and 2009 versions.

With respect to the relationship between the Treaty of Waitangi and cultural safety, it is the specific concept of *kawa whakaruruhau*, or cultural safety within the Maori context, that informs Maori health and nursing practice (NCNZ, 2002, p. 6). The basis of the practice of kawa whakaruruhau and the role of the health care provider in this, are clear and specific. The expectation in the Maori cultural safety paradigm is that health care providers are 'active Treaty of Waitangi partners' as Crown agents (NCNZ, 2002, p. 14). As such, nurses and midwives are required to critically analyse the Treaty of Waitangi and its relevance to the health of Maori and to demonstrate the application of the principles of the Treaty of Waitangi within nursing or midwifery practice.

Additionally, there was a significant shift in the 2002 guidelines to widen the cultural safety concept to 'incorporate a broad definition that expresses the diversity that exists within cultural groups' which 'in addition to ethnicity' includes, 'groups that are as diverse as social, religious and gender groups' (NZNC, 2002, p. 4). However, it is unclear what the underpinning principles for the practice of cultural safety are when applied to ethnically, culturally and

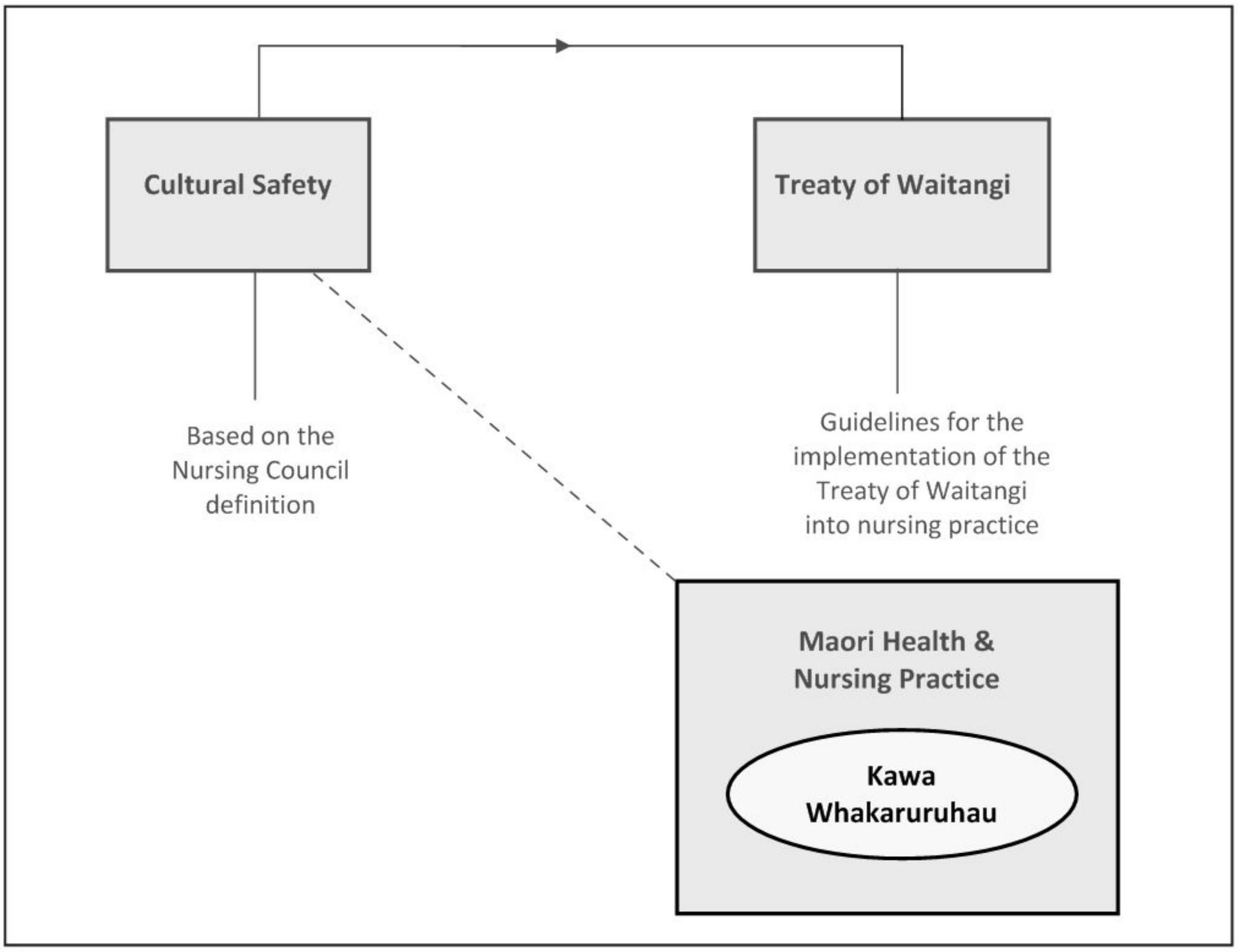

Figure 2. Revised model for the teaching of cultural safety, the Treaty of Waitangi, and Maori health in nursing programmes.

Note: Sourced from Nursing Council of New Zealand (2009, p. 3).

religiously diverse groups in this separation from the concept of kawa whakaruruhau. Indeed, as is shown in Figure 2, there is no identifiable paradigm underpinning cultural safety practices for ethnic groups in the cultural safety guidelines.

Culturalist Paradigms Debated in New Zealand.

The 1996 guidelines signalled a shift in the scope and interpretation of the New Zealand cultural safety model to include ethnic groups. However, the matter of the inclusion of culturally and linguistically diverse groups, when multicultural and transcultural approaches to nursing care are problematised, has yet to be resolved. The Council's view that multiculturalism is 'simply a statement of who is present in the country' (1996, p. 34) has previously been strongly influential in responsiveness to CALD groups. Wepa though, recognises that the:

> ... *implementation of multiculturalism need not be at odds with biculturalism as long as Maori are recognised as being equal partners with the Crown rather than having to compete for cultural space with other cultures. Once biculturalism becomes normalised within nursing and midwifery multiculturalism will unfold thereafter (2005, p. 38).*

There are significant tensions to be resolved between the cultural safety model, and the multicultural and transcultural models of health care used by other immigrant receiving nations such as Canada, Australia and the United States (Betancourt, Green, Carillo, & Park, 2005). Most particularly as will be shown in the next section, debate over the cultural safety model versus a rival theoretical perspective, *Transcultural Nursing Care,* as developed by the North American nursing theorist, Madeleine Leininger (1978), has extensively influenced the direction of nursing practice and education in New Zealand.

The Theory of Transcultural Care.

In this section, the theoretical models: transcultural care (Leininger, 1978, 1988) and cultural safety (Ramsden, 2001) are re-examined in the context of 21st century New Zealand migration, ethnicity and demographic patterns and trends (Bedford & Ho, 2008; Friesen, 2008). Cultural diversity in the population is a dynamic that nursing practice and education must respond to and therefore it is helpful to ground an understanding of this important cultural debate in the historic context of the differing immigration histories occurring in North America, and in New Zealand in the post World War II period.

In one sense, the differing models of practice that have evolved may be viewed as reflecting the differing immigration policies adopted by New Zealand, and the United States (and Australia and Canada) from the 1950s to the 1980s. Australian, Canadian and American Governments removed preferences for migrants from traditional source countries thirty years prior to the New Zealand Government's changes in 1987. It has been argued by some New Zealand nurses that transcultural models are problematic because they are applicable only to 'countries such as the United States of America with large immigrant populations', and that New Zealand's history 'its colonisation and its patterns of growth are unique as are its peoples' (Smith, 1997, pp. 16-17). In this sense, it is true that New Zealand differs from other classical countries of immigration (Australia, Canada, and the United States) in that New Zealand Governments until 1987 exercised highly restrictive pro-British immigration policies (Ongley & Pearson, 1995). Conversely, the United States maintained high levels of net migration from a wide range of source countries after World War II (Leininger, 2001).

The development of transcultural care reflects the nursing environment for North Americans in the 1950s. The settlement of multi-ethnic refugee and migrant

groups characterised immigration in the post war period in North America and Leininger observed:

> *... nurses were functioning in a multicultural society and expected to care for people of diverse cultures. But the reality was that there was no body of knowledge (discipline knowledge) nor principles, concepts and guidelines to care for clients of different cultures (2001, p. 16).*

Madeleine Leininger (1978) developed the theory of transcultural care from clinical experience during a period of high net migration to the United States during which it became apparent that culture was the missing link in nursing knowledge and practice. The term transcultural nursing refers to a:

> *...substantive area of study and practice focused on comparative cultural care (caring) values, beliefs, and practices of individuals of similar or different cultures. Transcultural nursing's goal is to provide culture-specific and universal nursing care practices for the health and well-being of people or to help them face unfavourable human conditions, illness, or death in culturally meaningful ways (Leininger, 1978, p. 8).*

The theory challenged the existing 'traditional medical and unicultural practice' in health care in North America in the 1950s (Leininger, 1996, p. 1). The transcultural model was designed to meet the health needs of a multicultural world (Leininger, 1997a). Leininger's contention was that 'if one fully discovers care meanings, patterns, and processes, one can explain and predict health or well-being' (1988, p. 152) in culturally diverse populations.

The Cultural Safety Model.

The cultural safety model is positioned as substantively and significantly different to concepts of transcultural nursing care (Ramsden, 2002). The Nursing Council of New Zealand defined cultural safety as:

> *The effective nursing or midwifery 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 belief; and disability.*
>
> *The nurse or midwife delivering the nursing or midwifery 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 (2002, p. 7).*

The main basis for critique of the transcultural approach is that it is reductionist in that it is assumed 'that cultures are simplistic in nature [which] can lead to a checklist approach by services providers, which negates diversity and individual consideration' (NCNZ, 2009, p. 4). In Ramsden's terms 'a simple differentiation between the two models is that cultural safety is about life chances and transcultural nursing is about lifestyles' (2002, p. 7).

Opposition to the transcultural model has centred primarily on the anthropological base of the theory (Cooney, 1994; Ramsden, 1993; Smith, 1997). In Ramsden's view, the transcultural model based on Western notions of anthropology remains 'focussed on the "cultural" activities of the patient' (2001, p. 26). However, Leininger has always maintained that 'transcultural nursing was not the same as anthropology, sociology or other fields. It was different – as professional nursing should be – focused on humanistic and scientific care to make a distinct contribution to society' (2001, p. 17).

By comparison, the cultural safety model is a broader concept which is focused on understanding the institutional power of the health system and the health professionals within it. In the cultural safety model, the role of the nurse is pivotal as the focus of social change (Ramsden, 2001, p. 26). The model emphasises 'health gain and positive health outcomes' for the health populations served (NCNZ, 2009, p. 6). The Council maintains that 'a nurse who can understand his or her own culture and the theory of power relations can be culturally safe in any context' (2009, p. 4). Transcultural models by comparison, neither adequately represent the impact of institutional power as a barrier to access for culturally diverse groups, nor promote the reduction of health inequalities in the population. However, understanding the dynamics of power, race and social inequities is an integral part of the North American culture care theory (Leininger, 1997b). Srivastava and Leininger, state that as a matter of basic human rights nurse leaders and educators are ethically obliged to develop 'explicit philosophical statements, policies, curricula and education practices' related to the care of culturally diverse peoples (2002, p. 500).

Claims that the cultural safety model provides safe nursing practice for ethnic groups is as yet untested in New Zealand. A number of studies of refugee and immigrant health care in New Zealand's main centres indicate that nurses are unprepared to meet the needs of the diverse ethnic populations served (Lawrence, 2007; Lee et al. 2010; Mortensen, 2008; North et al., 2006). North et al.'s survey of the impact of immigrant patients on primary health care services in Auckland and Wellington show that health professionals believed that clients from ethnically diverse backgrounds expressed their concerns, symptoms, and pain differently from other patients. Health practitioners reported that understanding the presentation of symptoms is central to diagnosing, and providing adequate treatment. Two-thirds of the respondents in the survey were nurses, less than half had received any training related to the care of CALD clients, and most expressed the need for cross-cultural education (North et al.). Mortensen's study of health service provision for refugee groups in the Auckland region found typically that the quality of care that refugee families received was inadequate compared to other groups. In the words of one nurse manager:

> *... [refugee] families don't get the best of services... But on the other hand, if they make a personal connection to someone in the practice, they might get more than what others might get ... (Mortensen, 2008, p. 209).*

In a newly opened general practice in Mt Roskill, Auckland, a suburb which is home to sizeable Somali, Afghan, Ethiopian and Iraqi and South Asian communities, a practice nurse commented that:

> *... we weren't prepared for that population. We were expecting completely different demographics and it wasn't 'til a few months later that we realised ... and didn't have the resources and the knowledge in all aspects, cultural, the whole thing ... (Mortensen, 2008, p. 191).*

There is a clear evidence base that developing an in-depth knowledge of and direct experience with ethnic groups does produce culturally competent care (Al-Krenawi & Graham, 2000; Betancourt, Green, Carillo, & Ananeh-Firempong, 2003; Brach & Fraser, 2002; Luna, 2002). Nurses and midwives need to have cultural knowledge and skills to work competently with clients who are from CALD backgrounds. Srivastava and Leininger rightly state that in relation to the care of diverse ethnic groups 'without a substantive knowledge base one cannot ensure safe, effective and quality' nursing care outcomes (2002, p. 500). There is compelling evidence for the efficacy of transcultural approaches to care because they can 'prevent nurses from placing clients in medical or nursing diagnosis categories or medical labels that fail to fit the cultural participants' (Leininger, 1997b, p. 22).

Cultural Safety Competencies for Registered Nurses

This section reviews the competencies required of nurses to provide culturally safe care to clients from CALD backgrounds in New Zealand. The concept of 'cultural competence' was first developed in the United States in health care to better meet the needs of an increasingly multicultural population, and in response to the growing evidence of disparities in the health of ethnic minority groups compared to other population groups (Betancourt et al., 2003; Brach & Fraser, 2002).

The Council (2009) *Guidelines for cultural safety, the Treaty of Waitangi, and Maori health in nursing education and practice* serve as the basis for the indicators of competence related to the practice of cultural safety for all ethnic groups in New Zealand. The 2007 *Competencies for registered nurses* provide the indicators that nurses are expected to demonstrate when practising "in a manner that the client determines as being culturally safe" (NCNZ, 2007, p. 13). The cultural safety competency indicators for nurses include:

> **Indicator:** Applies the principles of cultural safety to nursing practice.
> **Indicator:** Recognises the impact of the culture of nursing on client care and endeavours to protect the client's wellbeing within this culture.
> **Indicator:** Practises in a way that respects each client's identity and right to hold personal beliefs, values and goals.
> **Indicator:** Assists the client to gain appropriate support and representation from those who understand the client's culture, needs and preferences.
> **Indicator:** Consults with members of cultural and other groups as requested and approved by the client;
> **Indicator:** Reflects on his/her own practice and values that impact on nursing care in relation to the client's age, ethnicity, culture and beliefs, gender, sexual orientation and/or disability.
> **Indicator:** Avoids imposing prejudice on others and provides advocacy when prejudice is apparent (NCNZ, 2007, p. 13).

While the indicators for the competent practise of cultural safety identify some key attitudes and behaviours the list has limitations in terms of the knowledge and skills needed to provide culturally safe care for CALD groups. For instance, the 2007 *Competencies for registered nurses* does not address communication skills including the use of interpreters for clients who have little or no English language skills. For non-English speaking clients the ability to work effectively with interpreters is essential to client safety (Gray, 2007; Wearn, Goodyear-Smith, Everts, & Huggard, 2007). Nurses who can use interpreters effectively, and communicate cross-culturally are more likely to elicit accurate information, ensure that the client understands the result of tests and screening, and provide the client with information and instructions on medications, treatments and follow up.

Communicating effectively cross-culturally depends on the nurse's ability to gain rapport with the client. The ability to adapt to different verbal and nonverbal communication styles where the culture of the nurse is different to that of the client is another important skill needed to avoid misunderstanding and actions that may be unacceptable to the client. Using cultural assessment tools and the information gained in nursing assessments aids good client outcomes. Working with the client's cultural beliefs, values, and practices and applying this knowledge to nursing care plans is more likely to lead to client satisfaction with the nursing care offered.

Knowledge of the general beliefs, values, and health practices of CALD groups is important because these factors influence perceptions of health, illness and disease and families' expectations and interactions

with health care providers and the health care system. Knowledge of the social, cultural and religious factors that influence the perception communities hold with respect to health and illness are likely to lead to more successful health outcomes (Gany, Herrera, Avallone, & Changrani, 2006; Luna, 2002). The knowledge and skills described are not only about cultural safety, they also include what is required for the clinical safety of the client.

Conclusion

To return to the questions raised in the beginning of this article the following answers are given:

(a) *Have the guidelines provided culturally safe nursing (and midwifery) education and practice for CALD groups in health care?*

Nursing and midwifery in New Zealand have not yet developed education and practice that adequately addresses the care of the multi-ethnic groups served. Within the cultural safety model, a clear theoretical base is needed for the development of cultural safety practices for CALD groups. A tangible set of nursing knowledge and skills for the care of CALD groups needs to be added to the 2007 *nursing competencies.*

(b) Have the guidelines contributed to the provision of culturally acceptable health care for CALD groups?

New Zealand studies of Asian, refugee and migrant health have identified health professionals' lack of cultural knowledge and skills as a major barrier to accessible, safe and equitable health services. New Zealand studies have indicated as well that nurses feel unsafe and under- prepared for the care of their clients from ethnically diverse groups.

Ethnic diversity will continue to characterise the populations served by health care providers, in particular, in New Zealand's main centres. To improve the safety and quality of nursing care for CALD groups the following recommendations are made. First, within the 2009 guidelines clarify the theoretical base for the practice of cultural safety for groups from CALD backgrounds. Second review and revise the 2007 *Competencies for registered nurses* to include the knowledge and skills needed for the nursing care of CALD groups. Third, develop an evidence base for culturally competent care for CALD groups. Fourth, evaluate the impact and outcomes of culturally safe nursing care for CALD groups and incorporate the findings of evaluation processes into a review of competency indicators for culturally safe care for CALD groups; and last, develop nursing graduate, post graduate and CNE programmes which facilitate culturally competent practice for culturally and linguistically diverse groups.

Disclaimer Statement

The views expressed in this paper are the author's own and do not represent the views or policies of the Northern DHB Support Agency.

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