CULTURAL CARE IN NURSING:

A CRITICAL ANALYSIS

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CERTIFICATE OF AUTHORSHIP-ORIGINALITY

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of the requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature of Candidate

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To the nurses, who took part in the interviews for this study,

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To the international students, who have shared their world with me,

And to the patients, who have shared their lives

E haere rä

In memory of David James Moxon (1957 - 2009)

'Moxy' you were an amazing human being and an outstanding nurse

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ABSTRACT

The phenomenon of human globalisation has led to the creation of a new social world, one which is characterised by its cultural diversity. Health services constitute one of the most fundamental of social organisations, so with this change, has come a need for nurses to provide relevant and appropriate care to the multiplicity of peoples who now live in contemporary social communities. Providing appropriate nursing care today is demanding new skills of nurses and to ensure that they can meet this demand, new knowledge and understanding is required. To do this well, constitutes one of the greatest contemporary challenges facing nursing.

The aim of this study was to identify and analyse the theories and models of nursing that hold authority on and guide cross-cultural care giving in nursing. The thesis underlying this study was to respond to the question - when nurses have had access to cultural care theory and its related literature for some 30 years, why has this not, as yet, had a significant impact on nursing? The intent being to explore the genesis and development of the knowledge used to underpin cross-cultural care in nursing and by doing so assist nurses to better understand, in the fullest sense, the meanings that are being created and conveyed.

To achieve this, a qualitative methodology was employed to make possible the description and interpretation of existing theory with a critical approach being taken towards that text. Understanding and unmasking the theory revealed both overt and covert beliefs and ideas intrinsic to the discourse, which have the potential to shape and configure nurses' attitudes, opinions and perspectives. This research has considered, explored and analysed contemporary theories of cross-cultural nursing to provide clarification and enhance the capacity of nurses to gain a fuller understanding of cross-cultural care. It offers new insights into the viewpoints being advanced and opens up fresh possibilities for the development of a deeper understanding of Western scholarship on culture in nursing. The findings also identify areas for continued inquiry, which if focused upon and developed into the future, could contribute to improvements in nursing and greater understanding of the complex domain of cross-cultural care.

Chapter 1

INTRODUCTION

"If we do not dare to analyse the very institutions in which we work and the ways in which we and our colleagues are implicated in the reproduction of racism and the propping up of whiteness, then how can we move beyond theory at its most hollow. How can we move towards transformation?"
(Sherwood & Edwards, 2006, p189)

Background to the topic

Anthropologist Aruin Appadurai (1996) describes our modern world as one of intense globalisation, where "nearly everybody is a tourist, immigrant, refugee, exile or guest worker moving from one place in the world to another" (p 411). As a consequence of this, there is increasing cultural variability in many countries and communities. Australia is a country that it is distinguished by a tradition of continued and changing settlement. There are the original inhabitants, the indigenous peoples, as well as the more socially dominant Anglo-Australian population, descendants of the settlers who came here from Britain during the colonial era and, in more recent times, immigrants who have arrived from a range of countries across the globe. Today, Australia's population of 21 million people represents citizens who originate from more than 160 different countries, who speak over 200 languages, and practice 116 different religions.

Australia is now deemed a multicultural nation. Immigration, in the past few years, has contributed on an almost equal level with natural population growth: there is a new immigrant arriving in this county every two minutes. Projections into the future indicate that the current level of immigration will be maintained, if not increased. One in four Australians was born in or has a parent born in a country other than Australia (Australian Bureau of Statistics, 2007). In addition to the anticipated immigrant growth, there are numerous children of earlier migrants who, although born in Australia, are imprinted with their parent's cultural inheritance, which will guarantee an enduring social heterogeneity within Australia's population into the future. Multiculturalism requires that each culture is considered equal to the other and cultural diversity is tolerated and respected (Francis, 1999; Brannigan, 2000). Such a complex social

landscape has created an obligation for all Australians to better understand their own individual identity as well as their collective identity.

The social environment within which nursing takes place in Australia is necessarily also multicultural (Jackson, Brady & Stein 1996). This should drive a need for nurses to develop a deeper understanding of cultural diversity, because of its potential impact on the provision of nursing care specifically and the implications for healthcare generally. Historically, nursing care in Australia was provided by nurses of Anglo-Saxon origin and today nurses work in a healthcare system developed during the era of British colonisation which has an enduring tradition embedded in Western values and ideology. It has become apparent in recent years that growing cultural diversity has challenged many of the long-established assumptions about health, illness and health care provision. However, Bryant, Foley and Percival (2008) assert that regardless of "years now, of having large populations of different ethnic groups within Australia, the mainstream health care system is still largely geared to an homogenous Anglo-Saxon consumer base" (p10).

It continues to be challenging for nurses in Australia, and other Anglocentric countries, to find ways to accommodate the divergent and often unfamiliar social beliefs, values and life practices that have now become a part of the new social fabric of their communities. Nursing scholars and clinicians across the Western world identify and articulate a need to develop greater understanding about cultural care capacity, but they remain unsure about how to increase their knowledge of and ability to work with ethnically and socially diverse patient groups (Murphy & MacLeod, 1993; Bond, Kardong-Edgren & Jones, 2001; Grant & Letzring, 2003; Sergeant, Sedlak & Martsolf, 2005; Allen, 2006). The capacity to provide appropriate cross-cultural care must become an essential attribute of contemporary nursing practice. If nurses are to be effective in meeting the needs of their patients, nursing practices must be better informed and modified to address a wider cultural range of patients. The achievement of this is the new challenge facing nurses, one which nursing theory purports to answer and is the issue that this thesis will explore and respond to.

Nursing is a profession that engages at its most fundamental level with individuals, their families and communities, (Allman, 1992). The provision of nursing care is a significantly social activity. Nurses are in frequent and close contact with others and all nursing activity requires a high degree of interpersonal communication (Pallen, 2000). Nurses need to know how to

effectively relate to and interact with those patients in their care. Nursing is linked to physical, technical and social behaviour: "nurses need to know what to do with clients, how to do it and know how to be while they are doing it" (Stein-Parbury, 2008, p3). To attain positive outcomes when working with patients from a diverse range of cultural backgrounds, nurses must develop their understanding of that complex cultural diversity and accommodate it within their practice (Greenwood, 1996).

To accommodate cultural diversity in nursing, various cultural care theories have become a mandatory curriculum requirement in all undergraduate programs of nursing offered in Australian universities and schools of nursing. However, there is no single national approach and education providers have been required to exercise their individual judgment in choosing how to integrate cultural care teaching into the curriculum (National Review of Nursing Education, (the Commonwealth Department of Education, Science and Training, (NRNE), 2002). Whilst the establishment of standards regarding cross-cultural practice in the workplace are now in place, the introduction of a formal national philosophy and set of principles is still required and has not occurred to date.

In further support of this process, the peak Australian nursing bodies have instigated changes to governing policy by altering regulatory and professional standards which mandate that a nurse's practice must be culturally inclusive (Australian Nursing and Midwifery Council, 2003). This is an in principle acknowledgment of the requirement for the nursing workforce to be better prepared for coping with cultural diversity. However, apart from the general agreement that culturally-specific care is required by patients, and should be addressed by nurses, there is little general consensus on what this actually means, what form it should take, how it may be achieved or how its achievement may be assessed or measured (NRNE, 2002). The approaches to be adopted for use in education and the practice environment, or the 'how and in what way', seem even less certain. Evidence shows that questions are being asked and concerns voiced by nursing scholars and practicing nurses about the way that cross-cultural care is currently conceptualised, interpreted and practiced in nursing (Culley, 1996, 2006; Meleis, 1991, 1996, 1999; Baker, 1997; Duffy, 2001; Anderson & McCann, 2002; Anderson, et al, 2003; Gustafson, 2005, 2007; Lancellotti, 2008; McMurray, 2009; Racine, 2009; Reimer-Kirkham, Varcoe, Browne, Lynam, Khan & McDonald, 2009).

Of particular concern in Australian nursing practice is the presence of racial and cultural discrimination. As Dr Sally Goold (2001), Chairperson of the Congress of Aboriginal and Torres Strait Islander Nurses, unequivocally states: "Racism, prejudice and discriminatory practices are alive and well in nursing and the health care system in general" (Goold, 2001, p94). Henry, Houston and Mooney (2004) claim that Australian "health services are institutionally racist" (p157). Wilson and Neville (2008) advance this further by stating that, "despite the rhetoric, the intrinsic concepts informing nursing practice it is not always reflected in the practice of nurses. Vulnerable and marginalised populations are typically disenfranchised when they use healthcare services and their health needs are not always met" (p166). Johnstone and Kanitsaki (2009) describe the way in which "racism *per se* and its harmful consequences in healthcare domains have been largely ignored" in Australia and, for the most part, remain unaddressed at both an individual and institutional level. They stress that, "in the interests of patient safety and quality care, it is imperative that stakeholders redress this oversight" (p64).

Reilly and Perrin (1999) describe the gradual move toward a cross-cultural approach to nursing practice in Australia as a deep form of change. It is a change that "entails passing through zones of uncertainty, the situation of being at sea, of being lost or confronting more information that you can handle" (p1). Such bewilderment characterises, as this thesis will demonstrate, the current position of nursing in Australia towards providing adequate and appropriate cultural care. There is a growing need for a suitable knowledge base that encompasses the requirements of education, research and practice.

The intention of this thesis is to provide an account of the steps that Australian nurses have taken and continue to take on the journey towards accommodating cultural diversity in care giving and nursing work. This thesis seeks to offer nurses a thorough and credible examination and critique of existing cultural care theory and practices of inquiry. This thesis is aimed at exploring alternatives, at better informing nurses and assisting the drive towards attaining high standards in an industry-wide culturally inclusive nursing practice

Aims and significance of this thesis

This brings us to the key question that underpins this thesis:

When nurses have had access to cultural care theory and its related literature for some 30 years, why has this not, as yet, had a significant impact on nursing?

Despite a philosophical commitment to the promotion of cultural care theory, with theory and educational programs designed and readily available to promote such skill in practice, very little real change has taken place (Johnstone & Kanitsaki, 2005, 2009; Parker & McMillan, 2007). This thesis will respond to that issue by undertaking a substantial literature review to re-evaluate the relevance and value of the cultural care theory currently informing nursing education and practice.

It has been claimed by numerous nurses that current cultural theory has not been explored or significantly challenged to any extent or depth (Bruni, 1988; Ridler, 1993; Thomas & Dines, 1994; Mulholland, 1995; Culley, 1996; Meleis, 1996; Baker, 1997; Holmes & Warelow, 1997; Horsfall, 1997; Polaschek, 1998; Spence, 2001; Duffy, 2001; Anderson & McCann, 2002; Blackford & Street, 2002; Browne & Smye, 2002; Reimer-Kirkham & Anderson, 2002; Anderson et al, 2003; Hart, Hall and Henwood, 2003; Gustafson, 2005; Culley, 2006; Hassouneh, 2006; Jirwe, 2008; Lancellotti, 2008; Khalafzai, 2009; Racine, 2009).

Although the issues related to culture and health care in nursing are similar to those faced by the medical and allied health professions, this thesis will be specifically concerned with nursing. As Shields (2004) explains, “Our knowledge defines what we do as nurses, our knowledge gives us singularity as a profession, it is what makes us different from other health sciences” (p2). This thesis will explore cultural care in nursing by posing epistemological challenges to the ‘expert’ knowledge that is currently informing nursing practice. This thesis is one in which long held understandings about culture will be questioned and by doing so it will offer nurses an opportunity to think about and become more aware of culture as being profoundly influential in determining the effectiveness of their practice. Because of the significant requirement for cross-cultural care in nursing, it is important that knowledge about cultural care is sound and well constructed and any claims made are trustworthy. In undertaking this deeper exploration of cultural care in nursing, it is intended that this thesis will contribute to a greater depth of discipline-specific understanding regarding the phenomena of cultural care.

The practice of nursing does not occur in isolation and for this reason the healthcare system within which nurses' work constitutes an important site for examination within this thesis. Healthcare is a social institution which has been built from the cultural perspective of the society that it serves. Clinical encounters take place against a background of social, political, economic and ideological systems that have an effect on interactions within this setting (Browne & Smye, 2002). Nurses as frontline healthcare providers are the professionals who will likely spend the greatest amount of time with patients, and they are often the only practitioner that a patient will interact with on an interpersonal level (Healey & McKee, 2004). When services are delivered in a manner that addresses individual cultural preferences and needs, such services are received and utilised in a more effective manner. Developing greater capacity to anticipate and attend to the cultural needs of patients will improve the quality of service, contribute to more positive outcomes, increase health gains and enhance patient satisfaction (Goode, 2007).

However, individual nurses practicing to a high level of cross-cultural care will still confront institutional practices, conventions and behaviours that constitute systemically constructed barriers to effective practice. The nursing profession must increase its capacity to understand and work with cultural difference within these large and possibly inflexible systems (Johnstone & Kanitsaki, 2005). Because of the significant effect that the healthcare system will have on nurses' practice, this thesis will also explore issues related to human rights, equity, institutional traditions and will explore relevant associated topics such as institutional racism, power, professional domination and the cumulative consequences of such practices.

The findings of this thesis will have significance for both nursing knowledge and practice. The value lies in its capacity to advance nurses' knowledge and understanding of cultural care which will, in turn, advance capacity in this area. The findings of this thesis will offer nurses the opportunity to improve patient outcomes, contribute to the development of teaching in nursing education and will provide the basis for further research. Furthermore, this will offer new ideas for nurses to consider, which will support them in developing their own and others' practice.

Culturally constructed understandings are fundamental to both patients' and nurses' conceptualisation of what constitutes appropriate health and illness care. Beliefs, values, attitudes and perceptions are increasingly being identified as fundamental to securing positive

nursing service outcomes (Kanitsaki, 1983, 1993a, 1993b; Papps and Ramsden, 1996; Omeri, 1996; Searight, 2003). Patients who represent those outside the cultural 'mainstream' are both articulating and demonstrating that they have poor quality experiences with nurses. Negative outcomes are being documented as the result of these less than positive interactions with nursing service providers (Leininger 1970, 1978, 1995; Idrus, 1988; Jacks, 1993; Ramsden, 1993; Gorman, 1995; Canales & Bowers, 2000; Kanitsaki & Johnstone, 2004).

Nurses to date have demonstrated a low level of understanding and a lack of awareness about the significance of the needs of those patients who belong to vulnerable groups, which includes those who are members of minority ethnic groups (Leininger, 1978; Andrews, 1992; Andrews & Boyle, 1995, 1997; Goold, 2001; Browne & Smye, 2002; Johnstone & Kanitsaki, 2005; Wilson & Neville, 2008). Minority ethnic group patients have few advocates and whilst physical harm can be measured objectively and is uncommon, it is more difficult to quantify the subjective harm that is being experienced by such vulnerable groups.

It has been argued that the current focus on culture where it is characterised in terms of ethnic heritage alone may disregard more complex definitions which take social structure and socially mediated processes into account. Conceptualising culture by ethnicity also increases the probability for the social construction of disparity and inequalities related to difference and particularity and leading to marginalisation and discrimination (Meleis, 1996; Bent, 1999; Ramsden, 2002; Harrison & Falco, 2005; Lynam, 2005; Yosso, 2005; Allen, 2006; Blondeau, 2008). Reimer-Kirkham and Anderson (2002) contend that nursing must now begin to express a more contemporary approach towards defining culture in that "we have come to realise that our nursing scholarship needs to look beyond individual experiences of health and illness to encompass the social foundations that determine health status to a large extent" (p2). This thesis will, as a response to such criticism, undertake an in-depth analysis of the socio-political and the structure of social institutions and the role of nurses within such systems.

It is put forward, in this thesis, that the current notions of cross-cultural care need to be re-visited and re-examined. They are outdated and have been informed by traditional nursing models, based upon an anthropological framing of culture that renders it static and rigid. The traditional model asks that nurses learn *'facts'* about an ethnic group, which they apply to patients from that group. It assumes that the nurse is from a Western cultural heritage and positions the patient as the 'Other', as the one who is different, which can be demeaning. The

power is currently, in the hands of the nurse, not the patient. This thesis is driven by a recognition that this type of cross-cultural theory urgently needs to be updated and re-developed to make sure that it meets the needs of contemporary society and contemporary nurses.

A short summary of cultural care theory used in nursing

Ideas about cultural care in nursing constitute a relatively recent field of inquiry; such literature has only appeared in any significant volume over the last 40 years (Andrews & Boyle, 1995; Gustafson, 2000). Without doubt, there was always an awareness of the social world in which the culture of the patient was embedded: the patient's beliefs, values, knowledge and attitudes have always impacted on and influenced health and illness experiences and nursing care. Prior to this new and increasing globalisation, however, the patient was more likely to share the culture of the nurse and problems such as we face today would have been less common. Today's nurses need to think more deeply about how culturally based differences will have an impact on the provision of care. A nurse will now encounter daily a multiplicity of diverse and different life views held by their individual patients and they must learn how they might best provide care to those patients, who are increasingly likely have a very different worldview or culture to themselves.

Theory specifically concerning culture and nursing was first seen in the 1970's in the work of the nursing anthropologist Madeleine Leininger. Leininger's theory of cultural care has been extremely influential in shaping contemporary understandings about culture and nursing. The review of literature in this thesis will establish that Leininger's theory of cultural care diversity and universality, from which came transcultural nursing, constitutes the seminal work of influence in nursing knowledge informing both practice and pedagogy (Leininger, 1966, 1967, 1970, 1977, 1978, 1981, 1984, 1988a, 1988b, 1990, 1991, 1993, 1994, 1995, 1997, 1998, 2002, 2008). Leininger's theory is an anthropologically based model, where the belief systems from other cultures were learnt by nurses and applied to nursing care. From its beginning, transcultural nursing has existed within a framework of race and ethnicity, it was originally developed for the predominantly Anglo-European nurses of America to better understand the health beliefs of immigrant cultures and so anticipate the care needs, of groups from cultures other than their own. A body of knowledge has been built up and maintained over time which

contains the different cultural nuances, values and beliefs embedded in different ethnic groups and this is then used by nurses and can be relied upon to guide their practice. The goal of transcultural nursing is to provide "culturally congruent, sensitive and competent nursing care" (Leininger, 1995, p4).

Whilst globalisation was apparent some time before the appearance of Leininger's theory, it has been argued that nursing has been slow to develop an in-depth knowledge of the impact of cultural diversity on care provision because it has historically been grounded within a biomedical rather than a socio-cultural model (Traynor, 1996). Leininger's work was originally developed for application in the United States of America as a consequence of the growth in minority ethnic groups and the impact she perceived this had on the practice of nursing. Western nations have been at the forefront of cultural theory development because, as wealthier, developed countries, they are the preferred destination for many migrant groups.

Leininger's original concept has been further developed and hybridised by others (Camphina-Bacote, 1994, 1998, 2003, 2006, 2008; Andrews & Boyle, 1995 1997, 2007; Chrisman, 1998; Purnell & Paulanka, 2003; Price & Cortis, 2000). Leininger's work is also used in Canada (Leininger & McFarlane, 2002; Geiger & Davidhizar, 2003) and in the United Kingdom (Papadopoulos, Lees, Lay & Gebrehiwot, 2003). Transcultural nursing theory is increasingly evident in nursing literature from South East Asia, the South Pacific and the Middle East (Chang, Chi Man Yuen, Kit Bing Ho & Hatcher, 2003; Kawashima, 2003; Mebrouk, 2008; Doumit and Abu-Saad, 2008). Australian nurses have, in the main, utilised Leininger's theory as the model of choice within nursing education programs nationally (NRNE, 2002).

The only other major body of cultural care knowledge or theory evident in the literature is the work of New Zealander Irihapeti Ramsden, entitled 'cultural safety', (1989, 1990, 1993, 1995, 1996, 1997, 2001, 2002). Cultural safety is centered on the "notion of the nurse as a bearer of his or her own culture and attitudes, and who unconsciously or consciously exercises power" (Ramsden, 2002, p109). The cultural safety model went further than studying the cultural 'other' and avoided the teaching of ethnographically derived knowledge(s) such as the life ways of specific ethnic groups. Cultural safety has become concerned with social justice and "quickly came to be about nurses, power, prejudice and attitude rather than the ethnicity or cultures" of patients (Ramsden, 2002, p5). Cultural safety is primarily focused on the nurse as the bearer of their particular personal culture which might differ from and impact on the

recipient of care, the patient. Cultural safety offered an alternatively grounded cultural theory to Leininger's, in that it arose from the indigenous voice, rather than from Anglocentric scholarship. This theory too has captured some international attention and has been utilised in Canada and to a much lesser extent in Australia (Smye & Browne, 2002; Williams, 2002; Anderson et al, 2003; Stout & Downey, 2006). Cultural safety has, however, been predominantly utilised within the New Zealand context. Notably, New Zealand is one country that appears to disregard transcultural nursing theory (Cooney, 1994; Coup, 1996; Leininger, 1997; Ramsden, 2002).

'Cultural competence' is another term that is gaining increased prominence in international healthcare literature (Stewart, 2006). Originally associated with Leininger in nursing literature, cultural competence has now emerged as the 'modern mantra' for all health professionals where regulatory bodies have sought to apply standards to practices around cross-cultural care (Dreher & MacNaughton, 2002). This term has been taken up by a range of countries, particularly those with significant immigrant and indigenous populations. A review of the literature indicates that there is no universal description of cultural competency that its application is more regulatory than theoretical and it borrows meaning from any number of intellectual frameworks (Betancourt, Green, Carrillo & Park, 2005; Stewart, 2006; Goode, 2007; National Aboriginal Health Organisation, 2008). As cultural competency is not a specifically nursing theory and is not utilised in nursing education, research or practice in Australia at this time, cultural competence will not be explored in this thesis.

The new focus on cultural diversity, and the theory which has arisen in relation to it, has opened up important dialogue about culture and the way nurses might come to understand and deal with such concerns. There are positive and negative aspects to the theoretical models of cross-cultural care currently being used by nurses. On one hand, cross-cultural theory provides nurses with an increased awareness of human diversity and its significance in healthcare provision. On the other hand, the current theory has been criticised for compounding the problems it sought to address. Critics have argued that it is replete with generalisations, offers a limited definition of and perspective on culture, has a bias towards ethnic identity, initiates stereotyping, reduces cultural knowledge to a list of superficial labels and facts and collectively homogenises individuals from particular cultures into a conglomerate entity (Wilkins, 1993; Culley, 1996, 2006; Meleis, 1991 & 1996; Baker, 1997; Duffy, 2001; Anderson & McCann, 2002; Anderson, et al, 2003).

Some limitations on interpretation relevant to this thesis

It is important to note here that the body of knowledge utilised in developing this thesis has particular restrictions and limitations. Nurses from Western countries dominate the literature on cultural care in nursing and their conceptualisations of what culture might mean has become the voice of nursing internationally. It is important to state that this literature has a bias: these are purportedly universal views, but they are in reality, created, understood and legitimised fundamentally only by Anglocentric world (Herdman, 2001; Sherwood & Edwards, 2006).

Most of the textual material used in this thesis was generated within the accepted wisdom and scholarly traditions of the Western academy; white, Western, English speaking authors have generated much of the available material and have tended to speak on behalf of those other cultures they purport to represent. Authors from non-English-speaking and non-Western countries are less likely to publish in international nursing journals. Most recognised text in nursing is predominantly published in English, limiting access to non-English-speaking authors. Furthermore, material generated outside a narrow range of countries — the USA, UK, Canada, Australia and New Zealand — is usually less available and often considered to be less legitimate or authentic by historical precedent than those ideas developed by the White Anglocentric authors (Ramsden, 2002; Santos-Salas, 2005; Allen, 2006; Gustafson, 2007).

Those nurses more on the periphery of the knowledge generating world of nurses, such as Africa, Asia, the Asia-Pacific, Indonesia, India, the Middle East or South America, for example, are rarely held in high esteem by the Western world, or perceived as legitimate foundation builders in the construction of nursing knowledge. These, however, are the people, the cultures and the countries that are the focus of cross-cultural information in nursing (Davies, 1999; Kikuchi, 2005; Santos-Salas, 2005; Culley, 2006). Rarely are their voices heard, more often they are those 'spoken about' by the knowledge builders, the Western nursing theorists. Absolon and Willet (2004) describe how "today we face the fact that Euro-western theories remain safe guarded and upheld as superior sources of knowledge and analysis in text … they feverishly resist any loss of power and authority erecting even more barriers and moving the goalposts further along in an effort to exclude and isolate " (p11).

A central construct of this thesis: 'what is culture?'

As the meaning ascribed to the term 'culture' will have a profound influence on what follows, it is important to clarify the way in which culture will be conceptualised for the purpose of this thesis. Characterisations which explain the term culture are situated in a domain where a number of different interest groups have attempted to assert meaning and these need to be better clarified (Laugharne, 1995). In addition, as part of the scholarship on culture, there is a growing contemporary and innovative dialogue that has originated within a number of disciplines, including anthropology, indigenous, ethnic, cultural, queer and postcolonial studies which will be discussed in this thesis and which will bring to the field new ideas that are yet to be fully considered and appreciated by nurses (Gustafson, 2005; Culley, 2006; Blondeau, 2008; Browne, Varcoe, Smye, Reimer-Kirkham, Lynam & Wong, 2009; Racine, 2009).

Determining exactly what is meant by the term culture, in all the different contexts in which it is employed, can be challenging. As Barker (2005) tells us, "there is no one single correct definition of culture — culture is not 'out there' waiting to be correctly described by theorists" (p35). Marcus and Fischer's (1986) suggestion that "any discussion of current intellectual trends will be weightless and unconvincing if they do not concern themselves with the situation of their particular discipline" (pvii) is helpful here. Such a convincing recommendation will guide this thesis and any discussions of the meaning of culture will predominantly be restricted to those interpretations that have been utilised within nursing.

Finding a precise definition of the term culture as represented in nursing literature indeed proved difficult (Gorman, 1995; Reimer-Kirkham & Anderson, 2002; Browne & Smye, 2005). The term culture appeared to be freely applied across a broad range of descriptions, such that determining a definitive or distinct meaning was not always possible. Culture was used freely within any number of contexts and applied to any person or persons indiscriminately. It was used to describe, for example, race, ethnicity, any type of diversity, to those with differing national origin, to any number of life-ways, to all designations of 'otherness', it deemed multiculturalism as a collective and seemed to apply to any given group of loosely affiliated individuals (Leininger, 1966, 1978, 1991; Kringas, 1986; Kanitsaki, 1988; Cameron-Traub, 1993; Omeri, 1996; Ramsden, 1990, 1993; Holmes & Warelow, 1997: Hibler, 1997; Wepa, 2005).

As well as these uses, there were formal theories and models which conceptualised the provision of culture in terms of nursing care and used the term culture in a broadly encompassing sense, for example transcultural nursing, which employs ethno-nursing and cultural competency (Leininger, 1970, 1978), cultural safety (Ramsden, 1989, 1990, 2002), cultural intelligence (Earley & Ang, 2003), cultural security (Thomson, 2005), culturally responsive care (Johnstone & Kanitsaki, 2005) and cultural sensitivity (Benson, 2006).

There was also yet another variance in definition where the same or similar characteristic was in one instance individual and in another collective. For example, where a characteristic was deemed to be cultural yet was also unique to an individual, such as a particular belief or religious/spiritual understanding. Yet again, culture in other instances referred to a collective identity associated with groups of people and defined by those same, shared attributes, for example shared religion or ethnic origin, as in all Buddhists or all Vietnamese immigrants (Billington, Strawbridge, Greensides & Fitzsimmons, 1991).

The real stuff of culture in any of its meanings, which seem to be used in any number of ways, is confusing, paradoxical and unclear, permitting a number of possible interpretations (Spence 2001). However, as Razack (1998) identifies, the definitions of culture that seemed to have the widest usage were those which implied that culture was the "values, beliefs, knowledge and customs that exist in a timeless and unchangeable vacuum outside of patriarchy, racism, imperialism and colonialism" (p58). Leininger (1970) wrote in this way when first describing culture to nurses as "a way of life belonging to a designated group of people" (p48). It is clear that such an approach continues to be utilised today as a number of nurses (Andrews & Boyle, 1997; Chalmers & Allon, 2002; Bond, Kardong-Edgren & Jones, 2001; Wepa, 2005, Douglas & Lipson, 2008) all exemplify this type of definition in their work.

Culture, as it has come to be defined within nursing literature, is also characterised by the idea of difference or being different. Such an approach was established in Leininger's early (1970) work where she states: "the more obvious the cultural differences are between particular cultures, the more clearly one can appreciate and understand the relevance of culture" (p49). Leininger's work, however, was focused specifically on the beliefs, practice and values of particular ethnic groups other than her own. In over 40 years she has not observed, scrutinised or categorised her own social group or determined its cultural characteristics as distinctive of a particular ethnicity (Culley, 1996).

McConaghy (1997) also describes how assumptions seem to be made when stereotyped representations are used as the primary analytical tool for understanding differences across various groups of people. Price and Cortis (2000) discuss the way that "culture evokes any and all differences that distinguish life in one social collective from life in another" (p236). In effect a binary has come to be created between one culture and another culture. Ahmad (1993) cautions about this and states that such conceptualisations may lead to an unintended comparison being made, where one group becomes constructed and perceived as normal or superior to the other. Browne and Varcoe (2006) also suggest that "others are considered culturally different — with the reference for judging differences being the dominant cultural norm" (p155). Ramsden (2002) recognised this when she commented: "People evaluate and define members of other cultural groups according to their own norms. When one group far outnumbers or has the power to impose its own values upon another, a state of imbalance occurs which threatens the identity, security and ease of other cultural groups" (p111). What is held up as legitimate, logical and valid nursing knowledge today is invariably engendered from within the Western way of knowing, being and doing.

Using such an approach had led to cultural or ethnic traits being differentiated and 'measured' and people labelled according to their particular physical characteristics. Arbitrary ethnic or racial categories are assigned, which lead to people being defined according to such labels (Agnew, 2005). Leininger (1978) speaks in terms of "identifying the local or indigenous people's viewpoints, beliefs and practices" (p15) and Andrews & Boyle (1995) describe the act of collecting cultural data. McConaghy (2000) also cautions that "frequently these images and stereotypes ... objectify and dehumanise" (p83). Browne and Varcoe (2006) also express that culture has been portrayed in the literature of nursing as "fixed and static" (Browne & Varcoe, 2006, p155).

For the purposes of this thesis, I will lean upon Figes' sense that...

"Culture is more than a tradition ... it is something visceral, emotional ... a sensibility that shapes the personality and binds that person to a people and a place" (Figes, 2003, p583).

This open, fluid and esoteric definition was chosen as a guiding statement for this thesis, as culture today can be personal or shared and universal all at the same time. It was important in

this thesis for culture to have a new and innovative definition that moved meaning to a fresh purposefulness beyond limiting the narrow and constraining traditional construct which this work claims is inflexible and fixed. This definition was chosen because there are many ways to come to know culture and to create and convey that meaning. Figes' (2003) definition reflects a more contemporary meaning, one which represents the mobile and changing nature of people, one which speaks of those who might be from one national or ethnic origin but have adopted another and which represents the experience of the many who now shift and change in new contexts and under their different circumstances.

To capture culture, as a notion, as a 'real' idea with distinct meaning and to then interpret, understand and apply this knowledge to the practice field of nursing in Australia, which takes place within a social world, was the work of this thesis. It has not been without its difficulties or challenges and it seemed at times a work without end but, whilst this thesis has a conclusion, the hope is that it is merely a beginning. The beginning of a journey where nurses will continue to inquire, question and challenge and be part of the continuing evolution and maturing of the way in which nurses understand culture within their work.

Organisation of the thesis

This first chapter has provided a broad framework for this thesis and the following chapters are structured as follows:

Chapter Two will outline the philosophical approach and pragmatics of the methodology. It will clarify the underlying framework used in analysis and describe the method and design chosen which constitutes the central organising approach taken towards the textual material. The process of participant interview will also be outlined as well as ethical concerns and issues of conceptual rigor and trustworthiness around the conclusions drawn.

Chapters Three a***nd Four*** will describe and critically review the influential theories of transcultural nursing: the 'cultural care' theory of Madeleine Leininger and the 'cultural safety' theory of Irihapeti Ramsden. These are recognised internationally for their significant contribution to the field of cross-cultural nursing. Discussion of these key theories will involve a consideration of their origins and intent, examination of their key constructs and strengths

and weaknesses. A discussion of the observations of other nursing scholars on the usefulness or otherwise of these theories in the practice of nursing will be included.

Chapter Five situates this study within the context of nursing in Australia. This chapter will describe why cross-cultural care is important in Australia, the scholarly foundations underpinning cross-cultural care in Australia and the contribution of Australian scholars. National policy and regulation frameworks and the contribution of nursing education in developing the current approach to cross-cultural care will be described and considered. Indigenous concerns unique to Australia will be highlighted and taken into account. This chapter will also reflect upon the key issues regarding future nursing and cultural care in Australia.

Chapter Six will consider the contemporary debates, tensions and challenges around the established theories of cross-cultural care. It will draw on the new knowledges that have the potential to reinform the current position of nursing. Issues discussed include those related to ideology, ethnicity, racialisation, discrimination and whiteness and ethnocentrism. The socio-political context in which nursing takes place will be considered and explored in light of the way nursing takes place within the broader social institution of healthcare. This chapter will also present the opinions and observations of participant nurses who were interviewed to gain insights into the current situation of cultural care theory in Australasia.

Chapter Seven offers the findings and conclusions drawn from the collective work of the thesis. It will also offer suggestions for future consideration in this field of inquiry and has implications for the scholarship, research and education of nurses.

Chapter 2

PHILOSOPHICAL APPROACH AND PRAGMATICS

"The task for scholars is to find ways to apprehend and re-present different representations to achieve fuller knowing"

(Sandelowski, 1993, p3)

This chapter is presented in two parts: the first will outline the general methodological approach taken in this study and the second describes the more practical processes associated with method, such as the collection and analysis of literature, the undertaking of participant interviews and a consideration of ethical issues.

The goal of this study was to develop an in-depth understanding of the body of knowledge that represents the theory of cultural care in nursing. Theory is considered to be those bodies of work which are used to describe a range of perspectives that constitute a "conceptualisation of some aspect of nursing reality communicated for the purpose of describing phenomena, explaining relationships between phenomena, predicting consequences or prescribing nursing care" (Meleis, 1997, p12). The importance of established theory in guiding nursing is acknowledged, but at the same time, the merit of remaining open to new ideas and having a willingness to explore alternate points of view must also be recognised as important. The intention of nursing theory is to advance nursing practice. However, this may not have been as helpful in furthering the interests of nursing as was originally intended (Jonsdottir, 2001).

PART 1 – The methodological approach

Introduction …

It was essential to have a research approach that was congruent, or 'in tune', with the aims of this study and aligned with its exploratory intent. This study needed to be undertaken in a way that would make possible description, interpretation and analysis of theory and also facilitate a

questioning of the many different theoretical viewpoints that come together to represent the discourse of cultural care in nursing.

Qualitative description is a methodology that has been especially useful for researchers wanting to know the 'who, what and how' of a phenomena. A broad qualitative approach, as described by Sandelowski (2000), entails the presentation of the facts of the case in everyday language and which offers a comprehensive summary. The mandate for the researcher is to comprehensively and accurately detail these summaries "primarily as end products" but "secondarily, as entry points for further study" (Sandelowski, 2000, p339). It was deemed to be the most appropriate to use because of its essential interest with understanding the way that knowledge is both produced and understood by people and grounded in history and context. In general, qualitative research is social research, as it relies on textual data to understand the meaning within human accounts. Such an approach offers the opportunity to provide "largely straight and unadorned answers to questions" (Sandelowski, 2000, p337).

Researchers conducting qualitative descriptive studies do not "resort to methodological acrobatics" (Sandelowski, p335) but stay close to their data and to the surface of words through the use of diverse but reasonable combinations of data collection, analysis and re-presentation techniques. All inquiry requires description and all description inevitably involves interpretation. However, all research depends on the selections, perceptions and insights of the researcher. There is an increasing acknowledgement that choice of method and the choice of research question are influenced by the assumptions of the researcher. Understanding the researcher as a 'research instrument' in terms of their own history and approach is very important.

Why this thesis — the personal and its place in this study

The study is also centred in the interpretive skills of the researcher and aimed at gaining understanding rather than in measuring. The extent to which a researcher participates in their own research varies in degree but it is inevitable that the author's viewpoint is present in any research project. Unavoidably, one's own views and ways of seeing the world trickle intrinsically into the writing endeavour. Brewer (1994) advocates the need for researchers to

be reflexive and "to give attention to the social processes that impinge upon and influence" them (p223).

There are different ways of acknowledging or dealing with this and I have chosen one advocated by Abby (1995) who claims that we "should all begin a study knowing who we are and why we chose to study a certain problem" (p65). To this end, I have tried to set out where my interest derives from and in doing so recognise and acknowledge my own particular perspective. This section is intensely personal and somewhat emotional, but that is in the nature of such reflection and these are the experiences that have led to my undertaking of this study.

My motivation to undertake an in-depth study of culture and the way in which it might be taken into account in nursing has come from my experiences. My experiences constitute those of providing care to a diverse range of people: to patients in my role as a registered nurse, in my involvement in teaching cross-cultural care to student nurses and from lending personal support to international nursing students. I have observed, listened to and thought about the interactions between nurse and nurse, between nurses and patients and across the interdisciplinary team. I have contemplated at length how nurses, including myself, have acted and reacted and have wished to understand and know more about the intercultural relationship.

For me, the values of nursing were the preserving of an individual's fundamental human rights, respect for the beliefs and life ways of individuals and communities of people and safeguarding the interests of others in a perceptive, insightful and appropriate manner. Regrettably such ideals were not always achieved by me or by those with whom I worked. Although we tried, we were often unsuccessful and some nurses seemed neither to share these values nor even appreciate them as important. I had always wondered if personal values and beliefs impacted on the relationships that nurses formed with others, despite the rhetoric and façade of 'empathetic care and positive regard' that was allegedly underpinning nursing work.

I am a nurse of Pakeha (non-Mäori) ethnicity, originally from New Zealand, and have been closely involved with the introduction of cultural safety into nursing in that country. I was part of a group working closely with Irihapeti Ramsden and Mäori nurses in the early years of change, where we were instructed, and instructed others, about the need to provide care that

was culturally safe, an undertaking shared between New Zealand's Indigenous and Pakeha nurses. I was a participant in the national government inquiry into the teaching of cultural safety and took part in the development of standards and policy around its practice. These experiences awoke in me a sense of curiosity and this led to a desire to understand such issues in more depth.

I have often worked closely with indigenous and international immigrant patient populations and with nurses and student nurses also from those communities. The people I met and my interactions with them, the way and willingness with which they shared their understandings, thoughts, feelings and their worlds with me have changed my perspective and my ideas, albeit accompanied at times with much thinking, questioning and personal challenge on my part. Becoming and being culturally appropriate and 'in the moment' has now become an 'ordinary' and taken for granted part of my practice as a nurse and as a teacher of nurses. I have learnt and will continue to learn about culture and the importance of this to me as a person and as a nurse.

Some 10 years ago I moved to Australia and, as my new country was geographically close to New Zealand, I assumed professional life would be similar. I was to find my experiences in nursing very different to those I had previously known. I had assumed, naively perhaps, that working in the multicultural society of Australia, with its significant ethnic mix, I would begin to learn new and innovative ways of working with patients and students of nursing who had very different ways of 'doing and being' to my own. I was unprepared for the inadequate and unacceptable health care experiences both verbalised by patients and played out in 'front of my eyes'. The health-illness outcomes statistically demonstrated in this country's indigenous and minority ethnic and immigrant populations were simultaneously confronting and chilling. If nurses had a genuine concern with the health and wellbeing of people, then how was it acceptable for a sector of the population to be so disadvantaged and marginalised in quality of life and yet over-represented in morbidity and mortality statistics?

It was a disquieting discovery to realise that, in Australia, providing culturally safe care or even considering culture to be an element of importance to nursing or the work of nurses did not seem to be, as yet, a priority for Australian nurses. In my work as a nurse in Australia, I saw patients from ethnic minority and new immigrant groups unmistakably denigrated and marginalised. Open expressions of racism were often shared with me. I imagine that, as I

appear to be a white, anglophone nurse, it must have seemed to my fellow nurses and co-workers that I too would share such opinions.

Attracted again to the field of cultural care teaching, I began to work as a lecturer, with part of my work being the support of recent student nurse immigrants. I also taught, within an Australian faculty of nursing, about the issues and concerns facing the indigenous population. It became evident again, and this was reinforced through my own personal experiences, that Australia had a healthcare system that was mono-cultural and therefore in parts, intolerant and racist. Even more disturbing was the dawning realisation that this was accepted. Instances of racism and marginalisation were by-and-large either enacted by or ignored by nurses, who seemed not to appreciate this was a problem or understand this as significant. I was not the victim of racism myself — obviously to be a majority group member affords protection — but I stood alongside those in my care, who experienced such acts and what I can only describe as 'endured and survived' those experiences. My proximity to what can only be xenophobia was so unfamiliar and as such of profound concern to me that I sought to understand why this was so. In the tradition of my academic preparation, I took an intellectual approach and sought an answer from the literature of cultural care theory. However, this led to more questions than resolution and eventually brought me to the writing of this thesis.

This thesis has been, in part, my personal journey towards understanding how and in what way nurses can include cross-cultural considerations in their practice. I wanted to know how the theory might illuminate and deepen my own understanding and to try and identify why the theory and ideas that are so readily available have not yet resonated with, or seemed of any particular interest to, many nurses.

I hoped that by undertaking this study I would gain greater insight into the practice of cross-cultural care giving for myself, but also that in offering an analysis of cross-cultural theory and scholarship this might also provide insight, encouragement, and support for nurses to develop greater understanding. Lofty as it might seem, I hope that this thesis will call attention to the need for nurses to respond and provide sensitive cross-cultural care as a priority within the discipline and essential to the provision of nursing service at its most fundamental.

A 'history of the present' — telling the story of progress in cultural care and nursing

The thesis will provide a concise and comprehensive 'evolutionary history' of cultural care nursing theory. It is important to establish the epistemological underpinnings and progression of thinking about culture over time, in order to understand the way in which that particular philosophy has progressed and developed with the ideas of different people in different social locations contributing to the range of topics currently under discussion. The frameworks and constructs that nurses have used to learn about, teach, undertake research and enact cultural care in practice are imbued with the legacy of the past. In this study, the total context within which the phenomenon of cultural care theory was created will be identified. In order for cultural theory in nursing to be understood, it must be seen as the product of a particular time and place and appreciated in light of the historical and socio-political context from which it emerged. The conditions under which the theory was developed are deemed important because the history and traditions which influenced its creation will eventually determine its intended purpose (Holloway and Wheeler, 2002).

Retrospection becomes important for understanding the text in a way that will allow a vision of 'the way things were'. The temporal element, time, has been used in structuring this thesis to enable a 'broad brush' or comprehensive view to be taken of the development of cultural care theory. People and the phenomena they study are situated in time; as Sandelowski (1999) asserts, "life is a chronology" (p79). Cultural care theory is part of a longitudinal process that has both determined and shaped the growth of nursing understanding. This study of culture and nursing is essentially a pseudo-historical form of inquiry, as social changes over time have been pivotal in shaping theoretical development, by the determination of what is plausible and justifiable across the 50 year span of its development.

Contemporary text is a product of what passed before it and precedent has shaped what we believe today. Understanding today will only come about when there is a realisation that the past has lead to a belief in those ideas that are now held as true. The future stretching ahead speaks to possibilities as yet unknown and is of the new and of change but it is never totally isolated from the past: "it is not that the old ways of speaking were wrong it is just that they were useful to use as we worked to accomplish old projects" (Mason, 2008, p10).

Employing a critical approach in analysis

A critical position was taken towards the literature for, as Davis (2006) asserts, "questioning, debating and developing new definitions and knowledge are at the heart of any profession that wants to continue to be relevant" (p80). It is important, for the purpose of this study, to be clear about what is intended in the use of the term critical and a definition was sought to support the nature of this inquiry. Morton and Zarvazadeh (1991) write at length of a particular understanding of critical expression and this speaks in turn to the way that critical analysis is to be understood throughout this thesis.

> *"A critique (not intended to be confused with criticism) is an investigation … it subjects the grounds of the seemingly natural and self evident to an inspection and reveals that which appears to be natural and universal is actually, a situated historical discourse. Which is to say, that it is produced to justify and maintain a particular set of relations ... the function of the critique, unlike that of criticism is to demystify" (p13).*

The theory on cultural care is considered to provide insights that authors have put forward as facts or truths. Those philosophical 'truths' have the potential and power to influence the thoughts and constitute the understanding held by other people, so cultural theory is in a sense very powerful. Although it might be difficult to challenge accepted wisdoms, it is important "because these tightly held truths can act as the barriers that prevent critical thinking" (Phillips, 2000, p366). The approach taken in this thesis is to remain open to the possibility that there is no such thing as one single, correct interpretation of the text because, if the same questions continue to be asked in the same way, then very similar answers will always be generated. This study takes the position that there are a number of possible interpretations, some of which will be more likely to be relevant and useful than others and that there are, in effect, many feasible interpretation of the same text. It is intended that these theoretical 'truths' in which we often so firmly wish to believe are questioned in this study.

PART II - The pragmatics and process

This thesis will explore and analyse the text of cultural care theory. Text was selected because it is constitutes one of the more tangible ways that people communicate their ideas and

thoughts. It is through the 'literary' sharing of information and ideas, that an ideology or discourse of cultural care has been created in nursing. The ideas of scholars influence the thinking of others, through the particular understandings they tend to form and those ideas can be identified through examination of text (Munhall, 2006). Text provided a lens for viewing the authors' ideas and revealed their particular approach, their philosophical point of view, the extent of their comprehension of established knowledge and it also expressed the opinions they held (Hardy & Phillips, 2003). Each textual representation on 'the theory' about culture symbolised a particular position or a way to view reality from the perspective of the author.

Collecting textual material …

This section will describe the way in which the practical work of collecting textual material was undertaken and assembled. Effectively, a wide range of both international literature and more local work from Australia was collected to represent the full range of ideas and expressions about cultural care and nursing. This included: articles, books, conference proceedings and the publications of professional associations and bodies. Ongoing literature searches were undertaken, primarily using computer generated searches. For this, library catalogues and electronic search engines were employed, for example the Cumulative Index of Nursing and Allied Health Literature (CINAHL) and 'Expanded Academic'. Search terms such as culture, cross-cultural care, cultural safety and transcultural nursing were selected as illustrative of the literature that might be available and were used to gather text without restriction to author, source or date. Any literature procured was then searched for key descriptors which were added to the search strategy. The reference lists and bibliography sections of articles and books were also used to trace more material. Text was collected up until submission of the thesis, so that all contemporary additions to the literary field have been included.

The collection of text was complex and ongoing. It involved searching for a considerable amount of text produced over a number of iterations and also across an extensive time frame, especially in the case of Leininger's work. Ramsden's work has necessarily been limited by the date of her death in 2003, some six years preceding this thesis. Other authors have entered and left the field on a number of occasions, building their work progressively, often over a long period of time and returning sometimes up to 10 years later with expansion on and advancement of their ideas. For this reason, citations can be seen to date back for some years and range from the mid-1960's until the current day in 2009. Whilst this literature may span

some years it all remains relevant to the field of inquiry and older works in this thesis could not be dismissed as dated because, in a relatively small field, some of this writing made a seminal contribution, others of it contributed pivotal findings to the building of the discourse and many brought knowledge which has not just disappeared when this work reached what is deemed the acceptable academic ten-year exclusion point.

After texts were collected for this study, it was decided to augment the texts by interviewing nurses who were involved in cultural care. The reason for conducting interviews was that, although the 'hard copy' text revealed the theory and ideology of cultural care in nursing as understood by the nurse authors, these ideas were subsequently diffused into other nurses' understandings and ultimately into nursing practice. It is important to note that readers are not just passive consumers of text (Cheek, 1999). Readers of texts also have their own position and point of view, from which they negotiate viewing positions in relation to the particular texts and there are a number of alternate viewing positions possible (Cheek, 1997, McKee, 2008). Textually based messages are received and reshaped by the reader of the text in a number of ways that either coalesce with a reader's existing understanding or alternatively lead to the creation of new understandings. Every reading of a text is negotiated. This means that the particular knowledge that is cultural care is re-created each time it is read and a new form of understanding is fashioned in the minds of recipients of the text. Re-negotiating and re-generating ideas occurs on the part of the reader to form yet another construct or a different way to understand and use knowledge. As Frazer (1992) points out, "all too often theorists infer the ideological effect the text 'must' have on the readers (other than the theorist themselves of course" (p186).

Analysing text …

To examine theory, one must scrutinise what people say when expressing their ideas in developing that particular theory, determine relationships between the ideas and search for the inherent meanings expressed within the words. The theory on cultural care will be approached, as if it was speculative in nature and it will be assumed that it remains open to further development and revision, which is the work of this thesis.

Data analysis was a complex process that required a continual filtering of information, astute questioning, a growing recognition of the significant from the insignificant, the linking of

related and seemingly unrelated facts in a logical manner and then of determining relevant categories of relationship through the work of the researcher. Description was the first step, whereby it was important to capture what was actually being communicated through written expression. The intention here was to determine what ideas were contained within the field of interest. In doing so, there was a need to stay close to the words of the authors without altering their basic character or intent. For that reason, in this study, literal quotation has been used extensively so that the 'facts' of what is being said are clear. Interpretation or analysis is the next step and is essentially the breakdown and recombination of ideas. This involves a translation of those ideas, with a goal of coming to understand what meaning is being conveyed or constructed and summarising the informational content of the text. The last step was to critique or interrogate the text and determine in what way particular ideas have been framed, to come to understand their constituted and representative meaning and in developing new meanings as a result of this process.

Morse (1994) describes four processes that are integral to all qualitative methods and this explains what was to become an almost instinctive process that took place during analysis. Morse's phases are: comprehending, synthesising, theorising and re-contextualising. These processes are believed to occur sequentially, but when performed, often occurred simultaneously once substantial researcher immersion in the field of ideas had taken place. Articles and books were read to identify how and why the individual authors provided different versions of the same account and whether similar or different themes were reproduced, followed upon or deviated from established themes and concepts.

Comprehension was the first step. This entailed the isolation and comprehension of the different ideas put forward by the authors. Material relevant to the topic was selected and, from this, key concepts emerged, were identified, and understood. Initially, material was read and reread until general themes began to appear. These were then grouped together as common themes. For example, transcultural nursing, or cultural safety, or links with ethnic origins, or anthropology, or geographic differentiation by site of origin. Different accounts and the contradictions or differences between works were also identified. Micro or line-by-line analysis was important to ensure that implied meaning and linkages between and across concepts were detected.

Analysis commenced after comprehension had occurred, when "a process of selecting, revising, verifying and discarding" had been undertaken (Morse, 1994, p32). The strength of the thesis would be in its argument. The capacity to be comprehensive, robust and coherent in connecting all the diverse points of information was vital to the cohesion of the thesis. As the process of interpretation and reinterpretation continued, the identification of diversity or variability in different authors' interpretations became evident and contradictions and inconsistencies across different texts started to become more obvious. Contrasting ways of framing ideas and of creating an authoritative voice in the different ways of writing were determined. The texts were also explored to determine patterns of regularity and to conversely identify irregularity (Price, 2000). Whilst all text was considered to have meaning, some elements were more important than others and some were chosen over others for inclusion in the thesis. Such decision making is an important role of the researcher and this skill matured over time.

Analysis meant working across a number of different interpretations, determining the key points being made, evaluating their strengths and weaknesses in isolation and then cross checking these again across the large number of ideas and authors. Eventually, different elements regarding culture and nursing were identified and themes emerged. For example: the use of anthropological theory, a resonance with indigenous identity, ethnicity or whiteness, discussions about the subjugation of knowledge, human rights, marginalisation, racism and the analysis of power relations — role power, patient power and institutional power. All these related but different themes began to emerge from the text.

Synthesis is the "sifting' part of the analysis and is where a 'feel' is gained for the information. To achieve synthesis information was constantly allocated to categories and these categories were revised again and again to try and find the 'best fit'. This process was ongoing and eventually a number of constant themes emerged, as did a significant geo-temporal spread. The textual material was allocated to categories and this assisted in the sifting and sorting process. For example, material related to the work of Leininger was usually either in support of or in opposition to her work. These constituted separate groups and all similar material was assigned to that group. From this a logical flow began to develop.

Theorising and re-contextualising were the next and final steps. Theorising was the process of 'asking questions' of the theory contained within the text. The first step was to identify the

values and beliefs that were embedded in the information that was the text – what was underlying the conclusions that had been drawn and communicated in the claims being made. Once this was achieved similar concepts themes were sought for their presence or absence in other sources and the different theories were compared and contrasted. Re-contextualising is "where the real power of qualitative research is found" (Morse & Field, 1995, p129). In this aspect of analysis links were made between existing theories and published works and these established ideas were challenged to generate new conclusions and viewpoints for readers to consider. The goal of this phase of the study was to place the findings of the analysis within the context of established knowledge and to either to "support the literature or make new contribution" to the field of understanding (Morse & Field, 1995, p130).

It also became apparent that the text was aligned both to its country of origin and then again to other literature, which led to a sharing of ideas. Certain groups of authors working from one location had a resonance with particular authors and not others. For example, United States and United Kingdom authors both utilise 'transcultural nursing': authors in the UK adopted the concept and frequently cited and quoted the work of American colleagues. Likewise, authors from New Zealand and Canada formed a similar relationship, based around their shared experience of colonisation and the impact on indigenous populations, which was of interest, albeit in slightly different ways. Clearly, certain scholars read publications from other countries and then incorporated or re-developed concepts sourced from the work of others. These groupings offered a mechanism to link 'like with like' and the thesis began to take form.

Undertaking interviews …

Whilst this study sought primarily to analyse the theory of cultural care in nursing, it became apparent it also needed to acknowledge and work meaningfully with the probability that there were many different possible interpretations of the text. This work was also to be relevant to the local context of Australia, rather than merely contributing to the global knowledge field.

Therefore, in addition to analysis of the written text, a series of in-depth semi-structured interviews were conducted. The purpose of adding this dimension to the project was to gain a better understanding how Australasian nurse scholars, those immersed most directly in the field of interest, thought and felt about the theories of cultural care. Individual interviews allowed the researcher to develop a deeper understanding of the views of those reading and

using the theory in the Australian context and their re-interpretations of the work of the international grand theorists.

Participants from within Australia were selected for several reasons. This study has a significant interest in the utilisation and application of cultural care theory in that particular context. It was established that transcultural nursing and cultural safety theories were well understood and utilised in both New Zealand and Australia and there was a limitation on time and financial constraints to travel on the part of the researcher.

Purposeful or case based sampling was used in the selection of participants for inclusion in this study. Using such a method enables the researcher to deliberately look for information-rich cases that will capture analytical variations about the target phenomenon. Those participants or cases that were best thought to understand the phenomenon under study were then selected by the researcher (Roberts and Taylor, 1998). Given that it is impossible to target an entire population, those who were invited to participate in the interview must have been exposed to cultural care theory, which had lead to a deeper knowledge of and familiarity with such theory. All potential participants were included or excluded on the basis that they were resident in Australasia at the time of the study, aged over 18 years of age and could communicate in English (although not necessarily as a first language).

The principal intention was to find “good informants ... articulate, reflective and willing to share with the interviewer” (Morse, 1991, p127). This information had the potential to provide a further layer in interpretation. The reason for including interviews was that all written and published knowledge is, in turn, reinterpreted by a reader. Carson (2001) and Fairbairn (2002) advocate the use of this technique as a ‘go-between’ the theory and the reader. It has the potential to bring research and practice closer together, which is another goal of this study.

Potential participants were invited to take part in the study using the medium of email and letters (with telephone follow up of positive responses) and posters were placed in public spaces requesting people take part in answering several questions related to cultural care and nursing. All categories of nurses —authors, policy makers, teachers and students of cross-cultural nursing studies — were targeted as relevant participants. It was predominantly, however, authors and teachers who responded to requests for interviews. Despite extensive efforts at recruitment a total of only eight respondents agreed to take part in an interview. The

size of the sample in qualitative work is not as important when using purposeful sampling and, to an extent, it enabled the gaining of "phenomenal variation" (Sandelowski, 1999, p81). The participants who did take part were also those who had significant interest in and thus potential impact on, the field. It is also interesting to draw a correlation between the low level of interest in participation in this study and what this thesis claims as the significant disinterest in cross-culture on the part of Australian nurses.

An initial interview of one hour's duration was undertaken, although participants were advised they may be re-approached on a further occasion if clarification was required, to which they all agreed. The meeting place was determined by the participant, at a location of their choice and all costs were borne by the researcher, although it was required that the environment offer privacy, the assurance of confidentiality and be quiet enough for audio-taping to take place. Any risk to participants was anticipated as minimal, although a mechanism for support in the case of unintended distress was in place and privacy procedures around material was ensured. All interview transcripts were rendered anonymous through the use of pseudonyms, all material kept secure and transcripts separated from tapes.

The interviews were conducted using particular questions to initiate discussion. This ensured that the topic area was clearly identified and provided a starting point for conversation (Appendix 4). A narrative style of interview was used, as it was intended to facilitate the human impulse to narrate and so enable and permit participants to structure and sequence their accounts with minimal intrusion by the interviewer (Sandelowski, 1999). Audio taping of the conversation was undertaken with the permission of the participant. This was later transcribed by the researcher into a printed transcript and maintained under the standards required by the approving Ethics Committee. (Appendix 1)

Audiotapes were transcribed 'verbatim' into an electronic format by the researcher. The first stage of interpretation began with repeated listening to the tapes and this was followed by the repeated reading of the transcripts which lead to an increased sensitisation on the part of the researcher to the meanings being conveyed and the detection of nuances in meaning. This also became important to the process of increasing familiarity with the data. Extensive reading and re-reading over time, combined with the making of notations in the transcripts, assisted in determining relevant meaning within the material. The material obtained from interviews has been used as an adjunct and accompanying commentary to the analysis of written text to

authenticate, interrogate and complement the process of overall analysis. The transcripts containing the material gained during interviews became another element of interpretation.

Concerns regarding the outcome of participant interviews….

Whilst all the participants were supportive of this study and agreeable, even enthusiastic to take part in an interview, the analysis of their narrative presented some concerns. Efforts were made to ensure that interviews were conducted under optimal conditions, the guiding questions used for the semi-structured interviews were well constructed and unambiguous and adequate volumes of data were obtained. However, during the interviews and even more noticeably once thematic analysis commenced, it became apparent that the content of the narratives was disappointing as a source of rich or useful information. Participants had plenty to say, were relaxed and talked freely but it was evident that they, like the nurses who use or more correctly fail to use cultural care theory, were bewildered and uncertain about the subject field and unsure about the meaning intended within the actual theories of cultural care in nursing.

The value of the information gained from the narratives relied upon the interviewees having a robust and sound knowledge to communicate to the interviewer, which it was to be assumed they did, as they had been deliberately selected for their background. A semi-structured format had been elected to allow them to communicate their understanding in their own words. However the understanding of cultural care theory communicated by the participants showed uncertainty, perplexity and lack of clear understanding with current conceptulisations of culture. For this reason, it was decided that raw data would be used unedited and unexpurgated, so as to preserve the clarity and significance of their contribution and let the responses ‘speak for themselves’.

In retrospect, although puzzling at the time, this increased the evidence of the validity of the arguments in this thesis and is consistent with what was originally suspected. That is, that the writers and teachers of the theories on culture themselves have little to add that might clarify or illuminate current understanding. These interviews, whilst not yielding high quality information did meet the purpose of the study, in that they facilitated the interviewer to ‘enter the world’ of the participants and gain insight into their thoughts and understandings. This, in turn, supported the original concerns that underpinned the research question and goes

some way to explaining why nurses have not used existing nursing theory on culture despite it being available for a number of years.

Ethical considerations

Principally this study is an analysis of literature, which is published and freely available in the public domain. Therefore, there is no significant human subject protection or ethical issue associated with its use.

As already described, some of the material used in this thesis involved participant subjects taking part in interviews. Subject participation protection was put in place using the guidelines from the University of Technology, Sydney Ethics Committee. Verbal and written consent was obtained from participants prior to interviews commencing. An information sheet was also provided to participants preceding their interview (Appendix 2). Consideration was given to participants in regard to their having adequate time to read the information sheet and consent was obtained (See Appendix 3). Confidentiality was maintained regarding documentation and pseudonyms have been used to protect participant identity.

Authentication of the findings

Authenticity, or the 'validation' of findings, is important to any research endeavour. However, Sandelowski (1998) suggests that qualitative researchers need to think very carefully about the type of validation they are seeking of their work. Sandelowski (1998) advocates the use of clearly defined theoretical and philosophical underpinnings as a way of ensuring that findings are authentic and accurate in qualitative works, rather than relying upon those techniques utilised for quantitative studies, which are inappropriate outside of their own methodologies. So, whilst truthfulness and justification of the claims made in this study are extremely important, the positivist criteria of rigour and validity are considered less important and less appropriate to the method being used in this thesis. Im and Meleis (1999) suggest that conceptual rigour is a more useful construct for qualitative work, particularly for analytical and descriptive studies. Highly interpretive approaches, such as the one taken in this study, rely heavily on the development of complex discussion and this discussion must in turn generate a strong argument. Conceptual rigour requires the development of a robust argument and

appropriate use of in-depth critique to assure the appropriateness of the theoretical frameworks that have been used.

Popay, Rogers and Williams (1998) promote the provision of sufficient detail to allow "interpretation of the meaning and context of what is being researched" (Popay, Rogers and Williams, 1998, p348). Koch (1994) supports this by claiming that, whilst readers may not share the author's interpretation, they should nonetheless be able to discern the means by which this has been reached. This study has achieved such a goal by its consideration and inclusion of a full range of literature and in its careful and methodical process and technique of analysis. However, there remains a tension in any study such as this to clarify how claims are authenticated. This chapter and those that follow will document explicit details of texts and will present the epistemological position underpinning the research as a whole. The methodology is a constant companion to the work of interpretation and was not merely stated in this chapter, but informed every step of the thesis' process.

Wainwright (1997) describes how, at the heart of the qualitative approach, is the assumption that such research is very much influenced by the individual researcher's attributes and perspectives. The goal in this thesis was not to produce a standardised set of results that any other careful researcher in the same situation, or studying the same issues, would have produced. Knowledge itself is not value free and neither is interpretation of any body of knowledge, such as cultural care. The standpoint and position of the researcher has been made explicit at the commencement of this chapter. It is impossible to be completely detached from the literature, although every effort has been made to acknowledge this. It is this subjectivity that permits a deep immersion in the topic. Researchers in similar situations without my personal experiences and understanding may not have made the observations nor been able to offer the depth of interpretation that I have and this brings strength rather than a weakness to the process of analysis.

Usher, Bryant and Johnston (1997) write that in a qualitative paradigm, validity should be seen as being "primarily concerned with the production of a 'vigorous text' — that is one which works for the community of readers to which it is offered and is attuned to the habitus of its readers" (Usher, Bryant and Johnston, 1997, p215). Sandelowski (1998) considers that qualitative research should be "a good read" (p375) and asks that the data, with some help, be allowed to speak for itself. Morse (2008) also writes that excellent qualitative inquiry has an

element of "deceptive simplicity" (p1311), in that results should be understandable, comprehensive, contain minimal jargon and read seamlessly and elegantly — "rather like an interesting novel" (p1311). Well written qualitative work claims Morse should conceal, rather than reveal the "panic, sweat and tears" (p1311), and the analytical struggles of the researcher to make sense, to find themes and to tease out patterns. Many of the claims to validity in the findings of this thesis will be evident to the reader and lie in the clarity with which the reader can assess and evaluate the researcher's claims.

In summary

The intent of this study was to explore the genesis, development and re-interpretations of knowledge that have been made over time and used to underpin cross-cultural care in nursing. The range of text was selected for relevance and submitted to a series of robust and in-depth examinations. This chapter has elaborated on the process that was employed to achieve analysis through the key theoretical concepts being identified, explored and discussed. To assist in accomplishing this, a qualitative methodology was selected which supported and facilitated the description and interpretation of existing theory and ideas. A number of interviews were undertaken to augment the discussion and findings of this study. The processes that were used regarding participant involvement have also been explained.

Using a methodology that would support a critical approach being taken towards the text was crucial to this study as it sought a framework for welding together the diverse theoretical positions that have been constructed through the development of a discourse on cross-cultural care in nursing. Throughout this study there has been an effort to remain in a critical reflexive process with the theoretical material, the discussion with participants and to take into account my own position as a researcher. A stance was also taken that accepted uncertainty and but remained hopeful for a future in which there might be a deeper understanding of cross-cultural care in nursing.

In the next chapter the theory and works of Madeleine Leininger will be outlined and explored.

Chapter 3

THEORIES OF CULTURAL CARE IN NURSING

The theory of culture care: diversity and universality and transcultural nursing

"Every standpoint or worldview shapes what it is possible to see and what is obscured. Each standpoint is based on a set of assumptions that structures how one sees and interprets the world."
(Gustafson, 2005, p4)

Madeleine Leininger is widely acknowledged as the original architect of cultural theory in nursing (Chinn, 1991; Cooney, 1994; Rajan, 1995; Coup, 1996; Culley, 1996; Andrews & Boyle, 1995, 1997; Lister, 1999; Cohen, 2000; Price & Cortis, 2000; Chevannes, 2002; Fawcett, 2002; Papadopoulos, 2004; Narayanasamy & White, 2005). Leininger began writing in the 1960's and her theory of Culture Care Diversity and Universality, also known as transcultural nursing, has become a seminal work in the field and been widely implemented in Western countries. As Andrews (2008) suggests, "Transcultural nurses have taken action and are transforming nursing and healthcare in many places in the world" (p13). Leininger's theory has not only advanced her own philosophy but has underpinned the development of a number of later models that have contributed to its continued use today (Geiger & Davidhizar, 2002, Spector, 2000; Purnell & Paulanka, 2003; Papadopoulos, Tilki & Ayling, 2008; Camphina-Bacote, 1999, 2008; Andrews & Boyle, 2002).

In the 1960's, nurses in the United States of America began to develop and use structured nursing theory. These theories offered nurses a new approach to knowledge of cross-cultural care and provided a means to systemically order, analyse and interpret information and, by doing so, became a mechanism through which nurses might evaluate their thinking and reflect on their actions during patient care (Pearson, 2007). Nursing theory such as Leininger's serves a number of functions. It is used to explain, guide and structure ideas and it facilitates the promotion of a particular performance considered to enrich the practice of nurses. *Culture Care Diversity and Universality* was written in the style of an American mid-range nursing

theory of the time and Leininger employed the concepts of 'person', 'environment', 'nursing' and 'health' popular with American theorists (Fawcett, 2002). Among the theories from the USA, Leininger's theory of cultural care nursing is one that has received significant attention in the literature and consistent attempts have been made to establish its use outside its country of origin. As Daly and Jackson (1999) note, "Australia, like the United Kingdom, saw the introduction of North American theoretical perspectives that were accepted rather uncritically" (p342). Therefore, to identify and distinguish the contribution that Leininger's nursing theory might have had for cultural care development in nursing, it is important to examine the theory.

An outline of Leininger's theory and transcultural nursing

Leininger was the first nurse to formally explore the relationship between patients and their different ethnic backgrounds. She recognised that a patient's ethnicity had the potential to impact on health and illness. Leininger proposed that nurses might be more effective in their role if they developed a deeper understanding of the relationship between ethnicity and health. Leininger describes herself as an anthropologist and a nurse. She holds a PhD in Cultural Anthropology and wrote her theory whilst studying in that field. In 1969 Leininger established the first course in transcultural nursing in the United States and in 1977 initiated the first master's and doctoral programs specific to that field. During her career, Leininger has written 27 books, published over 200 articles and authored 45 book chapters (Marriner-Tomey & Alligood, 2006).

Leininger's theory was developed in a particular geo-cultural context — that of the United States of America. Thinking and writing occurs in a particular social location that reflects the culture and context of the author and this context will influence the manner of ideas development. When Leininger began her work in the 1950's, the American civil rights movement was just beginning to take hold. The USA has a modern history of settlement by immigrants from Europe, Britain and Ireland. As a consequence, Anglo-Celtic norms, beliefs and values essentially came to underpin the American social structure and dominate its social institutions, including healthcare. Social segregation of the African-American community had recently ended in 1954 and the black communities of former African slaves (brought to America 200 years previously), were becoming increasingly articulate about their human rights and were no longer happy to occupy a subservient social position. This black community began

to claim a voice as American citizens born in America and entitled to all the rights and benefits this implied. Also, during the 1960's and 1970's, immigrants from less traditional source groups such as the Hispanic and Asiatic communities were settling in the USA in increasing numbers. The former ideal of the 'melting pot' culture, where immigrants to the USA were expected to give up existing values and traditions and integrate into the 'American' way of life, was coming under question (Gleason, 1992). These minority communities were to become significant and ever growing groups, thus increasing the social heterogeneity of America. Joining them were the Native American peoples (The First Nations), formerly socially dislocated and disempowered during those eras of colonisation and immigration, and who also wished to be represented in the new human rights movement and claim equality with mainstream Americans (Price & Cordell, 1994; Naylor, 1997). The social time in which Leininger was originally writing was one where social change was rapidly taking place and there was a heightened and growing awareness of human rights and civic freedoms. This has something of a parallel with the rapid social change on a global scale that the nursing world is confronting today.

Leininger originally worked as a children's nurse in a psychiatric setting and noted that of "the children who came from diverse cultural backgrounds such as Afro-American, Spanish-American … their overt behaviours clearly differed" (Leininger, 1978, p21). These observations lead Leininger to develop an interest in anthropology. "I learnt that culture was a significant influence on behaviours … and I began to understand the important links between nursing and anthropology" (p23). Leininger's goal was to investigate her belief that a patient's ethnic background profoundly influenced their understanding of health and illness, which in turn determined the type of nursing care required by individuals. Leininger (1978) considered that "nurses tended to rely on uni-cultural professional values which are largely defined from our dominant Anglo-America caring values and therefore unsuited for use in the nursing of people from other cultures" (p11).

Leininger came to consider that belief systems from other cultures needed to be described and understood in order for the predominantly Anglo-American nurses of America to make predictions about the health beliefs, and so anticipate the care needs, of groups from cultures other than their own. From her studies in anthropology, Leininger's theory of cultural care was published in 1967 and over a 40 year span it has been further developed and refined. Subsequently, the theory of Cultural Care Diversity and Universality emerged. As Daly and

Jackson (2003) write: "The theory was to discover what is *universal* (or commonalities) and what is *diverse* about human *care* values, beliefs and practices" (pxiii). This led to what is known as the transcultural nursing approach, which Leininger considers 'ethno-nursing' and the design of a research methodology deemed 'ethno-science', was developed to collect cultural data. Ethnoscience provided a means "to obtain local or indigenous peoples' viewpoints, beliefs and practices about nursing care or the modes of caring behaviours and processes of the designated cultural group" for use in providing nursing care (specifically ethno-nursing) to that particular group (Leininger, 1978, p 15).

In her early work, Leininger (1970) adopted an all embracing definition of culture, in the tradition of anthropology, which comprised of "the total complex of material objects, tools, ideas, organisations, and material and non-material aspects related to man's [sic] existence" (p11). Leininger (1993) modified this original definition of culture to become more inclusive of values and beliefs and she also began to refer to "the learned, shared and transmitted values, beliefs, norms and life ways of a particular group that guide their thinking, decisions and actions in patterned ways" and "the ways of life of the members of a society, or of groups within a society" (p9). From its beginning, transcultural nursing has existed within a framework of race and ethnicity, with the fundamental premise that the term 'culture' refers primarily, if not exclusively, to ethnicity. Labelling by ethnicity is a position fundamental to Leininger's work (Leininger, 1988). In which she frequently referred to people of "different ethnic origins" (p107), "people of color" and "ethnic groups of colour"(Leininger, 1978, p451).

The background to her work was derived in an essential way from, and is embedded in, anthropology and the concept of care is drawn from nursing. Leininger (1970) acknowledged the influence of anthropology on her work when she wrote, "nursing and anthropology are unified in a single specific and unitary whole" (p2). Leininger felt that anthropology's most important contribution to nursing was to provide a foundation for the claim that health and illness states are primarily determined by the cultural background of an individual (Leininger, 1970, 1978). Her theory is in accord with the anthropological models that dominated in the 1960's when Leininger first undertook fieldwork in Papua New Guinea, a study which she still continues to reference some 40 years later (Leininger & McFarland, 2003). Specifically, transcultural nursing theory refers to "the set of interrelated cross-cultural nursing concepts and hypotheses which take into account individual and group caring behaviours, values, beliefs based upon their cultural needs, in order to provide effective and satisfying nursing care to

people; and if such nursing practices fail to recognise culturological aspects of human needs, there will be some sign of less efficacious nursing care practices and some unfavourable consequences to those being served" (Leininger, 1978, p 33). Leininger has long maintained that the specific cultural values or what she deemed to be the generic, emic or folk care beliefs, expressions and practices used by different ethnic groups must be known and used as a bridge by the nurse to provide culturally appropriate care.

To develop the body of knowledge in transcultural nursing, the ethno-science methodology was employed: "the systematic study and classification of the way of life of a designated cultural group to obtain an accurate account of their behaviour and how they perceive and know their universe" (Leininger, 1978, p76). Leininger (1978) claimed that the knowledge of cultural practices is best discovered by gaining and "studying the local (insider) views" (p36). In transcultural nursing, different cultural groups are studied in a highly specific way so that the researcher then becomes very knowledgeable or an authority on different cultural groups' norms and values. Nurses can then use this information to make predictions about a particular ethnic group's attitudes and beliefs towards health. This in turn facilitates the provision of appropriate and 'culturally specific' nursing care (Leininger, 1978).

Leininger (1978), states that the intention of using the ethno-science approach is to "reduce chaos so that it [ethnoscience] accurately portrays the indigenous people's views and provides a high degree of reliability and validity about them" (p76). The ethno-science research method involves the nurse researcher undertaking ethnographic study using direct observation and the interviewing of selected 'culture bearing individuals' from within a specific ethnic group, to gain data sets from the 'emic' or insider perspective. Once obtained, this information is combined with the nursing philosophy of caring. A body of knowledge is built up and maintained over time which contains the different cultural nuances, values and beliefs embedded in different ethnic groups and this is then used by nurses and can be relied upon to guide their practice. In 1992, Leininger claimed that more than 3000 international studies had been conducted, with over 300 ethnic groups having been researched and chronicled.

The goal of transcultural nursing is to provide "culturally congruent, sensitive and competent nursing care" (Leininger, 1995, p4). Using the data from ethno-science studies, the nurse from the 'etic' or outside group can then understand the perspective of the 'emic' or inside group and use that to modify or vary nursing care, 'tailoring' it and making it more appropriate. The

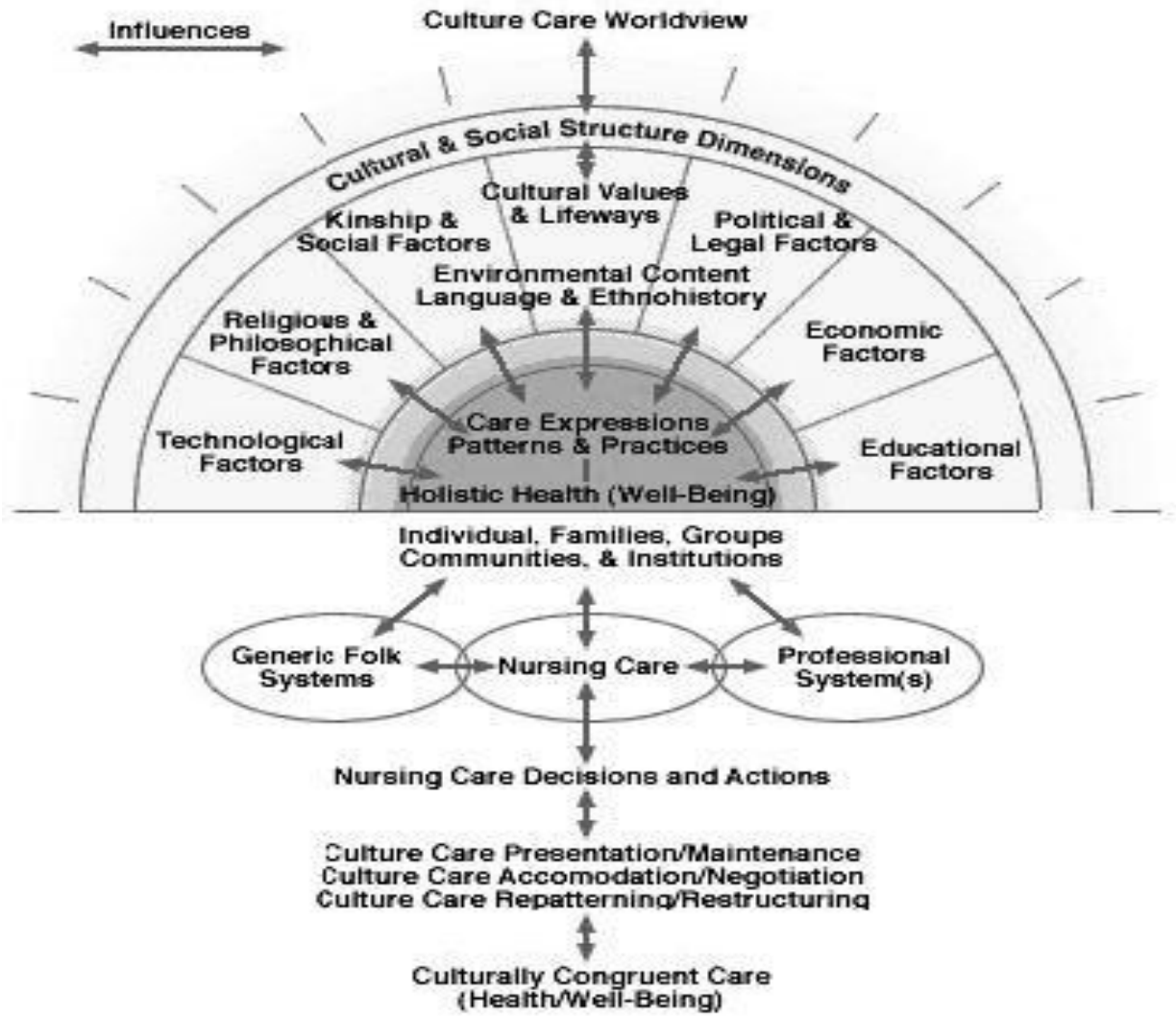
nurse's care giving is underpinned by the use of the 'culturological' assessment, in which "the nurse is involved in determining and appraising the traits, characteristics and smallest units of cultural behaviour as a guide to nursing care plans and intervention modes" (Leininger, 1978, p86). Culturally congruent care occurs when there is a meaningful and satisfactory match between the culture care beliefs, values and practices of the patient and the behaviour of the nurse. The nurse must preserve, maintain or change nursing care behaviours with the goal of satisfying the needs of clients (Leininger, 1998, 2002). Leininger further defined such nursing action as: culture care preservation and maintenance, culture care accommodation or negotiation and culture care restructuring or re-patterning (Leininger, 1978, 1981, 1984, 1988a). To become culturally competent, nurses require preparation and must undertake a course of theoretical study which gives them the ability to carry out ethno-science research, culturological assessment and develop the cultural sensitivity required to design and implement culturally relevant nursing interventions.

In transcultural nursing, the extent to which nursing care meets the clients' needs is directly related to the extent it meets the culturally determined standards and expectations of the ethnic group to which the patient belongs. Whether cultural congruency has occurred or not is determined by the nurse who has become a cultural knowledge expert. All successful transcultural care involves the use of research using the ethno-science method, sophisticated assessment and analytical skills and the ability to carry out culturally sensitive planning. It requires that the nurse has formal preparation in designing and implementing culturally relevant nursing interventions (Leininger, 1978; 1991, 1995).

Leininger later developed the 'Sunrise Model' (1991), purportedly an enabling cognitive map to support and guide nursing practice (see below). Cultural Care Diversity and Universality is illustrated in this model and it provides a framework for mapping and understanding a culture or subculture. As Omeri (2003) explains:

> *"The model demonstrates the different domains of the theory and is designed to guide the discovery of new transcultural knowledge through the identification and examination of the culturally universal. The model is holistic and addresses worldview, cultural values, beliefs and life ways, cultural and social structural factors. It focuses on individuals, groups and institutions. It allows for examining generic (folk) as well as professional care (the nurse) ... Implementing the theory stimulates nurses, as carers*

and researchers to reflect upon their own cultural values and beliefs and how they might influence the provision of care" (p181).



Source; Leininger's sunrise model to depict the theory of cultural care diversity and universality (Leininger, M.M. (1991). Culture Care Diversity and Universality: A Theory of Nursing.

There has been a significant uptake of Leininger's theory of Cultural Care Diversity and Universality, and transcultural nursing in the USA. The *Journal of Transcultural Nursing* first

appeared in 1989, followed by the *Journal of Cultural Diversity* and most recently the *Journal of Multicultural Nursing* in 1994 (now entitled *The Journal of Multicultural Nursing and Health: Official Journal of the Centre for the study of Multiculturalism and Health Care*). The Transcultural Nursing Society was formed in 1974 and its members and publications have advanced transcultural nursing philosophy and strategy across the world. Transcultural nurse leaders remain active in consultation, teaching, research and policymaking in national and transnational arenas. In 1998 Leininger was honoured as a 'Living Legend' of the American Academy of Nursing (Murphy, 2006). In 2006 the American Association of Colleges of Nursing endorsed cultural competency for Baccalaureate programs of nurse preparation in the US (Calvillo, Clark, Ballantyne, Pacquiao, Purnell & Villarruel, 2009).

Transcultural nursing has been utilised across a number of domains of nursing interest, including education, research, community and health promotion, obstetrics and gynaecology, mental health and primary health care. Clinical nursing specialties have also adopted various transcultural models encompassing a range of practice areas. These include: critical care (Hadwiger, 1999), diabetes education (Brown & Hanis, 1999), adolescent health, (Martinez, 1998), mental health & psychology (Hewitt, 1993; Williams & Becker, 1994; Kim, 1995; Kim-Godwin, Clarke & Barton, 2001), medical ethics (Richardson, 1999), primary care for women, (Rorie, Payne & Barger, 1996), and public health (Jones, Bond & Mancini, 1998).

Transcultural nursing theory continues to develop and has been further refined by contemporary nurse authors in a number of countries who have acknowledged and used Leininger's original theory and then added to its continued evolution. These new models have advanced transcultural nursing across a range of topic areas which include: a transcultural assessment mode (Geiger & Davidhizar, 1999); a model of heritage consistency (Spector, 2000); a model for cultural competence (Purnell & Paulanka, 2003; Papadopoulos, Tilki & Ayling, 2008); a health care services model (Camphina-Bacote, 1999); a teacher–learner conceptual process model (Andrews & Boyle, 2002) as well as the 'cultural desire' model (Camphina-Bacote, 2008).

Leininger's theory and transcultural nursing — utilisation and proliferation beyond the USA

Transcultural nursing has become recognised internationally as the most significant cultural care theory in nursing (Marriner-Tomey & Alligood, 2006). In 1981, the growing literature on transcultural nursing led to its entry in the international nursing database, the Cumulative Index of Nursing and Allied Health Literature, embedding it in the canon of nursing knowledge. From the beginning, transcultural nursing was conceptualised by Leininger as globally applicable (Andrews, 2008) and it is clear that transcultural theory currently dominates pedagogical approaches taken in nursing toward cultural diversity (Gustafson, 2005; Culley 2006; Campesino, 2008).

Western countries have taken the most interest in transcultural nursing, as can be seen in the geo-cultural breakdown, where the work of Leininger predominates, perhaps in part because of the absence of any alternative. Although there has been global recognition of the theory, there is also some significant variation in its utilisation and different adaptations are evident in the localised context of other countries, these will be discussed and some consideration given as to why this might have occurred.

The United Kingdom…

Nurses in the UK, as in other multicultural nations, have also looked for solutions to the challenge of coping with the increased cultural diversity in their communities. Thomas and Dines (1994) noted that "initiatives by the NHS to meet the healthcare needs of ethnic minority groups appear inadequate" (p802) and Gerrish and Papadopoulos (1999) suggested that "nurses frequently fell short of providing sensitive and appropriate care to ethnic minority patients" (p1453). However, the nursing community in the UK has embraced the transcultural approach to nursing and employed it, for the most part, as the basis of scholarship, research, education and practice development in cross-cultural care (Wilkins, 1993; Mulholland, 1995; Chevannes, 1997, 2002; Narayanasamy, 1999; Gerrish & Papadopoulos, 1999; Gerrish, 2000; Papadopoulos & Lees, 2002; Hart, Hall & Henwood, 2003; Leishman, 2006; Papadopoulos, 2004; Narayanasamy & White, 2005; Culley, 2006). Transcultural nursing has been described by Narayanasamy and White (2005) as the means to ensure that "nursing care [is] provided in a manner that is sensitive to the needs of individuals, families and groups who represent diverse cultural populations in society" (p103). Although Leininger, in 2002, stated

"transcultural nursing programs have not yet been established in Britain" (Leininger & McFarland, 2002, p195) the UK appears to be well represented in publications about transcultural nursing and through its application to education and practice in that country.

Nurses in the UK have therefore found transcultural nursing to be a useful theoretical concept, although there have been some concerns voiced that transcultural nursing was originally intended for the context of the USA and not the UK (Chevannes 1997; Hart, Hall & Henwood, 2003; Gammon, 2007). UK nursing authors have been eager to emphasise that their interpretation would be different from that of American transcultural nursing, suggesting that "Leininger's approach adopts a culturalist perspective whereby the focus is on nurses developing expertise in caring for specific ethnic groups, neglecting a consideration of racism and the structural factors that impact upon the health experiences of minority ethnic communities" (Gerrish & Papadopoulos, 1999, p1454). Scholars in the UK have also undertaken some critique of the theory and identify concerns that transcultural nursing fails to respond to deeper consideration of some issues, for example, those of racial stereotyping or the economic and social effects of immigration and exclusionary practices that might occur at an institutional level (Thomas & Dines, 1994; Culley; 1996; Gerrish, 1997; Lister, 1999; Hart, Hall & Henwood, 2003). Gerrish and Papadopoulos (1999) recognised the criticism levelled at transcultural nursing — for the manner in which it might have neglected the issues of racism and the impact of socio-economic and structural influences on the patient and their health — and concluded that this could be avoided. These authors believe, however, that in the UK there had been a realisation that nurses needed to understand more than the ethnic background of patients and had modified their use of transcultural theory to be more inclusive of the historical, political, social and economic factors which impact on the experiences of minority ethnic communities. As they state, "it is however important to emphasis the differences between the authors' use of the term transcultural nursing and Leininger's ... Leininger's approach to transcultural nursing adopts a culturalist perspective whereby the focus is on nurses developing expertise in caring for specific ethnic groups" (p1545). Gerrish and Papadopoulos suggested that whilst it was important for nurses to develop knowledge about cultural diversity, the use of ethno-nursing research studies alone was not sufficient in itself. They believed that in order to provide effective care in the multiethnic society of the UK, the nurse also needed to understand the complex way in which historical, political, social and economic factors interacted and impacted on the experiences of those in their minority ethnic communities.

Despite stating that the UK takes a different approach to transcultural nursing than the USA, UK scholars' interpretation and development of concepts is undoubtedly closely associated with Leininger's work. Transcultural nursing is consistently identified as the name of their construct (Purnell & Paulanka, 2003; Price & Cortis, 2000; Narayanasamy 2003; Narayanasamy & White, 2005; the Royal College of Nursing, (UK), 2005). Cultural competence has been referred to by a number of authors writing about cross-cultural care in nursing practice — Lister, 1999; Gerrish and Papadopoulos, 1999; Papadopoulos and Lees, 2002; Leishman, 2004 — and a number of ethnically specific studies have been undertaken (Burnard, 2005; McGee, 2008; Yu, 2009).

Nonetheless, transcultural nursing, in principle, was considered to be useful in the British context as it provided a resource and tools for nurses to face the challenge of caring for the growing ethnic communities. However, there has been some criticism of the transcultural approach in the UK as being ethnocentric (white European) and concentrated on nurses' reactions to working with minority ethnic groups, whilst failing to confront the issue that a nurse in the multicultural UK may well be a member of a minority ethnic group, rather than belong to the Anglo-Celtic mainstream (Serrant-Green, 2001). Narayanasamy and White (2004) also note that "most of the theoretically driven models of transcultural care are making slow progress in terms of application to practice" in the UK (p110).

Australia…

The use of Leininger's theory and transcultural nursing in Australia will be discussed in some depth in Chapter Five, as cultural care in Australia is a major focus of this study and will receive greater attention once international theory has already been outlined. Transcultural nursing is the theory that has received the most attention, "perhaps because of the desire of Australian nurses to meet the perceived needs of a multicultural Australia (Daly and Jackson, 1999, p344). However, it has only been endorsed by a few key proponents and has not generally been well accepted into nursing education, research or practice. Currently, there is only one transculturally 'certified' nurse in Australia (Kardong-Edgren and Camphina-Bacote, 2008, p43). As Omeri (2003) notes, however: "Although most acknowledge the pioneering work of Leininger and continue to use Leininger's terminology of transcultural nursing and culturally congruent care ... none do justice to the comprehensiveness of the theory and its applicability" (p181). This is scant evidence of an overwhelming endorsement of transcultural nursing in Australia. Support for the work of the Australian transcultural proponents Kanitsaki and Omeri

has come principally from authors in the USA, not their fellow Australian nurses (Leininger, 2008; Andrews, 2008; Raymond, 2008). Transcultural theory has not been accepted uncritically and there have been some significant commentary on its usefulness to Australian nursing (Bruni, 1988; Swendson & Windsor, 1996, NRNE, 2002). These criticisms and others raised a number of issues and "ultimately challenged the usefulness and appropriateness of the theory for the Australian context" (Daly & Jackson, 1999, p344).

New Zealand...

New Zealand nurses have taken a very different stance to transcultural nursing than that seen in British and Australian publications. Ramsden's theory of cultural safety, which will be discussed at length in Chapter Four, was developed in New Zealand and had been unilaterally adopted there for cultural care, scholarship, policy, research and education. It could be said that New Zealand is rather more characterised by its rejection, than its acceptance, of transcultural nursing. "I would contend that adoption of Madeleine Leininger's approach in developing cultural competence in nurses would constitute an extension of the colonising experience and would be demeaning and disempowering for Mäori, as such, it is not an appropriate model for nursing and midwifery in New Zealand" (Coup, 1996, p10).

In 1994, an exchange of ideas began between the proponents of cultural safety in New Zealand and Leininger. This was initiated by Cooney's (1994) publication, which provided a comparative analysis of the two theories. Whilst supportive of some aspects of transcultural nursing, Cooney was critical of others. Transcultural nursing, Cooney claimed, "ignores other problems and issues such as race, racism, religion, politics ... transcultural nursing theory does not give nurses strategies for challenge ... it may well reinforce the very problem of paternalistic and ethnocentric care it seeks to address" (p10). This was to initiate a published difference of opinion between New Zealander nursing authors and Leininger.

Leininger (1994) responded with the claim that "Cooney takes a false position ... and is inaccurate" (p14). Leininger wrote, "Both Bruni (1988) and Cooney (1994) reflect a misunderstanding and misinterpretation of transcultural nursing". She proceeded yet again with the claim that "Cooney, Bruni (and perhaps Ramsden) fail to comprehend the scope, focus, theory and practice goals of transcultural nursing" (p14). Leininger appeared not to acknowledge or recognise the value of critique as developmental, but rather she suggested

that, “if Cooney and Bruni were formally prepared in transcultural theory ... they would realize that Leininger’s ideas and her theory are more inclusive, comprehensive and holistic than Ramsden’s” (p15). Leininger broadened her commentary to include the entire nursing body of New Zealand and Australia, suggesting “in general New Zealand and Australian nurses who have not been properly prepared in transcultural nursing, need to correct their misconceptions, narrow views and false premises ... all the differences cited are false assumptions, are spurious and reveal a lack of in-depth knowledge” (p16). The reaction of Leininger is surprising, given that theory is usually strengthened by critique, albeit that it might seem challenging to proponents of a particular construct.

Coup (1996) from New Zealand joined the discussion. “I would disagree with Cooney that Leininger has much to offer New Zealand nurses and midwives ... Leininger’s educational and research approach contains aspects which would be culturally inappropriate and unsafe for Mäori” (p10). Leininger’s (1997) response to Coup was even more defensive, asserting, “it is clear that Coup, Ramsden, Bruni, Fawcett, Swendson and Windsor not only fail to understand fully the theory [of transcultural nursing] but fail to use the qualitative ethno nursing methods with the theory to arrive at their conclusions — a serious omission in scholarship” (p18). Leininger postulated that New Zealand nursing “lacks competent scholars and mentors to discover new knowledge and to respect true scholars in nursing” (p18). Leininger (1997) concluded by stating that, “A good course in transcultural nursing would seem to remedy their problems and concerns .... moreover, these authors seem excessively focused on cultural safety, power, social inequalities and the need to study and focus on holistic cultural care dimensions” (p22).

In the years since this debate, New Zealand has continued to use and develop the theory of *cultural safety*, as will be discussed in the next chapter, rather than that of transcultural nursing. Transcultural nursing has yet to be regarded as significant in New Zealand. Although it is acknowledged that further conceptual and practice based development has still to take place, progress is being made towards achieving cultural safety in nursing practice in New Zealand (McKinney, Cassels-Brown, Marston & Spence, 2005; Jungerson, 2002).

Canada…

Transcultural nursing is clearly recognised and relatively well established and utilised in Canada. A range of transculturally derived resources underpin professional standards in

nursing and, although these are predominant, there are also a growing number of references to cultural safety as well. It appears that Canadian nurses have researched a wide range of models in seeking to address cross-cultural concerns in that country. Leininger (2002), when commenting on the adoption of transcultural nursing in Canada, concluded that, whilst there were similarities to the USA, there were also significant differences. The response of Canadian nurses to transcultural nursing has been mixed according to Leininger and McFarland (2002): "they have struggled to make transcultural nursing a reality" (p195) … "transcultural nursing has had a slow and episodic development in Canada over the last several decades" (p493) … "there were some nurses who saw transcultural nursing as unnecessary or irrelevant to nursing, even though they were trying to care for cultural strangers in Canada … 'most of their leaders relied upon their Canadian practical and extensive home experiences' (p495) … "Canadian nurses as a profession have been slow to recognise the systemic and rigorous study, teaching and research in transcultural nursing" (p497). These comments suggest that complete adoption of the theory has not been achieved as yet.

Gustafson (2005) acknowledged that transcultural nursing was one of the most visible philosophies shaping the dialogue about inclusivity in nursing practice in Canada. However, she expressed some reservations, namely those related to the manner in which the theory was assumed to be politically neutral and in its grounding in the Western notion of individualism. Gustafson recommends that further critique of the theory would enhance its utility. Doane and Varcoe, (2005), and Kirkham-Reimer et al, (2003), also voiced similar concerns about the current framing and conceptualisation of culture in Canadian nursing. Browne and Varcoe (2006) likewise had a concern with "narrow conceptualizations of culture" (p157) and culturalist discourses such as that of transcultural nursing. Most recently in Canada there has been an interest in the work and theory of cultural safety. This may be in part related to the history of colonisation in that country and its similarity to New Zealand (Stout and Downey, 2006). Stout and Downey suggest that nursing scholars in Canada are beginning to show an interest in articulating an "indigenized approach to nursing indigenous populations" (p331), and suggested that there is the beginning of a shift away from transcultural nursing.

Elsewhere in the world...

Countries other than the white, Western nations already discussed have not generated a great deal of discussion from Leininger on the level of their utilisation or development of transcultural scholarship. Leininger (2008) has made little specific comment on the

development of transcultural nursing in large parts of the non-Western world such as China, South America, South East Asia or the Indian continent. Publications from the USA do, however, demonstrate research findings related to these as distinct ethnic groups of interest to American transcultural nurses where they constitute US immigrant groups. Leininger (2008) maintains that "transcultural nursing continues to expand worldwide" (piii) and yet, while it is clear that these countries are visited by transcultural scholars, Leininger does affirm that transcultural nursing is not as yet well known in such parts of the world.

Literature demonstrates that some early interest is also being shown in the theory from Sweden, (Jirwe, 2008). Leininger and McFarland (2002) indicate that nurse leaders from South East Asia, Japan, Korea, China, Borneo and India have all expressed openness to the theory but that translation problems and difficulties in providing the required support from skilled transcultural practitioners is an obstacle.

The current global position...

Leininger has acknowledged that, as yet, transcultural nursing has not been globally adopted by the nursing profession quite as well as she had hoped. She wrote, in 2002, that "comparative culture care has yet to be fully understood and used in client care" (p133). In discussing the need for transcultural nursing, Leininger stated during an interview with Jacqueline Fawcett: "It is a daily challenge to keep nurses and others focusing on the discovery of largely unknown phenomena related to … diverse cultures worldwide, I have predicted that nursing must become culturally grounded, I hope that by 2020 all nurses and nursing will become a transcultural discipline" (Fawcett, 2002, p132).

Critiques of Leininger's theory and transcultural nursing

As has been established transcultural nursing has for many years been the most well known approach to cross-cultural care in nursing and has also been largely "accepted uncritically" (Daly & Jackson, 1999, p342). With the passage of time and the growing importance of culture in nursing, more nurses have begun to explore the topic of culture and examine the central tenets that underpin transcultural nursing theory in greater depth. This has opened up new lines of inquiry and different positions have been developed towards the topic as evidenced in the literature. Much of this scholarship has taken the form of critical inquiry or critique.

The traditional anthropological framing of culture in transcultural nursing has increasingly been challenged in the last 10 years. Hermeneutics, structuralism, social constructivism, postcolonial, feminist and the more recent critical theoretical perspectives have been drawn upon to critique transcultural scholarship and research (Lynam, Browne, Reimer-Kirkham & Anderson, 2007). As those responses have occurred and been reinformed over time, the following account of their ideas will predominantly, but not solely, be ordered chronologically. This scholarship covers a considerable span of time, some 20 years, and during this period levels of interest in pursuing the topic have fluctuated.

Concerns identified with the framing of culture...

Nina Bruni (1988), an Australian nurse, made one of the first published analyses of transcultural nursing, in which she questioned the generalisability of transcultural nursing and accused Leininger of 'freeze framing' the culture of other ethnic groups with her anthropological approach. Bruni felt continuing with this traditional approach would lead to nurses developing a view of culture in which uniform sets of beliefs were built up about other cultures. Bruni maintained that such a 'static' approach, with its underlying assumption that an individual's country of origin or biologically racial group was the most significant dimension in determining an individual's culture, was being too uncritically adopted, when she noted that "the problem of stereotyping culture is compounded by the assumption that the country of origin of a person (or his/her parents) is the most significant dimension of his/her experience" (p29). Bruni argued that such a narrow definition would, in the long term, be of little use, given that people are influenced by social, economic and political systems, as well as the circumstances of their birth. To avoid misinterpretation and misunderstanding, there were, she argued, a number of complex variables about the way that ethnic categories were currently being designated that needed to be taken into account for building theory into the future.

McKenzie and Crowcroft (1994) also followed this line of argument, stating, "The categories of race or ethnic group are rarely defined, the use of terms is inconsistent and people are often allocated to racial or ethnic groups, arbitrarily" (p286). Mulholland (1995) reinforced this, describing transcultural nursing theory as being highly problematic in its conceptualisation of culture and that "there is a substantial limitation in the analysis of race, racism and ethnicity"

(p446). Mulholland claimed that "transcultural nursing presents a model of the individual as belonging to an internally homogenous group that appears clearly and unambiguously demarcated from others" (p446). She elaborates on this further: "this fails to grapple with the shifting and kaleidoscopic nature of ethnic differentiations and identities and their relation to internal divisions of class and gender" (p447).

Mulholland (1995) also claims transcultural nursing to be "vague and inconsistent in its use of terminology, lacking in any rigorous analysis of power and suspect in its conceptualisations of culture. Its capacity for enabling nurses to examine critically the socio-economic and political dynamics of nurse–client relations and develop strategies for addressing racisms, considered to be endemic within nursing and the health-care system generally, is seriously undermined"(p442). "Transcultural nursing models develop a highly problematic concept of culture … rather than discrediting and challenging the essentialisms of both traditional assimilationist approaches and those of the New Right, they have inadvertently reproduced them" (p446).

Meleis (1996) expressed similarly that "culture is only one component of what defines a human being; defining nursing clients as cultural beings may be as reductionist as defining them only as biological or psychological beings" (p2). Meleis (1996) also queried the continued focus on culture as ethnicity, asserting this skewed the line of reasoning whereby "culturally defined groups tend to homogenise ... when in fact variations within a culture may be greater than the variations from other cultural groups" (p4). Meleis suggested a focus on knowledge development that included ideas which were broader than culturally-specific phenomena, suggesting that "culture is a context in nursing, it may be a major unit of study in anthropology, but it is only one component of more integrated care in nursing ... individuals' responses are the sum total of socio-economic, structural, gender based and ethnocentric dynamics" (p5). This was to be reiterated again some years later by Ramsden (2002), who made the following comment: "if care is focused on the cultural activities of the patient, there remains the tendency to promote a stereotypical view of culture over time, making it difficult to respond to individual diversity" (p112).

Horsfall (1997) also challenged definitions of culture employed in transcultural nursing, stating that "some authors have noted culture as a concept and difference is not well defined" (p42). The NRNE (2002) reiterated this also: "we identify a missing definition of culture in nursing

education and emphasise the need for a description of culture as an agreed working definition" (Section 5.1).

Gustafson (2005) echoed this, asserting that "transcultural theory focuses attention on a broadly defined, but narrowly applied, concept of culture" (p2). Gustafson (2005) described transcultural nursing as using a "catch-all concept of culture which reaches out from the centre to embrace the margins … Western notions of healthcare and ways of thinking are the norm against which all other practices are measured" (p13). She evaluated and reframed transcultural nursing using a critical framework and concluded that transcultural nursing was operating from a broadly based but narrowly applied concept of culture. Mention is also made of a tendency to specify 'difference' as relating to ethnicity, rather than other variables such as age or gender. She claims that "the imposed homogeneity evident in texts ignores the many differences among group members ... such reductionist categories also do not reflect the multiple aspects of self definition between and among group members" (p7). The broad definition of culture used in transcultural nursing was also mentioned as a vague descriptor and by implication a deceptively neutral viewpoint. The strategy of using cultural competency as the process by which transcultural nursing is operationalised was seen as problematic by Gustafson because of its location in individual behaviour rather than the systematic and social processes that organise that behaviour. Giddings (2005) also added to the enduring concern, discussed since 1988, that transcultural nursing fails to acknowledge the "importance of individual differences and the fluid and contextual nature of cultural identity ... the approach continues to use a narrow definition of culture" (p224).

An impositional or 'cultural –brokering' approach...

Mulholland (1995) claimed there was a risk inherent in the design of transcultural nursing — one of oversimplification, leading to social value imposition. A nurse "using this theory takes the stance of an interpreter in developing knowledge sets about the little defined 'other' — the patient" (p442). Whilst acknowledging that multicultural analysis in nursing had created important spaces for challenging racialised identity, she asserted there was a lack of critical dialogue around transcultural nursing and concluded that issues of social justice and examination of the inherent role power of the nurse had not been addressed.

Culley (1996) suggested that nurses needed to take into account the limitations of what is termed the 'culture brokering' approach of transcultural nursing, proposing too that culture as a notion had been oversimplified. Culley argued against what she called the 'curricular dose' of other cultures brought about by transcultural nursing's ethnoscience method and stated that nurses need to be more aware of the dangers of attributing everything directly and solely to ethnicity. Culley described how, within transcultural nursing, groups of people were deemed to be different by virtue of ethnicity, but then they were blended to create a one-dimensional 'other', which denied differences within any given group.

Baker (1997) examined what she termed the doctrine of cultural imposition in transcultural nursing practice. She encouraged nurses to realise that all peoples' interpretations are contextual and provisional, as are the nurse's own. Baker argued that to understand the word of another, one must remain open and receptive to seeking the 'cultural other'. Leininger and the supporters of transcultural nursing were taken to task for espousing relativism and yet presenting a theory which is characterised by essentialism, ethnocentrism and cultural imposition.

Duffy (2001) added to the discussion and is highly critical of transcultural nursing. She asserted that cultural education in nursing risked becoming obsolete if it failed to move beyond adapting standardised care for diverse groups, who were identified through isolating stereotyped distinguishing features, which then did little beyond alerting nurses to the difference between themselves and others. Duffy advocated avoiding the traditional anthropological approach, which leads to stereotyping and the teaching of nurses to use adaptive techniques to temporarily accommodate a client with different needs from the dominant culture. Duffy wrote of the way in which she believes transcultural nursing guided a student to use descriptive-style data about other cultures and then to adapt care from the dominant Western model of healthcare, rather than using the patient's own belief system as the starting point. This Duffy deemed to be a type of cultural imposition. Education and care then become focused on "changing the individual" (p490) rather than acknowledging and working with the social institutions that perpetuate dominance and oppression. The transcultural nursing approach has been questioned about this, its assumption that nurses and the culture of nurses are normal and commonsense. "In the traditional western anthropological sense this theory is based on the idea that the culture of nursing represents the norm and that people who use the service are deemed exotic" (Ramsden, 2002, p109).

Naming and knowing 'others'...

Polaschek (1998) returned to the central question, namely, "how deeply can a person appreciate a culture they do not belong to" (p256). Lister (1999) later reiterates this line of reasoning: "inequalities are usually seen primarily as a function of ethnicity, whereas class or gender analyses, within and among ethnic groups, can show more complex relationships" (p317).

Gooden, Porter, Gonzales and Mims (2001) questioned the nature of the relationship being constructed between nursing and diversity. These authors believed that transcultural nursing had nurtured a greater concern with the outward appearance of patients as determined by ethnicity , than with being authentic or understanding from the patient's perspective. They believed nurses had failed to come to terms with diversity *within* a given culture, such as disability, sexual orientation, gender, social class, physical appearance (such as obesity) and differing ideologies (such as political or religious viewpoints). Indeed there was very little scrutiny of, or methodologically valid research on, these spheres of diversity, rather nurses focused primarily on ethnicity instead.

Conway (2004) undertook a meta-analysis of literature on transcultural nursing and a survey of nurses using this theory in practice environments in the USA. She found that nurses lacked a level of comfort and ability to perform transcultural nursing tasks when caring for patients from other cultures. The information found about prior qualitative studies [undertaken since 1995] also suggested that nurses lack confidence when caring for ethnic minorities" (p108). Conway reached the conclusion that, although cultural competence was an imperative in today's world, nurses still "lacked the necessary understanding and training to undertake this adequately" (p1090) despite having preparation in transcultural nursing.

Socio-political considerations...

Jacks (1993) first noted that "Leininger and her students have avoided analyses that challenge the dominance of western political and cultural systems" (p365). Similar criticism came also from Thomas and Dines (1994). Collectively these authors raised questions about the lack of evidence that transcultural nursing had for its adequate translation into practice. They

believed the ability of nurses to apply theory to practice had yet to be proven as effective after several decades of transcultural education in nursing.

Mulholland (1995) considered also that transcultural nursing literature shared the failings of the humanist approach from which it arose. A humanist approach "emphasises notions of equality and individual freedom and operates an assumption of human commonality" (Campesino, 2008, p 299). A humanistic ethic is problematic when it is mixed with a caring that assumes all clients should be treated in 'the same way' by nurses. To treat all patients 'the same' would in effect homogenise difference, rather than facilitate care for patients as individuals. Mulholland felt the focus in transcultural nursing was located at the micro-level of individual client care and not at the macro-social level which would better acknowledge the complex socio-economic, historical and political aspects within which human experience is constructed and embedded; "recognition of the subject as situated within a network of power, might begin analysis at a different level entirely" (p447).

Culley (1996) urged nurses to realise the poor quality of much of the current research on ethnic minorities, which she claimed perpetuated cultural and racial stereotypes. Culley encouraged nurses to drill down and explore the conceptual confusion and inconsistency which has to date been operationalised in transcultural nursing's ethnic categories. Culley also advocated a deeper exploration of the discriminatory practices she believed generically influenced racism, sexism, ageism and other socio-politically structured inequities.

Gustafson (2005) also noted that rather than transforming nursing practice with ethnic groups, as it aimed to, transcultural nursing reinforced the dominant social practices and relations that are imbedded in the ranked social order of nursing and wider society. Her criticisms contribute to the collective findings of others' recent works, which consider transcultural nursing to have a concern with individual client–patient interactions rather than being concerned with broader social issues of effect. Gustafson noted that transcultural nursing relied heavily on racialised categories, whilst carefully avoiding any direct reference to race.

Lancellotti (2007), whilst acknowledging the significant contribution of Leininger, determined transcultural nursing to be a problematic approach for the contemporary practice of nursing because it bypassed the challenge of addressing racism and the various forms of oppression in pedagogy, research and practice in healthcare. She identified the collective weaknesses of

transcultural nursing scholarship as "lacking rigor in theorising, essentialist conceptualisations of culture, ethnicity and race and the reluctance to address structural systems of power within nurse–client relationships and healthcare systems" (p300). Lancellotti expressed a concern that, unless the "daunting endeavour" (p303) was undertaken where nurses confronted and examined entrenched systems of power in nursing, then little forward progress would be made towards social inclusiveness and justice in health care.

The collective findings of critique...

Nursing authors over the last two decades have identified significant limitations in the process of developing cultural understanding in nursing and, in particular, transcultural nursing. These authors have collectively isolated certain presumptions within notions of 'culture' and nursing care that are apparent in transcultural nursing. Together the critiques of Leininger's theory embody the following concerns that transcultural nursing theory:

- Is largely ethnocentric;
- Is primarily constructed around ethnicity as the sole issue of concern;
- Is positivist and reductionist, leading to a mechanistic description of ethnic groups and of the nurse's interactions with those patients, who are potentially much more complex than currently conceptualised;
- Constitutes a doctrine at risk of inferring cultural imposition whereby it encourages nurses to bracket out the diverse reality of cultures;
- Avoids issues around the socially constructed nature of culture;
- Isolates engagements with nurses within the presumed vacuum of an individual-to-individual context;
- Fails to adequately address historically driven social practices, which are embedded in exclusionary and oppressive practices within the context of healthcare;
- Offers a model whereby the patient is absent from the voices that constitute the discourse. Whilst they are pivotal to its construction, they have a place only as 'objects of study'. They do not have a voice in either the design or the assessment of the outcome of care as being either culturally appropriate or competent.

Responses to the critiques of Leininger's theory and transcultural nursing…

Daly and Jackson (2003) note that Leininger "has blazed a trail for others to follow ... her pioneering work has created a space for people to speak, engage, debate, contemplate, deliberate, develop and grow" (piv). Leininger was certainly a pioneer that first brought attention to culture as a factor of significance for nursing, but whether her work has continued to create such a 'space' in which the free exchange of ideas takes place is less certain.

Leininger's cultural care philosophy has, from the beginning, been intended to promote and progress only her particular theory of cross-cultural care: "this body of knowledge could revolutionise nursing and healthcare ... most importantly this would support the new discipline of transcultural nursing envisioned by the theorist" (Leininger & McFarland, 2002, p4). Leininger's goal was to develop and nurture nurses' ability to apply her particular theoretical approach and to adopt and employ the concepts and principles associated with her theory. "After five decades the theory of culture care diversity and universality has been established as a major, relevant and dominant theory in nursing" (Leininger & McFarland, 2002, p3).

Meleis (2006), when writing of the effect of nursing theory, tells us that knowledge breeds knowledge; the more knowledge we have, the more we seek and when we gain an understanding of a particular phenomenon it should serve to stimulate us even more to re-develop that understanding. Meleis (2006) also cautions nurses that "if only one framework is provided it can be a stifling act that prevents a person from seeing other potential avenues in understanding" (Meleis, 2006, p25). The contribution of the 'new' scholars, with their judicious reflections and more critical stance towards Leininger's theory, should have led to the development of new insights in this domain. Critique constitutes a necessary part of knowledge development and evolution, but it also explicates theoretical tensions and challenges. However, does Leininger's theory of cultural care remain open to probing and encourage critical analysis as a means to continue its further development?

Regrettably and notably there has been only a scant published response, from the proponents and advocates of Leininger's cultural care nursing theory, to the contemporary debates about its effectiveness. There have been many questions and challenges posed by the 'new' authors, as already described earlier in this chapter, but few answers provided. Proponents of transcultural nursing, rather than welcoming these new opinions and insights, which might

open up fresh directions for inquiry, have instead responded in terms of countering criticism, rather than explicating their position or integrating these new ideas and direction into their work. Neither Leininger nor other transcultural authors have engaged to any depth with, or countered the claims of, those who might disagree. Lancellotti (2008), a transcultural supporter, expresses a view that refutes those criticisms: "Leininger's culture care theory has undoubtedly revolutionised nursing by shining a bright light on culture ... whilst Leininger's theory has been criticised ... it is more likely that there is misunderstanding or misuse of culture care theory" (p180). Omeri (2003) feels that a lack of what she sees as understanding of the theory might be as a result of misinformation on the part of those scholars not prepared in transcultural nursing. "It is clear that most of the critiques of the theory of Cultural Care Diversity and Universality lack anthropological and transcultural nursing knowledge and they have evidently not taken formal studies in transcultural preparation" (p182). Transculturally prepared nurses seem to exclude others from this inner circle unless they too are 'trained' in transcultural nursing. Omeri (2004b), when writing of the need for all nurses to be transculturally prepared, states "how else other [than transcultural nursing] could students be prepared to provide meaningful, competent, safe and culturally congruent care" (p6).

Those reactions that have come from transcultural scholars and leaders such as Andrews and Boyle (2007) typify the position that transcultural leaders have tended to take to perceived criticism from outside the transcultural community: "many of the issues raised by critics have deeply rooted historical, socio-economic, religious, cultural and political origins. Because the nursing profession is a microcosm of society, it mirrors the prejudices and biases found in the larger social order; it is unrealistic to expect that transcultural nursing can reverse all the inequalities cited by the critics" (p10). Transcultural nursing theorists' failure to analyse the deeper issues is related to their isolation from mainstream nursing and their continued commitment to a humanistic analysis that precludes explorations of deeper social issues that might impact on the nursing role. Transcultural scholars should not use their knowledge just to become an expert in their particular field, rather their deeper understanding should be used as the springboard with which to instigate even more meaningful inquiry into cross-cultural nursing (Meleis, 2006).

Leininger's theory of cultural care has, it might seem, served its purpose in enabling some nurses to build upon its theoretical foundation and adopt it as a mechanism to follow in deciding upon appropriate cross-cultural nursing practice. But the continued expansion and

espousal of cultural care is as dependent on the support of those outside the ideology of transcultural care as it is on those from within. This need for other nurses to espouse the theory has not gone unnoticed by Luna and Miller (2008): "as much as we like to think all of this progress translates into effective education programs ... we are still only beginning to understand how we can provide a critical learning environment for students to grasp the key components of transcultural nursing ... we are faced with two research studies that declare we are not finding positive results in many of our attempts" (Luna & Millar, 2008, p2).

The closed community that only sees itself...

Another concern of note is an apparent insularity evident among the proponents of transcultural nursing. Transcultural scholars Luna and Miller (2008) suggest that "we have … developed into our own discipline of transcultural nursing, boasting of our unique knowledge base within the discipline of nursing" (p1). That the transcultural nursing body is a rather closed community is also evidenced by the tendency of these scholars for self citation, or the use of publications predominantly from their own field to support their writing. Whilst in any specific subject area there will necessarily be a limited group of scholars with the same interest, the transcultural scholars seem to have almost ignored and avoided the work of others.

In any text or publication, it is common to see that many of the references are to Leininger and, typically, only from other transculturally prepared scholars, despite the work of others not transculturally prepared being widely available. The following provide an illustration of common practice in transcultural publication: Leininger's (2007) article on the future of transcultural nursing used 15 references, all were her own publications and dated from 1970, with one-third having been published more than 20 years previously. This same pattern can be found repeatedly. Andrews (2008), when writing on the global impact of the theory, had 28 references of which 15 were to Leininger, eight were to Omeri, one was from herself and the remaining three were transcultural nursing standards. Likewise Papadopoulos and Omeri (2008), when writing on the challenges of application of the theory, used 19 references of which four were Leininger, six were from the *Transcultural Nursing Journal*, three were from transcultural nursing texts and the other three were from Omeri herself.

These acts of 'in-house' referencing or 'citation-recycling' can be found in many transcultural publications. Murphy (2006) undertook a review of all transcultural nursing publications in the USA from 1998–2000 as part of an effort to compile a database of library resources. Her findings support the contention that transcultural nursing literature is sourced from a relatively narrow range of material and sources. A total of 154 articles were published across three journals, the *Journal of Transcultural Nursing,* the *Journal of Cultural Diversity,* and the *Journal of Multicultural Nursing and Health.* Altogether, these articles cited 4,843 items. The *Journal of Transcultural Nursing* was the source for 2,062 (43%) of these citations. Transcultural journal articles accounted for nearly 60% of the total citations. Thirty percent of the cited items were transcultural text books. Therefore, nearly 90% of the total cited works were to transcultural literature. Of 1,468 book references, 120 of the references were to Leininger's books alone, and various editions of her books in particular were highly cited: *Transcultural Nursing* (45 times), the first comprehensive textbook on the subject now in its third edition, and *Culture Care Diversity and Universality* (38 times). Government documents, Internet sources, and miscellanea accounted for only 11% of the cited items.

There is also scant evidence of any significant changes or redevelopments having been made to the fundamental underpinning concepts that Leininger embedded into the original theory when she first developed it in the 1950's. Most of the ongoing theoretical development originates from the USA and new work primarily entails only the creation of new ways to use Leininger's original constructs (Andrews & Boyle, 2003; Leininger & McFarland, 2002, Purnell & Paulanka, 2003 and Papadopoulos, Tilki & Ayling, 2008). Despite these new frameworks, the essential elements within the ideology do not change. Leininger's theory has become a catalyst for the development of newer iterations of her material, but other authors focus predominantly on utilisation of the original theoretical constructs to describe culture and cultural care activities, they employ its methodology to compile new case studies on ethnic communities and to develop educational programs (Jirwe, 2008). Only the ethnic subject groups being researched seem to expand, as different social groups are added to the body of cultural care knowledge. "In keeping with the philosophy and goals of transcultural nursing, specific cultural values, needs and practices of different cultures will be emphasised ... in-depth studies of cultures will be essential to advance nursing care knowledge" (Leininger, 2008, piv). Whilst transcultural nursing, using its own research methodology, which has material constantly being collected and published on different local, immigrant and indigenous

cultures, the guiding principles or building blocks of the theory still remain incontestable and unquestioned.

Given that Leininger is now 83 years old, retired from the academic nursing community and in poor health, there can be little doubt that her seminal work might need to be reconsidered and advanced into the future by others. Zoucha (2008) notes this also: "There is relevance in using classic work to articulate the use of theory and research method, however, presenting contemporary work would advance the development of the theory and research method" (p211). The original constructs and ideas of cultural care diversity and universality remain intact and have not been adapted or modified in any way to be more inclusive of new ideas and changes to nurses' thinking about and approaches to culture and from which this theory would benefit.

Some final considerations about Leininger's theory and transcultural nursing

The use of ethnography as method...

As described by Andrews and Boyle (2007), numerous authors have identified transcultural nursing as the blending of anthropology and nursing in both theory and practice. Leininger's theory of culture care diversity and universality is wholly grounded within the traditions of anthropology and anthropology was once considered the "science of description" (Brunt, 1999). However, the field of anthropology has undergone a radical transformation of ideas and changed its position significantly over the last 20 years regarding participant representation (Marcus and Fischer, 1986). Yet this progression in thinking seems largely to be unacknowledged within transcultural nursing theory, which has continued to rely on the anthropological constructs originally penned in the 1950's by Leininger.

During the 1980's, anthropology underwent what has been deemed a 'crisis of representation' (Clifford & Marcus, 1986; Geertz, 1988; Marcus & Fischer, 1986). Research and writing became more reflexive and researchers sought new methods. Denzin and Lincoln (2008) explain how critical reflections on race, gender, class, power relations and claims to truth inspired these new forms of representation and led to a re-examination of the way in which anthropologists described their own and other people's experiences. Critical theory, feminist theory and epistemologies of colour now had influence and challenged many long held beliefs about the

validity, reliability and objectivity of interpretations previously believed to be accurate, "Many critical ethnographers have replaced the grand positivist vision of speaking from a universalistic, objective standpoint with a more modest notion of speaking from a historically and culturally situated standpoint ... because all standpoints represent particular interests and positions and are partial" (Foley & Valenzuela, 2005, p 218) .

Such claims should be of interest to transcultural scholars who still use a method for cultural care theory development and conducting research designed and implemented by Leininger in the 1950's. Denzin and Lincoln (2008) describe what a crisis of 'representation' might mean when using the ethnographical method. Firstly, the ability of qualitative researchers to accurately capture 'the lived experience' of others was brought into question. The participants' 'rich description' it was claimed was actually constructed through the researcher's re-interpretation of narrative and written into the text by the author. The second concern related to interpretation of 'data' and claims made regarding truth, validity, generalisability and reliability. How accurately can the 'lived experience' of individuals first be clearly understood by a researcher and then extrapolated to represent the 'lived experience' of an entire cultural group? The first two concerns shaped the third: "is it possible to change the world if society is ever only a text?" (p20). Denzin and Lincoln (2008) challenge ethnographers to reconceptualise their approach using new strategies and new methods of analysis that are cognisant of the contemporary concerns around race, gender, ethnicity and class. The world of the ethnographer today, they claim, "is a politically charged space" (p21) and as a consequence the act of research can no longer be viewed from a neutral or ostensibly objective perspective.

Given this 'crisis', which changed the approaches taken to both methodology and method in anthropology, the original ethnographical approach, utilised by Leininger and still employed for the methodology of ethno-science and data collection in transcultural nursing, may perhaps not be as relevant or as able to claim 'truths' as it was once believed. The research currently being undertaken in transcultural nursing gathers and then analyses the views of ethnic group representatives to produce culturally specific information; realising that this technique may be flawed should be of great concern. Meleis and Im (1999) make reference to this aspect of Leininger's nursing theory when they state: "to describe our clients in terms of their cultural heritage is a useful exercise for an anthropologist but perhaps it is inadequate for nurses" (p96). Indeed if, as the transcultural nurse leaders claim, "many of the issues raised by

critics have deeply rooted historical, socio-economic, religious, cultural and political origins" (Andrews & Boyle, 2007, p10), then the time has come for transcultural nurses to deal with rather than avoid these issues, as challenging and problematic as this might be. It is concerning that a theory that claims to provide new insights into culture for nurses, to provide a trustworthy knowledge base and to influence positive outcomes for patients does so using a methodology that has not been responsive to contemporary trends and concerns.

Considering the context and authority of culture care theory...

Davis (2006) questions why nursing has embraced a theory developed for the USA and imported it into the nursing world of other countries so unquestioningly. As she notes, "it is what I call 'pop-trans-cultural nursing', it leads to bits and pieces out of a whole cultural cloth, this needs thinking about even more than before ... it is long overdue for all of us to start developing nursing knowledge and practice that is relevant to our own cultures. One might even say there is a moral imperative to do so" (Davis, 2005, p80).

Santos-Salas (2005) reiterates this concern when she asks to what extent the establishment of the American 'grand theories', such as that of Leininger, reveal a concealed hegemonic approach in nursing. She refers to the pervasive global spread of American nursing theory *per se*, of which Leininger's work is an example. Im and Meleis (1999) also discuss the way that the nursing profession has sought to consolidate itself as a discipline through the development of 'grand' theory. But the question must be asked, has the time for meta-paradigms that can be applied globally in nursing passed? Santos-Salas voices reservations about the introduction of American theories into the context of other nations: "the transplantation of American ideas to other places has been facilitated by the fact that nursing scholars often present their work in such a way that leads others to believe it is applicable to their own contexts" (p20). Fawcett's (2002) comment "that these [American] theories do not represent the values and beliefs of any one country or culture and are therefore international in scope and substance" (p95) seems ill considered at best. The extent to which these imported theories address the local life-world, culture and people of a country other than America is rarely questioned. Are values identified by ethnicity, for example 'Chinese' or 'African' really able to transcend context or country? Even if ethnic identity is enduring is being Chinese the same identity and experience in China as in the UK or the USA? This probable error in judgement can be seen in the relatively unquestioning way that nurses in other Westernised countries, like the UK and

Australia have utilised transcultural nursing with only minimal adaption to the local context. It is apparent that these nurses have leaned heavily on transcultural nursing rather than looking to their own scholars. It can also be seen in the way in which New Zealand nurses rejected the theory in that country and turned instead to more local theory.

The relative power within the nursing world of the USA, with its long held authority on the international stage and dominance in the literary and academic worlds of nursing, is perhaps a factor in the success of Leininger's cross-cultural theory (Santos-Salas, 2005; Hassouneh, 2006). Leininger and transcultural nurses may believe that their theory has the capacity to represent broad consensus about how to achieve excellence in cross-cultural care, but it might be that it actually represents only the views of white, Westernised American nurses. A silent minority within nursing, albeit less articulate, might hold other views and be hoping that the discipline will move in a new direction (Malinski, 1996). Santos-Salas (2005) and Hassouneh (2008) offer some thoughts for consideration, which would certainly support such a case: "theories in their desire for a unitary and totalising truth may easily lend themselves to marginalise and exteriorise the other" (Santos-Salas, 2005, p22). Read (2001) asks that we consider how "Americans establish a framework based on what they think is good for people but which is often unrelated to their reality ... then they try to fit the people into the ideas rather than the other way around" (p121).

Indigenous nurses from around the world are certainly saying that their views are not represented in terms of Leininger's theory of cultural care for nursing (Serrant-Green, 2001; Goold 2001, 2006; Ramsden, 2002; Wepa, 2005; Sherwood & Edwards, 2006; Hassouneh, 2006). This is echoed in the views of those authors already discussed in the critique section in this chapter, who lend their voices to concerns about both the legitimacy and relevancy of transcultural nursing for the profession today.

Chapter 4

THEORIES OF CULTURAL CARE IN NURSING

Cultural Safety — Te Kawa Whakaruruhau

Irihapeti Ramsden (1946-2003)

"Every culture has a right and responsibility to present its own culture to its own people. That responsibility is so fundamental it cannot be left in the hands of outsiders, nor be usurped by them" (Dowmunt, 1993, p7)

Leininger's theory dominated the field of cultural care philosophy for many years. However, recent times have seen the emergence of a small number of alternative views and approaches. Irihapeti Ramsden's (1992) model of 'cultural safety' (Te Kawa Whakaruruhau) is one such model that has been developed and used by nurses in Aotearoa/New Zealand. Over the last 10 years, cultural safety has also been recognised in the international literature on nursing and culture. Canadian nurses have become increasingly interested in exploring this model, as have nurses in Australia and the UK, albeit to a lesser extent (Davies, Finlay & Bullman, 2000; Browne & Fiske, 2001; Smye & Brown, 2003; Anderson et al, 2003; Reimer-Kirkham et al, 2003; Evans, Elder & Nizette, 2004; Funnell, Koutoukidis & Lawrence, 2004; Glasper, 2005; Wepa, 2005; Mitchell, Wilson & Wade, 2006; Pairman & McAra-Couper, 2006; Walton & Marriott, 2007).

Aotearoa/New Zealand was settled by the British in 1840 after the Treaty of Waitangi /Te Tiriti O Waitangi was signed with the indigenous population, the Mäori. This founding document was a unique social charter for its time, one which had not been used in other British colonies. It guaranteed particular social and economic rights to the indigenous peoples, among them the right to equality in all civil and social interactions and indigenous self-governance (Tino Rangtiratanga). After the first 200 years of colonisation, Aotearoa/New Zealand underwent a major shift in social direction in the 1980's. Significant levels of political activism, in which the Mäori people called for an increased recognition of indigenous rights, led to a restoration and honouring of the original rights, which had become neglected over time. These rights are now enshrined and mandated under the laws of Aotearoa/New Zealand and, most importantly, it

was now required that all citizens and government agencies honour these fundamental principles (Aotearoa/New Zealand Government, Treaty of Waitangi Act 1975). As a result, national legislative changes were enacted to foster a spirit of bicultural development and a number of social initiatives were put in place. Education and health services were among the first to respond (Spence, 2003). As Ramsden (1993) explains:

> *"Historians will describe this period in the Pacific as post-colonial. A time of redefinition of identity, of argument for the redistribution of power and resources from the indigenous people … the Mäori people of Aotearoa are beginning to recover sufficiently from the horrors of the colonial experience to carry out an analysis and examination of the Aotearoa/New Zealand health service … it has not stood up well to scrutiny in local or international terms" (p5).*

Cultural safety as a theory for guiding nursing care was developed in the neo-colonial context of contemporary Aotearoa/New Zealand, as a direct response to the poor health status of the Mäori people. In former colonies, indigenous populations may expect to experience a number of social inequalities. This can be seen most especially in relation to health status and burden of disease (Richardson, 2004). Life expectancy for indigenous people in colonised countries around the world is shorter than it should be. This has become evident in the former British colonies of Aotearoa/New Zealand, Australia and Canada. Poorer social and educational opportunities, poverty, crime and destructive lifestyle preferences all contribute to this inequity, but "failures in service organisation and delivery are part of the picture" (McPherson, Harwood & McNaughton, 2003, p443).

In Aotearoa/New Zealand, considerable value is now attached to the goal of offering culturally safe nursing services (Clear, 2008). Registered nurses are required, at the completion of their education, to demonstrate nursing skills consistent with the aim of cultural safety, in order to receive registration and subsequently retain a practicing certificate from the Aotearoa/New Zealand Nursing Council (NCNZ, 2005). The formal definition of cultural safety is: "the effective nursing practice of a person or a family from another culture as determined by that person or family" whilst unsafe nursing practice is "any action which diminishes, demeans or disempowers the cultural identity and well being of an individual" (New Zealand Nursing Council, (NZNC), 2005, p4). Cultural safety has become concerned with social justice and

"quickly came to be about nurses, power, prejudice and attitude rather than the ethnicity or cultures of Mäori or other patients' (Ramsden, 2002, p5).

Mäori nurses were adamant that the delivery of nursing care required profound change. This began a process of professional self examination that has led to the adoption of cultural safety in nursing education in Aotearoa/New Zealand. In the late 1980's, Ramsden (1990) first developed a model of 'Negotiated and Equal partnership', which was the precursor of 'cultural safety'. The perceived detrimental and enduring social effects of colonisation on the health status of the indigenous Mäori were a significant force in shaping the development of the concept of cultural safety for use by nurses. Cultural safety is an educational strategy and a practice-based model for bicultural nursing (Ramsden, 1990). Cultural safety is described by Ramsden as being concerned not only with individual rights but also with power and resources and their distribution and management in society. Cultural safety has a primary interest in the effect of unequal resource distribution on nursing practice and, as a consequence, its ongoing effect on patient well-being.

Cultural safety is framed within the history of Aotearoa/New Zealand as a British colony and grounded in the belief that the experience of colonisation is an explanation for the poor health status of Indigenous Aotearoa/New Zealanders. As Ramsden (2002) writes, cultural safety was designed to focus attention on life chances, that is, access to health care and the type of care that is provided, rather than being focused on the specific cultural practices of minority ethnic groups. Cultural safety is instead centered on the "notion of the nurse as a bearer of his or her own culture and attitudes, and who unconsciously or consciously exercises power" (Ramsden, 2002, p109). The cultural safety model went further than studying the cultural 'other' and avoided the teaching of ethnographically derived knowledge(s) such as the life ways of specific ethnic groups. Ramsden believed that an 'ethnicity' approach provided information that was non-specific to individual persons and that any definable ethnic group norms were too diverse to identify, isolate and use when providing nursing care to patients as individuals, albeit that those patients might be from a broader, identifiable ethnic group. Ramsden (2002) was concerned with a need to avoid the development of cultural stereotypes, which she felt increased the risk of building another anthropologically based nursing model when she wrote: "when care is focused on the cultural activities of the patient, there remains a tendency to promote a stereotypical view of culture over time, thus making it difficult to respond to individual diversity" (p112).

There has been some debate in the literature as to whether cultural safety actually constitutes a theory. Leininger (1997) claimed her theory of cultural care: diversity and universality "to be the only theory focused explicitly on cultural care phenomenon" (p17). Andrews (2008) and Omeri (2004a) also described transcultural nursing as the only true theory of culture in nursing, the implication being that describing knowledge as a theory in some way increases the legitimacy of its claims. As the development and structure of 'nursing' theory has predominantly been an American phenomenon, this might lead scholars in countries other than the USA to believe that without a 'theory' in the American tradition, they might be "still in the early stages of development, a 'barbarian' stage, so to speak" (Santos-Salas, 2005, p19). America's rigid schema of theory creation has seemingly justified the transference of American nursing theory to other countries and contexts. As Im and Meleis (1999) explain, American theories sometimes display a "lack of consideration of the socio-political, cultural or historical contexts in which nursing takes place and this may result in their providing guidelines of little use" (p14). For the purposes of this thesis, it matters little whether cultural safety is either a model or a theory. As stated by Ramsden (2002), the worth of cultural safety is not in its claim to tradition: "its greatest strength is to challenge ... what cultural safety as an academic idea does, is that it re-invents or reclaims the need to critically analyse things and I think that's most important and its greatest strength in a general academic sense" (p127).

An outline of Cultural Safety — Te Kawa Whakaruruhau

Cultural safety is a term developed for use in nursing education and is unique to Aotearoa/New Zealand (Wepa, 2005). Mäori student nurses originally coined the term 'cultural safety', which was taken up by Ramsden as a description for the particular type of nursing care believed to improve the capacity of nurses in Aotearoa/New Zealand to deliver services to the indigenous ethnic group (Papps and Ramsden, 1996; Polaschek, 1998; Hughes and Gray, 2003). Its genesis was in the 'lived experience' of indigenous nurses (St John and Kelleher, 2007). The model was written by Ramsden but she drew extensively on the experiences of Mäori and their accounts, as a minority ethnic group, of health and nursing experiences. The term 'safety' was intended to embody the meanings implicit in security and protection. Safety was chosen as it was a construct already well embedded in healthcare and it is clearly understood as defining minimal standards for nursing care: "it is in line with the requirement that nurses are legally, ethically and physically safe to practice and that practice is underpinned by sound

knowledge" (Ramsden, 1993, p6). Safety was intentionally linked to culture to imply that the users of nursing service might reasonably expect not to be harmed or compromised in a range of ways, physically, emotionally or spiritually, by the provider of nursing care. Cultural safety professes to empower patients to 'feel safe' and, if they do not, to express their feelings about that 'lack of safety'. In cultural safety it is the patient, not the nurse, who decides whether the service is appropriate for them as an individual and this is to be judged from the perspective of the recipient of care, not the provider (Papps & Ramsden, 1996).

What makes 'cultural safety' from Aotearoa/New Zealand unique is that it originated in a bicultural rather than a multicultural context. The model arose from within an 'ethnic' minority group itself, rather than being generated by the dominant cultural group, the Anglo-Europeans, for application to other ethnic groups. Ramsden (2002) describes how "initially, I too adopted a multi-culturalist/multi-ethnic approach" (p81) but cultural safety was instead developed for use in a bicultural context, that of Mäori and Pakeha (non-Mäori) peoples. Ramsden (2002) describes culture in her model as "based in a postmodern, transformed and multilayered meaning ... diffuse and individually subjective" (p109) and, further, that "culture is the accumulated socially acquired result of shared geography, time, ideas and human experience. Culture may or may not involve kinship but meanings and understandings are held collectively by group members" (Ramsden, 2002, p111). Ramsden adapted her definition of culture to make an association with the following viewpoint related to social power and minority cultural groups: "when one group far outnumbers another or has the power to impose its own norms and values on another, a state of serious imbalance occurs which threatens the identity, security and ease of other cultural groups, thus creating a state of dis-ease" (NZNC, 1992, p1).

As well as this, cultural safety constitutes a distinct shift away from the more traditional anthropological schema used in transcultural nursing and moves instead toward a more critical socio-political approach (Hepi, 1997; Wepa, 2003). Cultural safety is also inextricably linked to the Treaty of Waitangi; this remains a key instrument for defining equal and negotiated partnership and for power and resource sharing between Mäori and Pakeha, which can be translated into contemporary action. The use of the Treaty in a model of nursing may also have been one of the reasons that nurses outside Aotearoa/New Zealand, such as Leininger, may find cultural safety difficult to understand.

Cultural safety is based on the premise that the term 'culture' "is used in its broadest sense, to apply to any person or group of people who may differ from the midwife/nurse … rather than being focused on ethnicity" (Ramsden, 2002, p114). This emphasis on bicultural means people are seen as Mäori and 'others'. Others are anyone who is not Mäori, which might include European, Asian Pacific or any 'other'. This 'other' might well be deemed multi-cultural, so that construct is not excluded (Richardson, 2004). Ramsden maintains that the term bicultural does not exclude any group of people, as she concludes that whenever two people meet and engage it involves a meeting or convergence between them. Ramsden (2002) explains that, "all nurse interactions are bicultural, as that interaction can only be with one person at a time, there is one giver of a message and one receiver, regardless of the number of cultural frameworks through which the message is filtered" (p6). All nurse–patient meetings are said to be bicultural within cultural safety, because they involve individuals who will differ in social terms; this might be by an ethnic cultural identity but it might be in terms other than ethnicity (Richardson, 2004). Every relationship and interaction between a provider and consumer is considered unique and power laden. In the case of the nurse and patient, they might well be unequal in terms of knowledge and power. Ramsden (1993) also argued against the use of the construct of multiculturalism: "Multiculturalism is simply a statement about the range of cultural groups present in a society, [especially] if those people do not have the power to define and negotiate the policies and practices" (p6).

Cultural safety represented an ideological shift for nursing in Aotearoa/New Zealand, with its move away from a more positivist approach to care and the need for scientific proof to underpin thinking, towards a more interpretive approach, which included having a range of possible interpretations and 'truths' about the reality of a situation (Richardson, 2004). Cultural safety differs from transcultural nursing, in that cultural safety is concerned with the persona of the nurse rather than the cataloguing of the beliefs and practices of various minority ethnic groups which can then be applied to patient care. Cultural safety is primarily focused on the nurse as the bearer of their particular personal culture which might differ from and impact on the recipient of care, the patient, in this case the indigenous population of Aotearoa/New Zealand (Ramsden, 1990). Providing culturally safe care for patients involves the nurse recognising their own personal cultural understandings, perceiving their own potential for holding negative attitudes and developing a knowledge of the risk that lies in mono-cultural healthcare systems towards stereotyping some individuals/patients which then leads to stigmatisation and a negative affect for the patient or receiver of service. As Ramsden

(2002) explains, “for me the exciting thing about cultural safety is, if colonisation was about civilized England creating a ‘primitive other’ whom they could dispossess, what cultural safety tries to do is make the Pakeha the ‘other’ “that’s why it’s so difficult for many Pakeha, they are so used to being ‘it’, and everything else is different” (Ramsden, 2002, p109).

Cultural safety differs from transcultural nursing in that it does not require the nurse to learn specifics ‘facts’ about particular ethnic groups, rather it eschews the provision of ‘data-bases’ in the manner of ethno-nursing, which for the most part is based on cataloguing and developing specific lists of ethnic group cultural norms. In transcultural nursing, specific information on the target ethnic group is sought by the nurse from ‘cultural informants’, those who belong to a specific ethnic group. The skill for the nurse in cultural safety, on the other hand, does not depend upon knowing the customs of ethno-specific groups. Rather, the obligation is for the nurse to recognise that they themselves differ from the patient and the skill lies in coming to understand the patient on an individual level. This leads to a valuing and respect for that difference, rather than the consulting of a ‘list’ outlining specific ethnic differences. The act of nursing involves engaging with any number of persons from different cultures all of whom will have unique and different, shared or individual history and different ethnicities and varying levels of material and social privilege. The nurse using cultural safety is required to explore the ways that these issues might influence the nurse–patient relationship (Chevannes, 2002). There is “a focus on the nurse; their attitudes, prejudices and role power rather than being about the ethnicity or the culture of the individual as a patient” (Ramsden, 2002, p4). Cultural safety relates more closely to the promotion and protection of an individual’s identity, rather than the nurse merely gaining an appreciation of the beliefs, rituals, customs and practices of that other group (NRNE, 2002).

Although cultural safety had a convincing philosophical platform and was framed within a critical emancipatory theoretical paradigm, it became apparent that it was challenging to clarify its translation into more practical terms (Ramsden, 2002; Richardson & Carryer, 2005). Scholars, educators, students and practitioners all voiced confusion about translating this philosophy into the less abstract format required for teaching and practice (Richardson & Carryer, 2005). To clarify this, cultural safety came to be taught using broad sociological principles that included educating nurses to examine their own cultural and social reality and to more deeply understand the attitudes they bring to their nursing practice. The goal was to encourage nurses to be more open-minded and flexible towards the patients they worked with

and to ensure that the victims of historical and social processes should not be blamed for their current situation (Ramsden, 1993). As a consequence, a number of different teaching methods and resources were used and varied with the provider institutions and individual teachers. There was no national standardised curriculum. Ramsden (2002) again sought to clarify this with the development of the following model, which is the process towards achieving cultural safety in nursing and midwifery practice (Figure 6, p117)

3. CULTURAL SAFETY is an outcome of nursing and midwifery education that enables safe service to be defined by those that receive the service.

2. CULTURAL SENSITIVITY alerts students to the legitimacy of difference and begins a process of self-exploration as the powerful bearers of their own life experience and realities and the impact this may have on others.

1. CULTURAL AWARENESS is a beginning step towards understanding that there is difference. Many people undergo courses designed to sensitise them to formal ritual rather than the emotional, social, economic and political context in which people exist.

This model determined a series of steps that are to be achieved in developing culturally safe nursing capacity and practice. Cultural safety is essentially not Anglo-Celtic in origin or schema and, as most measures of process and outcome have more traditionally been based on Eurocentric or American principles, this caused some confusion (McPherson, Harwood & McNaughton, 2003). Ramsden (2002) specifically counselled teachers to avoid "cultural tourism or voyeurism" (p80) which she deemed to be the teaching of specific information about the culture of the patient, which she believed "belongs to the culture and as such, cultural identity and traditions should remain with the culture" (p113). Ramsden reported however that nurses preferred information that "gave them something to quantify and repeat back" (p80) and that "I came to struggle hard against the checklist mentality' (p80). Culley (2006) also discusses how nurses invariably favour a 'check-list' approach and that this approach to ethnic identity is easier to understand and apply. However, this turns cultural care into a task, rather than a process, an approach not fostered by Ramsden. Basing a curriculum and nursing practice skill set on philosophy, guidelines and open frameworks, not on ethnic 'check-lists', has been the source of much of the confusion and critique that exists about cultural safety. Fitzpatrick (1998) describes one of the challenges in understanding cultural

safety: “there is little literature relating to its application in education and practice from a Pakeha/Tauiwi perspective” and “another significant factor relating to cultural safety is the perceived difficulty many students experience when attempting to put theory into practice” (p3).

Cultural safety is supported by a variety of sociological theories and concepts, which whilst providing a foundation, require that nurses develop the skills to analyse and critique contemporary health care delivery and service. The central principle of cultural safety is an exploration of professional knowledge and position and the power that this infers, which has an impact at both a personal and an interpersonal level. For nurses, cultural safety is about learning to work in a partnership by coming to understand *themselves*, their identity and how they define and legitimate their place in the world (Jungerson, 2002). The teaching of cultural safety involves nurses examining how power is expressed by nurses in communication and in what way power influences the nurse–patient relationship, the healthcare settings and provider organisations. Nurses are required to reflect upon and examine their attitudes, beliefs and values rather than exploring those of an ‘anonymous and absent’ simulated patient, which is the more traditional and familiar teaching method. Cultural safety involves the recognition of negative attitudes and stereotyping of individuals on the part of the nurse, but “it is not easy to see yourself as others see you and not very comfortable seeing yourself as the possible problem” (Jeffs, 2001, p43). To explore personal attitudes and beliefs when presented with the reality of a discriminatory and exclusionary healthcare system supported by evidence and statistics to that effect was challenging. Often this led to the examination of quite complex topics such as marginalisation, prejudice, discrimination and racism (Bickley, 1988; Ramsden, 2002) Quite how to manage critical analysis and challenge and confront nurses’ deeply held personal and professional assumptions has been much debated by educators and scholars in Aotearoa/New Zealand (Ramsden, 1995; Wepa, 2003; 2005; Spence, 2003; Richardson, 2004; Simon, 2005; Gibbs, 2005).

There has been some controversy about the model of cultural care and its introduction into nursing in Aotearoa/New Zealand, especially given that it has been seen as critical of current healthcare services and is perceived as advocating for the rights of minority groups (Gibbs, 2005). This controversy has highlighted and fuelled misconceptions and misunderstandings about cultural safety that persist to this day. Over time there have been many interpretations and descriptions of cultural safety, not all of them accurate (Ramsden, 2002; Richardson,

2004). Progress has certainly been made and cultural safety remains the central cross-cultural teaching model in Aotearoa/New Zealand. However, Jeffs (2001) and Wepa (2003) both report that there are outstanding issues that require resolution. Nursing teachers often felt under prepared, and some professed they felt a lack of institutional support for teaching in this area. Warren (2003) found that students generally lacked a cogent understanding of the concept of cultural safety, some remained puzzled by biculturalism and others did not have a clear appreciation of their own culture. The question remains here: does this speak to the failure of cultural safety or does it symbolise the inherently difficult nature of describing and teaching about culture?

Since its introduction in 1992, the concept of cultural safety has been in a process of constant refinement and re-definition. In 2005 the NZNC published the most recent guidelines, which reflect some changes from its original conceptualisation. Although Mäori health remains central to the concept, Kawa Whakaruruhau (cultural safety within the Mäori context) has become a separate but still inherent component of cultural safety. Criticisms of a perceived inequity in the way that vulnerable groups, other than those defined by ethnicity but who were also marginalised, have been defined, has also been addressed and acknowledged. Certain clauses were amended, as was the definition of culture, to acknowledge wider social diversity. Culture became underpinned by a new description: "the beliefs and practices common to any particular group of people" (NZNC, 2005, p1). The cultural safety model already defined that all nurse–patient interactions were bicultural in nature, so application of the concept bicultural has been extended beyond Mäori and 'ethnic' groups for a more inclusive approach: "difference by age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief and disability" (p3).

Cultural Safety — Kawa Whakaruruhau: its utilisation and proliferation

Since the 1990's, the nursing model of cultural safety has been integrated into the nursing curriculum and regulatory structure of nursing in Aotearoa/New Zealand and has contributed significantly to the recognition of the place of Mäori in healthcare services in that country. It is also used in the training of social workers (Fulcher, 1998) medical students (Crampton, Dowell, Parkin & Thompson, 2003) and occupational therapists (Jungerson, 2002) in Aotearoa/New Zealand.

Over the last 10 years, cultural safety has been attracting some international interest and adding to the discourse on culture, most noticeably in the Canadian and Australian contexts (Horton & Fitzsimmons, 1996; Williams, 2002; Smye & Browne, 2002; Anderson et al, 2003; Stout & Downey, 2006). The ex-colonies of the former British Empire are now finding that they have a common experience in the post-colonial and are considering the approach taken in cultural safety for its relevance to their own indigenous peoples. The indigenous nurses in Australia, the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN), endorsed cultural safety in 1995 and Canadian nurses have also shown an interest in its applicability for them (Reimer-Kirkham & Anderson , 2003; Anderson et al, 2003; Stout & Downey, 2006; Browne et al, 2009; Reimer-Kirkham, et al, 2009).

Canada…

Canada is the country most notable for its examination and utilisation of cultural safety outside the context of Aotearoa/New Zealand. Canada has found a resonance with cultural safety in its search for understanding about providing health service for its own indigenous population. The concept of cultural safety had an "unequivocal pull for nurses" in Canada (Reimer-Kirkham et al, 2003, p226). Canadian scholars on culture have extensively cited cultural safety, see: Smye and Brown (2002), Reimer-Kirkham and Anderson (2002), Anderson and McCann, (2002), Anderson et al (2003), Gustafson (2005), Browne and Varcoe (2006) and Stout and Downey (2006). Collectively, these authors have made significant contributions in advancing arguments across a range of issues related to culture and nursing. As a group, they have pioneered the use of a postcolonial critical approach, as an analytical tool for exploring matters of race, racialisation, 'difference' and culture, hence their favourable reception of cultural safety.

Browne and Fiske (2001) cited cultural safety for its use as a philosophical framework in developing greater capacity in nurses to work cooperatively with Indigenous Canadians and noted that cultural safety "extends analyses well beyond culturalist notions ... it fits well within a broader theoretical orientation" (p127). Reimer-Kirkham and Anderson (200) looked to post-colonialism when they determined that multiculturalism had failed to address the hierarchies of power and legitimacy that existed among different centres of cultural authority. They suggested that all nations are colonies of one sort or another and as such constitute binaries of

national identity. They also felt that nursing attention was being too focused on particular ethnic groups and practices defined by their being different, exotic and interesting to Anglo-Saxon researchers. Reimer-Kirkham et al (2003) write of being introduced to the concept of cultural safety in the late 1990's and realising its potential and usefulness because of "its post-colonial attention to historical power differences, it also seemed to offer the capacity to critically analyse the current health care system and the hospitalisation and help-seeking behaviours of diverse ethnocultural populations" (p224).

These authors declared a twofold interest in the model, firstly in its potential for application to research and also in the possibility of "exporting the concept of cultural safety for use in Canada, particularly in understanding the experiences of racialised migrant groups" (p226). This interest led them to consider its potential compatibility and its fit with the national multicultural policy mandated in Canadian institutions and communities, unlike the bicultural context of its original country. The conclusion reached was that cultural safety offered a critical direction to foster and deepen understanding of social history and especially that of post colonial societies, most especially Reimer-Kirkham et al (2003) stated "we reframed cultural safety, not as a concept cast within biculturalism or multiculturalism but as being within a space in which cultural meanings are being negotiated and transformed" (p230).

Smye and Browne (2002) used cultural safety to analyse health policy affecting the aboriginal peoples of Canada. In this instance, they employed Ramsden's model, not in its educative sense but as a guide to postcolonial scholarship. They saw cultural safety as an alternate view of culture to that currently being advanced in Canada or the United States. They claimed that current conceptualisations mask the way that people are disadvantaged on the basis of culture. They claim that cultural safety was not something they looked at, but rather "something they looked through, an analytical lens, which itself is being reflected on and interrogated" (p45). They advocated using cultural safety as a guide by which "we can better critique issues of institutional racism and discrimination" (p54). Cultural safety they felt provided a discourse within which to frame up questions about the 'rightness' of policy developed within a dominant Anglo-Saxon health sector for use by the Canadian indigenous peoples. "The postcolonial framework offered by cultural safety alerts us to examine not only current inequities … but also the long histories of economic, social and political subordination that are at the root of current health and social conditions among aboriginal people" (p49).

Browne and Fiske (2006) also found positive features in this model "this line of questioning differs significantly from culturalist approaches that focus (superficially) on cultural sensitivity or basic communication strategies" (p143). Stout and Downey (2006), Indigenous Canadian nursing researchers, described cultural safety as "moving the nursing of indigenous people in a new trajectory" (p327). These indigenous nurses from Canada feel that cultural safety as a conceptual model "makes room for self determination and traditional knowledge" (p330).

Browne et al. (2009) state they were drawn to using cultural safety because of its compatibility with critical theoretical perspectives "that foster a focus on power imbalances and inequitable social relationships in health care" (p167). They recognise that aspects of the theory, such as its conceptualisation of culture and safety, require ongoing development. Nonetheless, they consider that its central objective of social justice is well matched to supporting cultural care development and capacity in Canada's nurses. The authors consider that it has much potential and merit for translation into a Canadian teaching–learning model.

Australia…

Australia has also shown interest in cultural safety as a useful model, especially in relation to indigenous health. Eckerman et al (2005) believe that cultural safety "is a way of understanding the workings of power within healthcare; it exposes inherent assumptions and offers potential solutions to critical imbalances of power" (p175). They also note that, "unfortunately far too few writers today are aware of the roots of the concept of 'cultural safety' and indeed even of its meaning" (p175). These authors draw extensively on Ramsden's model and writing for their applicability to indigenous health and health outcome improvements. Australia, like Aotearoa/New Zealand and Canada, is looking for tools to explore the complex post-colonial social order that these societies have inherited into the twentieth century. Indigenous health statistics in Australia, like those of New Zealand, reflect the combination of historical, cultural and economic issues that translate into negative health outcomes for its first-citizen peoples. Health services in Australia, "with all their goodwill, are still seen as part of the white bureaucratic system, which in the past has been one of oppression and imposition" (Eckerman, et al, 2005, p181). The approach of cultural safety is supported by a number of indigenous authors (for example, Goold, 2001; Williams, 2002, 2003; Goold and Usher, 2006; Sherwood and Edwards, 2006; Kelly, 2006; Willis, Rameka and Smye, 2006).

Many textbooks used in Australian nursing education now contain chapters citing cultural safety as relevant and useful for the Australian context and advocate its use across a range of different nursing interests. For example, see : Evans, Elder and Nazette, (2004), on mental health nursing; Roger-Clark, McCarthy and Martin-McDonald, (2004), on chronic illness; Mitchell, Wilson and Wade in Elliott, Aitken and Chaboyer, (2006), on critical care nursing; Pairman and McAra-Couper in Pinchcombe, Thorogood and Tracey, (2006), on midwifery; Crisp, & Taylor, (2005), on the fundamentals of nursing; St John and Kelleher, 2006), on community nursing; Walton and Marriott in Brown and Edwards, (2007), on medical surgical nursing; McMurray, (2009), on primary health care; Kerridge, Lowe and McPhee, (2009), on ethics and law for health professionals. However, whilst recognised in education, its application to nursing practice has yet to be realised (NRNE, 2002; Johnstone & Kanitsaki, 2005).

United Kingdom…

In the UK there has been some recent, if limited, interest in cultural safety. Narayanasamy (2003) claims that "clients need to derive a sense of cultural safety in the healthcare environment" (p186) and states that cultural safety is congruent with, and part of, Leininger's theory. However, the claim made that cultural safety has an origin in transcultural nursing might not resonate with Ramsden as the author of the model, or with the nurses of Aotearoa/New Zealand (Cooney, 1994; Coup 1996; Smith, 1997; Spence, 2003; Richardson, 2004). Narayanasamy concludes that nurses in the UK have a need for further professional development and should incorporate cultural safety into the literature of interest. Some texts in nursing — for example Davies, Finlay and Bullman, (2000), and Glasper, (2005) — cite cultural safety in chapters on cross-cultural care.

Nurses in the UK, unlike those in Australia and Canada, have not appeared to explore or use alternative models of cross-cultural care to any great depth. Narayanasamy (2003) does suggest that "there is a consensus that a sense of cultural safety is most likely to promote trust and therapeutic relationships" (p186). But it seems that she also considers cultural safety to be part of transcultural nursing: "the other important aspect of transcultural care is the issue of cultural safety" (p191). As has already been stated, subsuming cultural safety within transcultural nursing is an act that would be vigorously protested by Ramsden (2002), but it is

a claim made by Leininger (1997). Narayanasamy's conclusions show some knowledge of the model of cultural safety, but she is confused about its conceptulisation. Hart, Hall and Henwood (2003), also from the UK, write about cultural safety as having usefulness for that country. They express some concern about its application in contexts beyond New Zealand and "its vague nature" (p7), but they state, "it is clearly a concept that has relevance" (p7). Cortis (2003) also cites cultural safety from New Zealand as an essential element in acknowledging the validity of the patient's perspective. Cortis (2003) utilises the writing of cultural safety when discussing opportunities for the development of cultural care nursing practice in the UK.

Culley (2006) has also considered the model of cultural safety and stated: "the concept of cultural safety usefully prompts us to consider how health policy discourses have been shaped in relation to political, social and economic structures" (p146). Culley wrote that cultural safety potentially offered a new analytical lens and encourages researchers, practitioners, and educators to question the culturalist assumptions that underpin nursing services and mistakenly reduce racism, inequity, and marginalisation to ethnocentrism, lifestyle choice, and cultural difference.

The new work on culture, such as the post-colonial work of Canadian scholars — for example that of Anderson and McCann (2002); Reimer-Kirkham, et al (2003); Smye & Browne, (2002) or Browne and Varcoe, (2006) — which has an association with cultural safety, does not appear to have had any significant impact on or response from cultural care scholars in the UK. In the main, the UK still relies predominantly on transcultural nursing philosophy.

Critiques of Cultural Safety— Te Kawa Whakaruruhau

Whilst the philosophical and theoretical basis of cultural safety has been developing in Aotearoa/New Zealand for over two decades, there has been little vigorous public debate or critique about the model from nurses in Aotearoa/New Zealand. One reason for this might be the strong resistance that was the initial reaction from the public of Aotearoa/New Zealand at the time of its inclusion into nursing curricula. The response from the public was largely driven by a fear of Mäori separatist politics, as Ramsden was Mäori and very vocal in criticism of the health service and its failure to meet Mäori needs. The general public were worried that accepting cultural safety as a part of nursing education would provide Mäori with a means of

social primacy and feared that studies about culture would take the place of the more bio-medical and technical aspects of nursing (Papps and Ramsden, 1996; Warren, 2004).

Since the strong public reaction to cultural safety in Aotearoa/New Zealand in its early days, nurse scholars in Aotearoa/New Zealand have themselves provided little developmental critique of the concept, and seem more inclined to defence in the face of such a strong public reaction (Papps, 2002; Ramsden, 2002). As stated by Ramsden (2002), "as a result of all the [external] political involvement there was a galvanizing of support for cultural safety education from the nursing and midwifery professions'" (p102).

Aotearoa/New Zealand is a small country, with only four million people and just over 48,000 registered nurses (NZNC, Annual Report, 2006). In such a small professional community, key nursing figures tend to be well known to most nurses. The lack of critique of cultural safety from New Zealand nurses may well be a testament to the high level of respect and strong personal support which has always been shown towards Irihapeti Ramsden as an individual. Ramsden undertook much of her work developing the concept and introducing cultural safety into nursing education while she was terminally ill (she died in 2003) and this was well known to the highly cohesive nursing community. Ramsden did note, in 2002, that healthcare service infrastructure and patient empowerment were two areas of concern to her in the model and which needed further development (Clear, 2008).

Polaschek (1998) wrote the first critique of cultural safety to come out of Aotearoa/New Zealand, when he explored the contradictions and anomalies of the model. Polaschek commented on the ambiguous nature of the model and the way in which the definition of cultural safety had been always articulated in the negative. That is, whilst unsafe practice was clearly delineated as being that, which diminished, demeaned and discriminated against individual patients, no cohesive definition existed of the positive aspect or detailed exactly what constituted culturally safe nursing practice. This would seem a highly relevant point to be made and one which deserves further inquiry; it is concerning that cultural safety is better defined by its absence than its occurrence. Reviewing the work of Ramsden, Polaschek concluded that the supposed beneficiaries of this new nursing knowledge, the Mäori, were described collectively, based on their poor health status. This, Polaschek (1998) claimed, intensified rather than diminished the confusion between the personal and the societal which Ramsden claimed to be addressing in her work. Polaschek (1998) thought that changing

individual nurses' attitudes and ideas was only a partial solution. Ramsden, he asserted, wrote about cultural world views as the cause of the problem, and founded in power and oppressions outside of nursing and yet Ramsden relies on the individual nurses gaining enlightenment to alter them, an evident contradiction. He argued that a single nurse, no matter how enlightened, will have little effect on large-scale social institutions and embedded structural inequalities. Polaschek claimed that cultural safety needed to be reconstructed to be more inclusive of the organisational context within which nurses' work for it to have any significant impact.

Fitzpatrick (1997), another nurse from Aotearoa/New Zealand, wrote that "many of the sociological and cultural safety concepts are extremely abstract and indistinct to students … it often seems difficult for them to grasp the concepts of attitude, difference and issues of power" (p2). Fitzpatrick also showed some concern about how safe and unsafe practices by nurses were defined. This has also been an aspect remarked upon in a number of publications by student nurses and nurse clinicians (Sillifant, 1999; Egan, 1999; Clair, 2004; Meyst, 2005). Warren (2004) undertook a study which indicated that nurses continued to have trouble understanding the concept of cultural safety, and that the word 'safety' remained a source of concern for many, including patients. Ramsden (2002) acknowledged that the concept was open to misconception. There have been calls to replace the title, but these were resisted by Ramsden. She argued that using the title 'safety' was deliberate, because it conformed to a mandated requirement in nursing practice. 'Sensitivity' and 'awareness', she felt, did not place sufficient emphasis on the construct. Richardson (2004), whilst supportive in principle of cultural safety, was mindful of the need and requirement to have outcomes evaluated not by nurses, but rather by consumers. Richardson (2004) states that as yet "there is little evidence to support a measurable change in healthcare practice" (p41). This statement of Richardson's is a concern for nurses hoping to carry the cultural safety approach into the future, if a demonstrable outcome cannot be confirmed.

DeSouza (2006), again from Aotearoa/New Zealand, wrote of a need for the people of Aotearoa/New Zealand to "enlarge our world" (p2). She wrote of the changing composition of the population of Aotearoa/New Zealand, with its growing immigrant population and wondered if a bicultural health system might need also to include those from different ethnicities. DeSouza (2006) speculated that multiculturalism might be the outcome of completed bicultural negotiations. The current social framing in Aotearoa/New Zealand gives

primacy to biculturalism and DeSouza stated that, even though many of the debates over culture remain unresolved, "I believe it has paved the way for the majority culture to consider cultural issues at large" (p2). DeSouza urges a greater consideration of what she deems "the buzz words such as cultural safety, cultural awareness and cultural competence and how they sit together" (p8). Multiculturalism, through biculturalism, remains a possible solution that has been under-explored and she believes under-utilised.

Australian authors Johnstone and Kanitsaki (2005) undertook a large study into the understanding and usefulness of cultural safety for the Australian nursing workforce. This work was intended to be an analysis of nursing. However, it became instead a broader study that included a range of participants alongside nurses: allied health workers, cultural trainers, ethnic liaison officers, translators and a small health consumer group. When Kanitsaki and Johnstone concluded that few participants had heard of cultural safety, this was hardly surprising. The majority of the nurse participants were over 30 years of age and some considerably older, therefore they are unlikely to have received any preparation or exposure to this model, as it had little presence in the Australian curriculum until the 1990's. Likewise, allied health workers have had minimal exposure to cultural theory of any type, particularly not cultural safety. Although Kanitsaki has dedicated her professional life to teaching the theory of transcultural nursing, believing it well suited to nursing — and given that most nurses in Australia are prepared using this theory, rather than cultural safety — she did not identify this bias. Analysis of the data revealed that the majority of participants had no familiarity with cultural safety. The study concluded that cultural safety was found to be unsuitable for application in the Australian context; "as for the notion of cultural safety, few participants had heard of the term" (p188); and "There is little evidence of its impact ... it is of limited scope, descriptive rather than critical and hence of questionable value" (p33). Firstly, it seems difficult to understand why Johnstone and Kanitsaki would have undertaken such an 'end user', healthcare worker based study of cultural safety given the limited uptake, teaching or application of this model in Australia. Ironically, these authors also criticise the model in terms of the feedback from nurses in Aotearoa/New Zealand: "also unhelpful is that most of the publications on the topic are academic commentaries or personal anecdotes and experiences related by nurses and nurse educators at the 'cutting edge'". It is hard to see, given the philosophical foundation of cultural safety, that the views of those nurses at the 'cutting edge' of practice constitute a negative aspect of cultural safety.

Canadian scholars have also critically appraised analysed cultural safety, employing a detachment and objectivity that has so far eluded nurses in Aotearoa/New Zealand. A probable reason for this is that nurses in Aotearoa/New Zealand see cultural safety as their 'own'. Their investment in and familiarity with the model may have made it quite challenging to see its limitations and weaknesses. Anderson, et al (2003) explored the theoretical and methodological issues that they confronted in their attempts to apply cultural safety to nursing research in Canada. They found, as did Polaschek (1998), that cultural safety was difficult to define, and was more easily understood in the negative, i.e. culturally unsafe practice. They especially described issues that cultural safety did not provide solutions for, such as the categorisation of research participants by ethnicity; this has not been an issue in bicultural Aotearoa/New Zealand. To be deemed Mäori or Pakeha (white Aotearoa/New Zealanders) was relatively unproblematic. However, in Canada, the act of naming a wide range of ethno-cultural and linguistic groups was a concern. For example, using such terms as Chinese-Canadians or Anglo-Canadians was problematic, when the participants merely wanted to be deemed Canadians.

Anderson et al (2003) identified another issue, that research designed to be culturally safe had the capacity to become marginalising. They also found it frustrating that cultural safety "did not announce itself in the transcripts" (p207) but had to rely on the researcher undertaking interpretive work. Additionally they felt that in cultural safety there was an assumption that nurses were from the dominant white group, even though in the Canadian context many of the nurses were women of colour, the colonised group. There was little in the model of cultural safety to position indigenous nurses as being anything other than a minority and oppressed group. Likewise, communication problems related to language diversity were not accommodated in cultural safety, because in Aotearoa/New Zealand the patient is most likely to speak or understand English as a first language. In conclusion, they felt that cultural safety had significant possibilities because of its capacity to bring post-colonial discourse into nursing practice, not as a set of concrete standards for nursing to adhere to, but as a means of acknowledging context and a way of questioning.

Stout and Downey (2006), Indigenous Canadian authors, are not quite so unquestioningly accepting of cultural safety as perhaps Anglo-Saxon authors might be. They claim that "too much can be taken for granted with a perceived panacea like cultural safety" (p327). Whilst they welcome it as a possible solution for nurse reparation for cross-cultural care when

working with indigenous populations, they ask that nurses continue to question and determine that which is still unknown about caring for indigenous populations. The authors advocate a move "beyond the boxes of multiculturalism and diversity, where too often indigenous populations are further marginalised" (Stout & Downey, 2006, p330). Stout and Downey also ask that the challenges by cultural safety to the hegemonic institution of healthcare systems are further advanced to truly effect change and alter the current conditions for indigenous populations using mainstream healthcare services.

Culley (2006) likewise notes that whilst cultural safety provides a useful critical approach, it still needs further development to take it beyond "the terrain of bounded cultural groups, in this case Mäori and the descendants of the white European colonists in New Zealand" (p147). However, she also adds that the work of the Canadians — such as Reimer-Kirkham and Anderson, (2002); Smye and Browne, (2002); and Anderson et al, (2003) — in reframing cultural safety by placing it within a "post-colonial, post-national frame, is a promising contemporary development" (p147).

Browne, et al (2009) write of the challenges in translating critically orientated cultural safety theory into the practice of nursing. Their recent work highlights the "complexities, ambiguities and tensions that need to be considered when using the concept of cultural safety" (p167). They considered that, whilst cultural safety proved a useful mechanism for a critique of the culturalist approach, it also became apparent that there has been a failure within the model to recognise any individual variation in the life experience of those designated as having a shared history, or belonging to 'particular ' groups, such as indigenous peoples.

Responses to the critiques of cultural safety — Te Kawa Whakaruruhau

Irihapeti Ramsden died in April 2003, so clearly she could not respond to any critique or continue theoretical development of the concept herself after that date. Much of the in-depth work of articulating the model of cultural safety with clarity and illuminating its key concepts was undertaken by Ramsden during the writing of her doctoral thesis, published in 2002. However, Ramsden was gravely ill at that time, which limited the opportunities for further publication, debate or discussion on much of her theory. The continued work in relation to this model must now be undertaken by others and responses to criticism may only be extrapolated retrospectively from documentation existing before the time of Ramsden's death.

Cultural safety, since the time of its introduction into nursing education in the early 1990's, has been the subject of significant and wide reaching critique. This commentary came, not as much from nurses and nursing scholars, but from the allied health professions, the lay community and from the general media of New Zealand. The reason for their criticism was on the grounds that cultural safety constituted a "program of social engineering" (Horton & Fitzsimons, 1996, p171). What ensued has become known in Aotearoa/New Zealand as the 'cultural safety debate'. However, Ramsden at the time described a large amount of the public response as "much smoke and little fire" (Ramsden, 1995, p3) and many nursing commentators agreed. A good deal of the reaction, to what was essentially a single component within a professional program of nursing, has been ascribed to the goals of cultural safety being " at odds with the prevailing neoliberal discourse" and "attempts at the restoration of a conservative ideology in New Zealand" (Horton & Fitzsimons, 1996, p172).

Ramsden (2002) described what she saw as the fundamental issues which led to criticism of cultural safety as being "misunderstandings of the concept" (p118) and "the lack of educational building blocks … on which to move forward such a concept" (p121). Ramsden discussed the need for change in nursing and healthcare as being most problematic, because this required shifts to deeply held attitudes and beliefs and changes to the power relationships between nurses and consumers of nursing services. Ramsden (2002) described these changes as those which "enable the less powerful to genuinely monitor the attitudes and services of the powerful" (p121). Given the hierarchical nature of health care service, such an undertaking presented significant questioning and naturally has engendered some resistance. Cultural safety has been underpinned by the need to "find out what you have, the second stage is to dismantle it and the third stage was to put something else in its place" (Ramsden, 2002, p130). Significant social change in nursing, which might lead to more inclusive practices with patients, is personally and professionally challenging and may be confronting and difficult to put in place. Much of the criticism made of cultural safety in the past has remained unresolved and partially or fully unanswered.

Clear (2008), from Aotearoa/New Zealand, writes that nurses in that country desire to "continue debate, discussion and consequent movement of the cultural safety journey" (p2). Clear (2008) notes that infrastructure to support the continued development of cultural safety must be fostered and concurs with Ramsden's (2002) recommendation that the issues around

consumer assessment of standards for attaining cultural safety on the part of the nurse must be progressed. However, Clear (2008) also considers that the issue of concern is how "the current expression of cultural safety fails to comprehend the intrinsic complexities of ethnic identity" (p30), which is in line with the comments made by Browne, et al, (2009). Evidence has suggested in recent years that confusion persists around nurses' understanding of ethnicity. That is, the model of cultural safety has become associated only with ethnic identity or being Mäori. A reductionist approach has developed around this model, which is the antithesis of its original intention, in that it sought to promote the uniqueness of each individual as defined within many possible meanings suggested by cultural identity. Clear suggests that the way forward is for a deconstruction of cultural safety philosophy and guidelines as a means to prevent scholarly inertia in the absence of its original author.

Some final considerations about Cultural Safety - Te Kawa Whakaruruhau

The understanding and approach to cultural care of nurses in Aotearoa/New Zealand has undergone significant transformation over the last 20 years, "from being well intentioned but assimilationist — to a more explicitly political interpretation that recognises and seeks to eliminate health inequalities that are culturally based" (Spence, 2003, p224). Nurses in Aotearoa/New Zealand have been challenged by the need to address those aspects of their practice that might have been considered discriminatory, exclusionary or racist. Cultural safety education has presented a significant challenge to the philosophical underpinnings of both the nursing academy and healthcare services in Aotearoa/New Zealand, not all of which was well received.

Cultural safety has developed almost entirely from the experiences of a minority indigenous group, with the findings then developed into a model for application to the discipline of nursing. The conscious and well considered challenge by Mäori (a minority indigenous group) to the institutional conventions of Aotearoa/New Zealand was confronting to the dominant and Eurocentric ideology operating in the healthcare services in that country and was not received without some mainstream hostility. Previously subjugated Mäori knowledge was positioned alongside established Western biomedical discourse and for Mäori this was the first time they had made a claim that requested acceptance of the legitimacy of their beliefs and practices (Kearns and Dyck, 1996). Ramsden's model has been "inspiring, challenging and threatening to many Pakeha (non-Mäori) New Zealanders who were, and still are, often

ignorant of the country's history and fearful of difference" (Ellison-Loschman, 2003, p453). Cultural safety, in shifting the focus from the patient to the nurse, had unwittingly opened up a new and unanticipated debate.

The process of introducing cultural safety as a pedagogical tool was not always comfortable, nor was it always well managed (Ramsden, 2002). As Richardson and Carryer (2005) identify, those nurses teaching cultural safety were working at the margins of a new paradigm "which sometimes put them at risk of being isolated and criticised for being political" (p208). A sizeable volume of the literature of cultural safety has been in the form of published articles. The first text was not produced until Wepa's edition of 2005. Much of the knowledge of cultural safety was embedded in the teaching and the personal experiences of the teachers of the subject in faculties and schools of nursing in Aotearoa/New Zealand (Fitzpatrick, 1997; Hughes & Gray, 2003; Wepa, 2003; Richardson & Carryer, 2005).

Consequently, the teaching of cultural safety has undergone intense scrutiny and this speaks to the earlier reaction around its introduction into the nursing curriculum in 1992. Damaging and sometimes contested claims were made by students and a small number of teaching staff during the early adoption of the model. Much of this centered on the teaching style and assessment methods being used rather than the model itself. Whilst the research undertaken on teaching practices has benefited the teachers of cultural safety and offered insight into the many experiences of teachers, it has not contributed significantly to the development of the model or its constructs. Cultural safety as a theory was not itself examined in these challenges; rather, the inquiry was concerned with the pedagogy, not the model.

Narayanasamy and White (2005) write that cultural safety seems "particularly relevant in healthcare contexts in which there has been a legacy of colonialism and imperialism" (p108). Richardson (2004) suggests that there is a need to "introduce the concept to a wider population base" (p41). This would seem to be supported by the interest that has been shown by Indigenous Australians and Canadians for its usefulness in their own context.

On one level, cultural safety is concerned with the education of individual nurses in the interests of changing their attitudes and engendering social equity. Yet the outcome of cultural safety as judged by consumers has still to become a reality. Wepa (2006) asks: "How do you measure attribute acquisition by individuals … attributes such as empathy, patience, creativity,

honesty, respect and compassion do not lend themselves to simple measurement" (Wepa, 2006, p6). Cultural safety also seeks to challenge and change organisational philosophy by stimulating structural and social transformation. Whilst there has been some pedagogical success towards meeting the first goal (Ramsay & Kermode, 1997; Warren, 2004), the proponents of cultural safety have yet to undertake a critical analysis of the existing social, political and cultural structures that affect episodes of care or the collective construction of healthcare services as an institution exercising social power. Wepa (2006) describes cultural safety as an evolving concept: "it is still in quite an adolescent phase of its development in Aotearoa/New Zealand … you can't freeze it in time and say 'that's cultural safety'" (p40).

Ellison-Loeschman (2001) notes, "while the significance of the term and its application for understanding and recognising difference as an issue in nursing practice was immediately understood, the challenge of defining and developing the concept continued" (p12). As well, Johnstone and Kanitsaki (2007a) identify, "there is also a paucity of critical scholarship addressing the inherent contradictions that continue to plague contemporary conceptualisations and operationalisation of the construct … until 'good' research is undertaken to address these and related issues, it is likely that confusion, conflict and controversy surrounding the cultural safety movement in New Zealand will continue" (p249). With the death of its creator and key author, Irihapeti Ramsden, nurses in Aotearoa/New Zealand will need to look to local Mäori nursing scholars and other experts to guide and ensure its continued development. Cultural safety advocates remain quite open to the possibility that they need to still determine how cultural safety is best achieved and are seeking resolution of these questions and how best to shape the future of this model.

Chapter 5

CULTURE AND NURSING IN AUSTRALIA

Without the background knowledge of the history of a nation and its people, it is impossible to understand the present."

(Goold, 2001, p96)

As Midgley (1991) pointed out, "virtually everyone, even in quite remote corners of the earth, now grows up with the background knowledge that there are many ways of life, deeply different from their own — a kind of knowledge that used to be quite rare" (p72). Migration is a global trend and as such has a global impact. Societies all over the world are facing rapid social change. Australia is not alone in its search for answers to the questions and challenges that are part of adjusting to cultural diversity. These new social environments are not as familiar or as predictable and becoming accustomed to them provides many challenges. Coming to understand how and in what way we might best adapt is the subject of much deliberation and concern across various fields of interest, not only within nursing.

Australia is 'framed' within its own social environment, although it is part of the new global community. It is also uniquely its own place. Caldwell (1997) describes how the Australian Government espoused ethnic pluralism in 1985, "where each ethnic group, desiring it, is permitted to maintain its own cultural heritage indefinitely, while taking part in the general life of the nation" (Caldwell, 1997, p23). Acceptance that Australia is multicultural is essential to understanding this country and subsequently to, come to terms with the implications of what this might mean. Legislation has been enacted which mandates and determines how Australians are required to respond to the new social mix. Ethnic pluralism has signaled a change from Anglocentric monoculturalism to multiculturalism which has, at its foundation, the principle of social justice, which embodies social inclusion and includes civic responsibility, cross-cultural respect, fairness and benefits to all (Stewart, 2006). The implication of this for health care is a requirement for equity in service access; all citizens may expect and demand the right to accessible, affordable and appropriate health care. Health care and nursing service

must now "be a good fit" with what patients expect (National agenda for a multicultural Australia: sharing our future, 1989).

In practical terms, however, such ideals are not quite as easy to understand, implement or achieve. Despite the mandate of multiculturalism and its formal ratification, adapting to cultural diversity and difference remains a challenge in the community and to nursing in Australia. Australia's health care system, including nursing, is not as responsive as it needs to be in adapting to and accommodating the cultural diversity of the population it serves (Kanitsaki & Johnstone, 2005). It is evident that Australians from minority groups and the indigenous community still face "barriers to equal access to health services, particularly when their difference is seen as inferior to the dominant (Anglo-Saxon-Celtic) culture in Australia" (Bryant, Foley & Percival, 2008, p10).

This chapter will provide an overview of what is fundamentally a time of transition for nursing and examine the ways that the nursing body in Australia has attempted to cope with and accommodate the cultural diversity of its patient population. Whilst there is a widespread commitment and acknowledgement of the need for nurses to develop a deeper understanding of cultural diversity and build cross-cultural skills, it has also become evident that progress towards that goal has been neither easy nor straightforward (National Review of Nursing Education (NRNE), 2002). There have been different theoretical models used in nursing education, although none have proved an ideal fit. Local scholarship and leadership around the central concepts of cultural care has been minimal and has yet to provide a feasible solution. A number of new policies have been developed to endorse and drive such an initiative, set the required standards and underpin change and these will be discussed. To identify progress towards the goals of developing cultural capacity in nursing, a number of reviews have also been undertaken and these provide insights into the ongoing efforts of the nursing profession.

The 'big picture' in Australia — health care and society

Australia is recognised as amongst the wealthier 'developed' or 'first world' nations and is rich in material resources that enhance the capacity to provide quality in health care. Australia offers the best available in science and technology. Health is an important social resource. It is desirable not only for individuals but it has significant social capital for the community and the country. A key feature of Australian health care policy is that it is inclusive of multiculturalism

and concerned with social justice and human rights. Health policy in the last few decades has generally been focused on social equity and service access (Asghari-Fard & Hossain, 2006). The government in Australia remains firmly committed to "ensuring that all Australians irrespective of their race, culture or first language, are able to benefit equitably from the resources it manages on behalf of the community" (Bolkus, 1994, p1).

Health care in Australia is predicated on the principles of democracy, pluralism, tolerance and equity. Braverman and Gruskin (2003) define equity as it applies to health as "an ethical concept grounded in the principle of distributive justice ... equity in health reflects a concern to reduce unequal opportunities to be healthy, lack of equity is associated with membership in less privileged social groups, such as poor people, disenfranchised racial, ethnic or religious groups, women and rural residents .... it focuses attention on socially disadvantaged, marginalised or disenfranchised groups" (Leeder, 2003, p1). This definition emphasises the way in which an individual's need for health care services should be based on both their medical condition and their social situation.

Multiculturalism as a national policy has aimed to accommodate cultural diversity and might on the surface seem desirable, but it can be fraught with contradictions and serve different and often conflicting interests. Perhaps the resolute pursuit of multiculturalism by the Australian Government has been successful in that it has blunted what little 'ethnic conflict' might potentially have arisen (Jupp, 1995). Cultural pluralism can be either a facilitator or a barrier to health care, as the belief systems of different individuals will affect encounters between the patients and health care service providers. The approach taken within the health care sector to accommodate cultural difference and social diversity is predominantly one that has identified ethnicity and immigrants as the dominant variable in the patient demographic. Generally, health care systems in most countries with a diverse ethnic and social mix are struggling to provide quality care to such diverse populations (Asghari-Fard & Hossain, 2006).

In 2005 the Australian National Health and Research Council (ANHRC) launched a policy document, *Cultural Competency in Health: a guide for policy, partnerships and participation*. This document was aimed at policy writers and service provider organisations and is intended to put cultural issues in health firmly on the agenda and to advance changes at every level: "All Australians have the right to access health care that meets their needs in our culturally and linguistically diverse society, this right can only be upheld if cultural issues are core business at

every level of the health system — systemic, organisational, professional and individual. This guide is one step towards this goal, giving a model for cultural competency that can be applied by health systems and organisations to improve health for all" (Walters, 2006, p1*).* Whilst much hope is held for its ability to achieve change in the health care sector, its effect has yet to be widely identified.

It is also evident that there are unresolved concerns and problems associated with introducing the notion of equity into health care systems in Australia. The penetration of multicultural policy and ideas has been identified as superficial in many agencies and its impact on programs and services limited (O'Brien, 2001). O'Brien believes the goal of achieving consistent adoption of policy across the public sector, or even within any one agency, remains a significant challenge. Consultative processes to assist access and equity have had variable success and there appears to be a lack of widespread participation by target groups. A number of marginalised groups such as minority ethnic groups, women, the elderly and youth, but most especially the Indigenous population are still reporting barriers to their obtaining adequate and appropriate health care (Mooney, 2003; Merrington, 2006).

Henry, Houston and Mooney (2004) have reflected upon some of the reasons behind what seems to be a continued resistance to multicultural policy and the failure of health care reform, policy and processes. They consider that this failure relates to the inequitable distribution of power and resource allocation in health care. The argument they present rests on the idea that Australia's health services are "institutionally racist" (p517). Institutional racism refers to the ways in which beliefs or values have been built into the operations of social institutions so as to discriminate against, control or oppress various minority groups. These authors claim that institutional racism is embedded in Australian institutions. Whilst acknowledging that such an accusation may be challenging for some service providers to hear, they argue that this form of racism is one of the greatest barriers to the achievement of better outcomes in health and must be confronted. The evidence of institutional racism can, they judge, be seen in the collective failure of organisations to provide an appropriate and professional service to people because of their colour, culture or ethnic origin and can be demonstrated by a collective inaction in the face of obvious need. Often institutional racism is covert or even unrecognised by the agents involved in it. The authors believe that there is a "lack of political will and of leadership to deal with such health inequalities generally in Australia" (p520).

Any health care system is a social institution built on the cultural platform of the population it serves. It follows that those same social values will provide the basis for health services policy and these will in turn shape the service that they inform (Henry, Houston & Mooney, 2004). For the most part, mainstream health care services in Australia reflect a scientific, Western ideology, with a focus on pathophysiology, bio-medicine and allopathy (Omeri, 1996). The public service system is characterised by Anglo-Saxon-Celtic social structures. Allen (2006) argues that the mainstream is invariably white and that cultural groups cannot simply be imported unchanged. He claims that the term multicultural often implies "a bunch of 'other people' who need to be taken into the mainstream" (Allen, 2006, p66). This situation inevitably creates a public health service environment which is normally more accessible to those who share the dominant cultural world view (NRNE, 2002).

The needs of a significant sector of the patient community have been ignored through an apparent lack of consideration of the 'way' in which that care is delivered. Given that the model of health care in Australia is, first and foremost, grounded in bio-medical science, there has been a considerable emphasis on treatment. The more person-centred aspects of patient care have been rather neglected and in some instances ignored altogether. In Australia, health care is provided within a Western bio-medical paradigm and for many patients this will be a 'mismatch' with their own belief systems. As Stewart (2006) attests, this is because of the tendency of the health system to represent itself as a 'culture of no culture' thus resulting in a "culture-blind and ethnocentric approach ... this effectively creates an exclusionary system" (Stewart, 2006, p10).

Cross-cultural care and Australian nursing

The work and findings of this thesis are primarily intended to be relevant to and useful for nurses and nursing in Australia. One impetus for this study was that Australia is the country in which I now live and work as a nurse, in a profession which, as will be shown, is unquestionably struggling to accommodate and cope with the impact of the significant demographic shift in its patient population over recent years. Whilst what is happening in Australia has a resonance with global concerns in nursing and nursing education worldwide, there are particular issues facing nursing in the unique context of Australia that require deeper

examination. To date a thorough and deep critical analysis of cultural care has not taken place in this country (NRNE, 2002).

Australia has traditionally relied heavily on international theory and literature as the basis of its cross-cultural theory and knowledge in nursing, with little local endeavour, contribution or active participation. However, there has also been little evaluation of the possible ramifications of this, or consideration of the risks associated with the direct transference of externally generated knowledge into the setting in which nursing takes place in Australia. Evidence suggests that the wisdom, or lack thereof, in using American theory was not taken into account (Daly & Jackson, 1999). Cultural care constitutes a curriculum theme in all undergraduate and many postgraduate programs for the educational preparation and ongoing skill development of nurses in Australia. Historically here, again, the choice of material and the character of cross-cultural education in programs of study in nursing have largely been left to the discretion of individual academic institutions (NRNE, 2002). The appropriateness or wisdom of this choice is one of the issues that will be explored in this thesis.

The accommodation of cultural diversity has not been easily achieved in most Western countries, including Australia. Primarily, Australian nurses belong to the dominant or mainstream Anglocentric, white culture. Their patients, now more often than not, belong to a minority ethnic group (Baker. 1997). Baker pointed some years ago to a growing body of evidence which suggested that nurses, rather than taking account of cultural difference, may instead unwittingly "compromise their clients' health and wellbeing by riding roughshod over cultural values, beliefs and norms" (Baker, 1997, p8). The ethnic dominance of Anglo centrism in nursing intensifies a "tendency for them to be blind, deaf or intolerant of others" (Baker, 1997, p8). Many argue that this is still the case in Australia, as Johnstone and Kanitsaki (2009) assert when describing the Australian health care system as being "under the illusion" (p63) it is not racist. Johnstone and Kanitsaki (2009) state that, despite increasing recognition that ethnicity and racism have a particular, consistent and negative effect on health and health care for minority groups, it remains largely ignored and poorly addressed in this Australia. Such observations attest to the fact that nurses, despite the increased levels of preparation in cross-cultural care giving capacity, are still feeling confronted and often challenged by the need to work with patient groups that have very different cultural traditions from themselves (Stewart, 1998, Johnstone & Kanitsaki, 2005, 2009).

One of the reasons why nurses find it difficult to work with cultural groups that differ from themselves is that they do not know, understand or share the same meanings or values as the patient, family or community with whom they are working. This lack of knowledge can result in misunderstanding and potentially lead to incorrect judgements being made. It becomes difficult to provide nursing care that is "appropriate, meaningful, therapeutically effective and ethically just" in a variety of different ways to different people (Johnstone, 2009, p71). Excellent communication is essential to nursing practice; it permeates every action and interaction, every assessment and intervention.

> *"Specifically nurses need to be able to 'read' people and situations, be able to pickup non-verbal cues and behaviour ... network effectively and transverse boundaries, to work in an interdisciplinary manner, to provide education and share information, to give direction, all require diplomacy, tact, assertiveness and personal relations skills" (Jones & Cheek, 2003, p123).*

Health care services in Australia must come to realise that there is a need to look more widely than just at the individual experience and they must begin to encompass the wider social structures that impact on health status. A range of legislation and public health policy now mandates equitable and accessible health care and this has the potential to force change. A number of these influential policy directives have multiculturalism as a central theme and this has been generated by the Australian Government. Nurses now have little choice but to comply with these and they are intended to compel nurses' to begin addressing the issues associated with culture. Australian Government policy initiatives over recent years include the *Ethnic Affairs Commission Act 2000*, (an update of the 1979 Act); the New Agenda for Multicultural Australia, (1999); the Community Relations Commission & Principles of Multiculturalism Bill, (2000); the *Anti-discrimination Amendment Act 2001*; the National Public Health Partnership —statement of core functions (2002); Cultural Harmony — the next decade 2002–2012 (2002); Multicultural Australia — strategic directions Federal Government, (2003); and the *Evolution of Australia's Multicultural Policy* , (2005).

It is becoming increasingly important that nurses realise that perceptions of culture and health are inextricably linked (NRNE, 2002). However, in reality, the laudable aims of central policy, with its focus on cultural care, is as yet to be integrated into current practice, nor have these goals been realised in the wider health care workplace (Johnstone & Kanitsaki, 2009).

Australian health care services and nurse providers are now being challenged to discover realistic, achievable strategies which provide appropriate services for the culturally diverse population of Australia, with its wide range of patient needs, demands and expectations. But being effective in the nursing role and taking responsibility for nurse-sensitive patient indicators and outcomes depends upon individual nurses having the capacity to establish, nurture and maintain productive relationships within the context of the bigger health care structure.

Why is culture important for nursing in Australia?

Johnstone (2009) considers that discovering how nurses might best learn to work with Australia's multicultural society in an effective, appropriate and ethical way constitutes one of the greatest challenges faced by nurses here today. Good health is "a product of reciprocal interactions between individuals and the environments that shape their lives" (McMurray, 2009, pxiii). The need for considerations of 'culture' to become a specific focus in the acquisition of good health must become a priority for the discipline of nursing. Whilst this might seem to be just another demand on nurses, it is imperative that nurses accommodate such a requirement and it is appropriate that nursing is responsive to the needs of the nation and those priorities will necessarily change from time to time and over time. Nurses are also members of the community in Australia and work as clinicians, researchers and educators. All of these roles also place upon nurses the responsibility to become more engaged with ideas around culture and culture's place in contemporary society.

Nursing service has a particular place in health care. Nurses are important contributors to the promotion and achievement of health gains for the Australian public. Not only do they support a patient's need for direct personal care, but nurses are pivotal in determining and maintaining the social structure within health care facilities and communities in terms of management, policy and collective function. Nurses carry out a range of functions and perform a complex mix of roles that are undertaken in a number of different settings within a holistic context; the nurse has been called the "wide ranging health care practitioner" (NRNE, 2002, p80). However, what characterises the nursing role, regardless of the individual setting, is the capacity to provide a patient focused service

The role of the nurse has traditionally been, and still is, defined and conceptualised, especially within the profession, by its focus on 'the person' (Stein-Parbury, 2008). The distinctive positioning of the nurse is as direct caregiver and one who has close contact with the patient, which potentially offers them the opportunity to work effectively in a person centred manner. Nurses have the potential to build upon this ability to develop an interpersonal therapeutic relationship that permits him/her to gain knowledge of the whole person and the ways in which each person describes their illness. It is this 'insight', this knowledge, along with the nurse's theoretical knowledge of disease and his/her therapeutic skills, that provide the basis for humanisation and a 'holistic' nursing approach to patient care that is required in cross-cultural nursing (NRNE, 2002). It is becoming increasingly important that the nursing profession maximises this potential to provide a patient-centred service that is cognisant of cultural diversity and difference (Omeri, 1996; NRNE, 2002; Blackford, 2005). Nurses' proximity to the patient offers them the opportunity to develop relationships that are inclusive in a cultural sense. The challenge for nursing is to develop a better understanding of how to move into this position, take full advantage of their potential capability and increase their focus on the person as patient, and thus culturally constituted, by learning to be more responsive to the social and ethnic mix of the Australian community.

Those from other cultural and ethnic backgrounds share with Australian nationals the same range of biological and physiological responses to disease, illness and dysfunction. Hence the assumption might arise in relation to health that 'we are all the same'. Whilst compared to those who are Australian-born, on arrival there is an apparent 'healthy' migrant effect. This is achieved by a government requirement that entry is only permitted for those migrants who are healthy. Epidemiological measures such as mortality, hospitalisation rates and the prevalence of lifestyle related health risks support this (Australian Institute of Health and Welfare, (AIHW), 2005). However, this relative advantage tends to diminish as length of stay increases and former migrants become integrated into the Australian community. Evidence is beginning to suggest that morbidity and mortality from certain diseases are increased in certain ethnic minority groups for a number of reasons but one major factor is identified as an avoidance of health care services that are perceived as culturally incongruent (Young, 1992; AIHW, 2005). There is also a range of social, economic and environmental determinants that will impact on the experience of ethnic minority groups. Language barriers, financial difficulties, housing problems, unemployment and a range of other social barriers can pose problems. These make it very difficult for migrants, in both the short and long term, to settle

into their new country and over time this increases their risk in terms of health burden across a range of categories. In spite of the settlement services available to new migrants and refugees, they often still remain at a disadvantage with a very negative correlation to good health (McMurray, 2009).

In terms of health, it is well established that cultural beliefs will shape human understanding of and responses to health and illness; the 'culture' of an individual will affect their perceptions and experience of health care (Stewart, 2006). Ideas and beliefs about health and illness generally will have a significant impact on individuals, their families and communities, in fashioning their understanding of illness, the treatment of disease and the prevention of ill health. When individuals seek assistance in times of sickness, their conceptualisation and understanding of social roles and their own personal beliefs and expectations will impact on health care encounters (Merrington, 2005). Indigenous and minority ethnic group patients have very specific needs across a range of important requirements, for example, levels of linguistic competence, variability in their capacity for comprehension and conceptualisation, style of communication and other specific personal, spiritual or religious needs. Any health care encounter will be influenced by both the patient's and the nurse's attitudes and understandings. For many minority group patients, there is a risk that there will be a mismatch between their belief systems and understandings and those of the health care system or individual service providers they will encounter. All of these might constitute barriers to nursing service and if their needs are not met this might lead to negative outcomes, even though curative therapy could well be effective.

While tolerance and sensitivity towards cultural difference may be formally espoused and articulated in principle, and reflected in policy and standards, there are indications that this is not always easy to accomplish. There have been concerns articulated about a 'mainstream' intolerance to diversity on the part of health care service providers (Meleis & Im, 1999; Blackford, 2005; McMurray, 2009). Despite changes in the population demographic, Australia has remained largely monocultural in the broader terms of social institutions, norms and attitudes. The same is true for health care and nursing; it is still rooted in the white Anglo-Celtic origin of the majority culture. The tendency of the health care system in Australia to present itself as a place of neutrality results in a "culture-blind and ethnocentric approach, effectively creating an exclusionary system" (Stewart, 2006). There is a lack of acknowledgement of this and a resistance to change in the power structures of nursing and in

health care that inhibits adjustment and the changes that are needed to positively advance cultural care in Australia (Stewart, 2006; Martin-McDonald & McCarthy, 2007). Although some small gains have been made regarding heightened awareness of the legitimacy of cultural difference, by and large, these have only been marginally effective in changing the attitudes of nurses, improving and changing service delivery, or in improving health experiences and outcomes for minority group populations (Goold, 2001; Blackford, 2005; McMurray, 2009).

Goold (2001), a senior nurse academic and Indigenous Australian voiced her concern: "I do not believe that many Australian nurses are capable of delivering culturally appropriate, culturally safe care" (p99). Goold is critical of nursing and nurses for what she sees as their failure to have any significant impact or effect any improvement on the quality of nursing service delivery and health care in Australia. Goold claims that despite cultural care theory having been available and taught to nurses for over three decades, its implementation had not yet taken place in practice because "nurses are not prepared to care for Australia's indigenous people ... racism, prejudice and discriminatory practices are alive and well in nursing and the health care system in general" (p94).

Reinforcing this is an Australasian study by Spence (2003) where it was found that nurses attested to feeling greater uncertainty when caring for patients from other cultures, as a result of being made more aware of their cultural differences through education. The nurses in Spence's (2003) study expressed feelings of inadequacy in establishing relationships with patients who were culturally different from themselves. As a result of this, the nurse's perceptions of their ability to provide individualised and appropriate care was compromised. The inability of the nurse to form effective relationships meant that patients failed to divulge crucial information to the nurse. Because of this the patient's needs were not well understood or utilised in the planning and delivery of nursing care, which inevitably impacted poorly on the patient's health care experience. This demonstrates that apprehension and uncertainty about interacting with minority group patients affects the ability of nurses to gain a deeper understanding of needs in cross-cultural care. Cioffi (2006), in a qualitative study of Australian nurses' experiences working with culturally and linguistically diverse (CALD) patient groups, found that whilst nurses were informally acquiring the cultural knowledge they needed to care for patients, stereotypical views of the patient's culture were often used rather than the perspective of the individual patient. They described assessing patients "informally on a 'just in

time'" (p83) basis and comprehensive assessment of a patient's cultural needs was poorly addressed.

The most important summative finding from a major review of multicultural nursing education in Australia (NRNE, 2002) was its suggestion that the culturally competent nurse of the future needs to be flexible, respectful, able to understand different value systems and adapt to changing needs: "the new nurse engages with cultural diversity as core practice, rather than an optional extra" (NRNE, 2002, Section 8, p1). This is a requirement that will be difficult to meet given the apparent entrenched mindset of the 'old nurse' and the inevitable conflicts of a 'new nurse' educated to provide multicultural care. Both of these stances might well be at odds with the nursing role required. On one hand, the 'old nurse' must change, so how does this happen? On the other hand, the 'new nurse' will need to be accepted into the established social patterns of interaction and patient care, already well embedded in the present health care system, but which are currently intolerant and discriminatory. If any progress is to be made in shifting the outlook of nurses, who belong most predominantly at the moment to the mono-cultural dominant group, but who will be required to work in a multicultural environment, it will be necessary to deal with the issues that remain around cultural diversity and its impact in nursing.

Cultural care policy and regulation in nursing — are these providing a framework for change?

Legislative and policy frameworks operate at both national and state levels in Australia to determine and arbitrate acceptable standards of compliance across a range of directives mandating compliance with human rights and cultural needs relevant to nursing and health care. Professional and regulatory bodies in Australia are very influential and hold much power in terms of determining what constitutes acceptable minimum standards. Currently they have a responsibility for guiding the workforce and for judging the meeting of those standards across the entire health care workplace and in the practice of individuals. In the last decade a number of peak nursing bodies have developed and instituted new standards and guiding principles regarding multicultural care in nursing.

The Royal College of Nursing, Australia (RCNA) was the first professional organisation to endorse the preparation of nurses for cross-cultural care practice in 1988. The RCNA has supported the development and growth of cultural care nursing in Australia for well over two decades. The College's leadership role has been evident on a number of fronts providing education events, publications and national networking opportunities for nurses. In 1994, they established a Transcultural Nursing Society and today remain the only national nursing body to exclusively support transcultural nursing. Their support resulted from the strong lobbying and representation by Akram Omeri and Olga Kanitsaki, two Australian nurse advocates of transcultural nursing (Bryant, Foley & Percival, 2008).

Over the last 20 years, other key professional nursing organisations and accreditation authorities — such as the Australian Nursing Federation (ANF), the Australian Council of Nurses and Midwives (ANMC), the State and Territory Nursing and Midwifery Regulatory Authorities (NMRA) and the Congress of Aboriginal and Torres Strait Island Nurses (CATSIN) — all began to recognise and acknowledge cultural care in their standards and codes, referring both to cultural safety and transcultural nursing theory.

The ANMC is the peak nursing body in Australia, established in 1992 to facilitate a national approach to nursing and midwifery regulation. The competency standards and codes of practice of this organisation constitute the minimum requirements to enable nursing registration in Australia. The ANMC works with local Nursing and Midwifery Regulatory Authorities to ensure that new graduates from programs in their states meet the AMNC competencies through an accreditation process. The ANMC is also an authorised assessing authority for the Government Department of Immigration and Citizenship (DIAC) and undertakes skills assessments of internationally qualified nurses and midwives seeking migration into Australia. The ANMC policies and position statements include the Inclusion of Indigenous Australian Health (2007), Cultural Issues in Courses leading to Registration or Enrolment (2007) and the Re-orientation of Internationally Qualified Nurse and Midwives to the Australian Context (2007). The ANMC National Competency Standards for the Registered Nurse (2005) are the core competency standards used by universities as the minimum standards they are required to meet when developing nursing curricula and as a gauge for measuring student clinical and academic performance during a program of study.

The preface to the standards state, "the registered nurse recognises that ethnicity, culture, gender, spiritual values, sexuality, age, disability and economic and social factors have an impact on an individual's responses to, and beliefs about, health and illness, and plans and modifies nursing care appropriately*" (p2).* The following standards relate directly to the culturally specific aspects of nurses' work, although this is also intrinsic in all nursing action:

> *"2.3 Practises in a way that acknowledges the dignity, culture, values, beliefs and rights of individuals/groups; … 3.2 Uses best available evidence, nursing expertise and respect for the values and beliefs of individuals/groups in the provision of nursing care; … 5.1 Uses a relevant evidence-based assessment framework to collect data about the physical socio-cultural and mental health of the individual/group; … 9.5 Facilitates a physical, psychosocial, cultural and spiritual environment that promotes individual/group safety and security"* (The ANMC National Competency Standards for the Registered Nurse, 2005).

The ANMC Code of Ethics — Standard 3 (2002):

> *"Nurses value the diversity of people, this involves acknowledging and responding to each person as a unique individual, and to their culture. It requires nurses to develop cultural knowledge and awareness and greater responsiveness to the languages spoken. Enabling them to better understand and respond effectively to the cultural and communication needs of people in their care, their families and communities during a health care encounter."*

The Code of Professional Conduct — Standard 4 (2008) states: "Nurses respect the dignity, culture, ethnicity, values and beliefs of people receiving care and treatment, and of their colleagues*".* These codes and competencies all stipulate the need for nurses and midwives to demonstrate cultural safety and an awareness of the social diversity in Australia.

Two other key professional organisations in Australia — the Royal College of Nursing, Australia (RCNA) and the Australian Nurses Federation (ANF) — both support cultural inclusiveness in nursing. The RCNA (2000) has developed a number of position statements which recommend that nursing schools and faculties address the issue of cultural education and support the preparation of nursing faculty staff. To enable this they encourage examination of

undergraduate nursing curricula to ensure that the cultural component is adequate and that it prepares students to provide culturally empowering and appropriate nursing services to people from different linguistic and cultural backgrounds. The RCNA encourage cross-cultural nursing research and actively foster the growth of cultural nursing as core knowledge for all undergraduate and postgraduate curricula. The ANF has position statements relating to Indigenous Health (2006), the International Recruitment of Nurses and Midwives (2007), Nurses and Midwives Working Internationally (2007), Female Genital Mutilation (2007), Refugees and Asylum Seekers (2007) and an Indigenous Reconciliation Plan (2007), advocating health equality and self determination for Indigenous Australians.

There is evidence that health care policy has assisted in the development of greater understanding about culture and improved recognition of the impact of culture in the health care gains which have made a positive contribution and brought improvements to what was a previously somewhat overlooked area (NRNE, 2002). Despite these gains, there is growing evidence and increased recognition that this area is still underserved, despite the presence of such policy. There is a case for supporting a more robust, strategic and planned approach to policy development (Johnstone & Kanitsaki, 2007b, p177). Whilst policy frameworks and directives regarding cultural care have the potential to increase competency and direct practice, they need to be integrated into the profession. Unless they are reflected in priority statements, resourced and reported upon, which is not the case currently, they will not be either upheld or perceived by the profession as central to determining standards and quality at the level of service provision. Policy, no matter how well intended or well designed, if not supported in principle or linked to action by individuals or organisations, will fail to link to the development of cultural care in nursing.

Nursing education and its role in preparing nurses to provide cross-cultural care

Educational institutions also play a major role in developing and shaping the knowledge base, understanding and attitudes of student nurses as they enter the profession. The National Review of Nursing Education (NRNE), conducted in 2002, is the most recent and to date the only major study of multicultural nursing education in Australia. The overall aim of the review was to explore the ways in which multicultural education was addressed across Australia. The NRNE committee had a mandate to "explore the assumptions and concepts about multicultural health within the context of Australian nursing education" (NRNE, 2002, 1.1, p1)

and "to map the ways in which current nursing education addresses multicultural health, with a view to recommending strategies for enhancing cultural competence in nursing" (NRNE, 2002, 1.3, p2). The committee evaluating cultural education in nursing determined three main objectives to achieve this: to clarify what was required of nurses in terms of cultural competence or safety; to further investigate how to broaden both the content and context of culture in the education sector; and to develop a consistent learning framework for faculty and schools of nursing to use when planning their curriculum.

The goal of cultural education identified, by nursing education providers, as most important and relevant to Australia was that nursing students developed an awareness of diversity and became sensitive to the needs of other cultural groups. It was hoped that through this process student nurses would achieve a deeper understanding of and become more accepting of the social and cultural differences of patients (NRNE, 2002). The approach taken by Australian nursing education providers has been to develop in student nurses a broad understanding of culture which, it was hoped, they would then draw on and continue to develop once they qualified, gained employment and entered practice. To this end, teaching strategies were sought which facilitated the exploration of the perspective of other cultural groups and many providers also offered clinical placements to expose the students to diverse cultural groups. International educational models were examined and the work of international nurse scholars, who wrote about culture, were scrutinised for their applicability to Australia (NRNE, 2002).

No national approach was ever developed for Australia and, as a result, there was a considerable range of different designs evident across the Australian nursing education sector, as universities and schools of nursing used their own judgment in choosing how to integrate cultural care teaching into their curriculum. The strategies chosen utilised both the theories of transcultural nursing and cultural safety and the model of cultural competency, although a small number of providers used a compilation of both (NRNE, 2002). Curricula varied greatly. Some built around the theme of multiculturalism, choosing for example 'cultural awareness or respect for others'. Other universities selected ethnic diversity as an overarching descriptor and utilised sociology, with teachings on the social determinants of health, equality and ethnicity as guiding principles. Still others designed programs which included teaching about the belief systems of different cultures. In other instances again, a cultural focus was integrated into related subjects such as primary health care, ethics, indigenous health and mental health studies. Most integrated culture into the curriculum, rather than teaching it as a

discrete unit of study. Although some courses were specifically focused on explicit cultural theory such as transcultural nursing or cultural safety, courses of this design were offered primarily at third year level or as postgraduate elective subjects and programs (NRNE, 2002).

When it came to underpinning the curriculum using a theoretical model, some used Leininger's theory of transcultural nursing; others avoided Leininger because of a perception that this theory did not deal adequately with issues other than ethnicity, such as those of power, gender and social position. A lesser number adopted Ramsden's cultural safety theory, as the dominant theme. This was used particularly when teaching indigenous health (NRNE, 2002, 5.21). An even smaller number chose to use cultural competency, a more generic and practice-oriented, skills-based model, less based in a distinct theory and more focused on making adaptations to service delivery that reflect cultural understanding (Goode, 1995). Transcultural nursing and cultural safety are nursing theories and so are relevant only to nursing, whereas the model of cultural competency has also been used by other health care and social services provider groups for training (Stewart, 2006).

Nursing education providers were faced with a challenging task in progressing students from a position of cultural singularism to one of cultural pluralism. To be given responsibility for providing cultural diversity education, it was assumed that academics and teacher were individuals who already understood and were committed to such social reform, able to design and implement an educational process and develop educational content to reflect a commitment to cultural pluralism. The task of achieving this goal was difficult and a number of universities and schools of nursing expressed confusion about how exactly to define and understand culture and, as a result, properly determine the appropriate teaching models and strategies to use in achieving such a goal (NRNE, 2002). Teaching about culture, with its focus on personal attitudes, beliefs and values, had an inherent complexity and was described as intense and challenging by nurse educators across all areas of education: the curriculum, the classroom and in the clinical environment. Practical delivery of the program, such as classroom debate and group activities, were seen as especially demanding as those situations required extra skill and sensitivity and this was even more difficult when the student represented a multicultural group themselves.

However, although different approaches have been taken, all these approaches share a common theme and that is their focus on ethnicity and the cultural difference between

individuals which might be encountered in health care and which cause both interpersonal and organisational problems. Fewer education providers took a socio-political approach, which would have looked at health care as a social institution, with nursing comprising only part of the larger social system. This approach would have changed the focus more toward social institutions and power, rather than individuals. Education providers in rural locations also placed less emphasis on the cultural aspect of the curriculum than did larger urban providers, primarily as multicultural communities were less common in rural settings and therefore the cross-cultural preparation of students in rural communities was not seen as particularly important. In addition to the registered nurse education providers there are also a range of programs which prepare enrolled (or second level) nurses. In these there was an even greater diversity noted, although they are similarly constructed with regard to cultural care preparation and, again, wide variety was seen as to content and choice of program themes (NRNE, 2002).

A number of conclusions were drawn by the NRNE committee regarding program development and the processes of learning and teaching about cross-cultural care into the future. The committee concluded that the community sector needed greater recognition as a setting in which nurses have a role and most education providers had focused only on the acute care setting of the hospital. They noted a need for better preparation and resourcing of teachers. Factors that made teaching a subject like culture difficult were many and varied but principally related to workload, funding and resource issues, assessment concerns, different levels of teacher expertise and unfamiliarity with the topic. It was also noted that teaching resources, texts, visual representations and the 'mind-set' or approach was overwhelmingly monocultural and Anglo-Saxon, which demanded further attention and rectification. One of the means suggested to address this involved increasing the diversity of the teaching staff, the student body and the nursing workforce. Institutional racism was also identified as a critical issue for resolution and hooks (2003), albeit in a different context, might be describing this when she suggests, "one of the bitter ironies ... is that the folks, who most perpetuate it, are the individuals who are the least willing to acknowledge that race matters" (p28). In terms of postgraduate studies and ongoing education, there have been few specific recommendations. Whilst a range of concerns were identified and discussed and suggestions for forward movement suggested in the NRNE (2002), there were no action based mechanisms offered to facilitate this undertaking and in the six years since this review, very few of the concerns noted have been addressed. Surveys of undergraduate curricula carried out in 2003 and 2004 found

that although indigenous and multicultural content had risen markedly, there was as yet little impact or improved capacity or understanding on the part of the student nurses (Goold & Usher, 2006). There have been no further evaluations or reviews undertaken of multicultural education since.

At the time of the national review in 2002, there were 34 participant universities. There are now 47 universities across Australia offering preparation programs for entry to the profession of nursing. Variability may be even greater in terms of curriculum in the six years that have elapsed since the national review of multicultural education was completed. Although variability of cultural content will likely be present, the state and territory Boards of Nursing and Midwifery in Australia all require that multicultural and indigenous content is included in any curriculum that is approved as preparation for registration and enrolment in this country. For example "Aboriginal and Torres Strait Islander Health studies must be included in the course and students must be able to develop awareness of the cultural diversity which exists in the Australian community" (Nurses and Midwives Board of New South Wales, 2009). Whilst how to achieve cultural understanding, is still open to interpretation by the different providers of nursing education, there is a directive that its inclusion in the curriculum will continue into the future.

Reviews of cultural care in nursing education — moving forward.

The Reid Review (1994) was the first national evaluation of nursing education to take place since the transfer of nursing education to the tertiary sector. Of particular interest was the requirement for the nursing workforce to take into account the many cultures now within Australia who require a different type of nursing service. It was noted that the population of Australia was changing in its cultural mix and that, in particular, the health of immigrants and the indigenous Aboriginal and Torres Strait Islanders was coming into sharp focus as needing attention from nurses. One of the primary objectives of the Reid Review Committee was to assess whether the transfer to the tertiary education had resulted in a broader and more diverse educational preparation for nurses. The review noted that nurses and nursing education needed to become better attuned to cultural diversity, with a need for more Indigenous nurses, more training placements in remote areas, and more cross-cultural content in the curriculum of every nursing course (Reid Review, 1994). The Australian Government Department of Science, Education and Training undertook a major review of education in

nursing — the National Review of Nursing Education (NRNE) — in 2002. As well as the universities and schools of nursing, a number of national peak professional bodies were surveyed to determine the breadth of cultural approaches being adopted and its findings have already been discussed in respect of nursing education practices.

In 2005 a study of cultural care in nursing was funded by the Department of Human Services in Victoria. It is a state based study and was undertaken by Megan-Jane Johnstone and Olga Kanitsaki (2005). It was intended to be an analysis of the relationship between cultural safety and cultural competency as used in nursing and the health outcomes for people from diverse cultural and linguistic backgrounds. The aims of the work were to operationally define the terms 'cultural safety' and 'cultural competence' as they were understood and used in nursing; to identify the relationship between cultural safety and competency and health related outcomes; to specify and make recommendations for the processes best suited to promoting cultural care in nursing; and to develop baseline data for furthering research in this area. However, in the completed report, the scope of the remit had changed and it had moved well beyond the boundary of nursing. It became instead a broader study to include a range of participants, other than nurses: allied health workers, cultural trainers, ethnic liaison officers, translators and a small health consumer group.

The final report contains a substantial literature review. The key findings clearly indicate that despite some 30 years of multicultural policies and programs in Australia, "health care services are still not as responsive as they should be to the health and care needs of people from diverse racial, ethno-cultural and language backgrounds" (Johnstone & Kanitsaki, 2005, pviii). The authors recommended that focused attention be given to developing national standards for service delivery, that culturally responsive health care indicators be better aligned to existing patient safety and quality care indicators and that a national research agenda be developed with a focus on culture. The most noteworthy finding was "that cultural care development to date had been through the work of a few committed individuals and organisations rather than due to a systemised response of the health care provider structure" (Johnstone & Kanitsaki, pix). One of the most troubling findings in this study was that patients and their families still expressed that they "did not feel safe in hospital environments" and felt "vulnerable to the harmful prejudicial attitudes and behaviours of others" (Johnstone & Kanitsaki, 2005, pix). The authors refer to "unacknowledged racism in the health care system"

and "a need to break the culture of silence that surrounds this problem" (Johnstone & Kanitsaki 2005, pix) if appropriate health services are to be provided to the Australian public.

This study has much to offer in terms of its general conclusions, which identify what gains have been made in this area and where further work needs to take place. However, there are also some limitations to this study, which has a "covert agenda to reinforce the inappropriateness of cultural safety for Australia, along with a lack of key information on aspects of the research design and in the reporting of the findings" (Wilson, 2008, p173). By and large, however, the literature and theory that underpinned this study were not from either Australia or New Zealand.

Two further national nursing taskforces have been instigated since the NRNE review, although they worked specifically within the terms of reference of the NRNE and were not independent. These are the Crowley and West Report (2002), called 'The Patient Profession: time for action' and the National Nursing and Nursing Education Taskforce (N.3.E.T.) 2003-2006. Neither of these had any specific interest in, nor indeed made mention of, multicultural care provision or education. Both the Crowley and West Report and N.3.E.T have been more focused on the nursing shortage and the interface between recruitment into nursing education programs and future labour needs. There has as yet been no output from either of these taskforces in relation to issues around culture. It appears that Australian nurses over the last few years have been more inwardly focused and introspective in their concerns. Nursing appears engaged in recent times with other types of issues, such as the skill mix and work patterns of nurses, recruitment, augmentation and retention of the current nursing workforce, training of care assistants, funding of clinical education, educational pathways, specialisation frameworks and research and training (N.3.E.T., 2003–2006). Workplace culture, professional culture and historical inter-professional relationships are specifically mentioned in Recommendation 4, in terms of the scope of nursing practice, but 'people culture' in terms of the population in a social or ethnic sense is not mentioned. Omeri (2004c) noted also that, "Pressing issues such as profound workforce shortages, inability or lack of knowledge of faculties to meet the market needs for health care and lack of incentives in nursing programs and courses to address transcultural nursing care needs of students and faculties in combination with the misuse of existing resources in nursing, may have left nursing at a loss" (Omeri, 2004c, p35). Culture and social diversity would hopefully be an intrinsic part of these discussions but there is no specific mention of culture per se, so its continued presence on the nursing agenda can only be

speculated upon. With one of the solutions to a shortfall in workforce numbers being the recruitment of overseas trained nurses, this may be somewhat short-sighted.

The Australian National Health and Research Council (ANHRC) undertook a national review of cultural competency across the health care workforce and its professional bodies and organisations in 2005. Although this was not specific to nursing, it speaks to health care generally and the findings drew some important conclusions, namely that: across the health sector there was generally a lack of uptake of policy; there was a small research or evidence base relating to minority ethnic groups; there was inconsistent practice in health care and health promotion and insufficient resources to overcome the constraints affecting policy, planning, professional development, language services and community development for minority ethnic groups. Contributors to this review included some nursing bodies, namely the Australian Nursing Federation, the Royal College of Nursing and the College of Nursing, NSW. All of the issues identified by this review are relevant to nursing and the contribution of these key bodies might be seen as an indication that this topic should still be of concern to nursing.

In Australia, as is the case around the world, there is still much debate as to what constitutes an appropriate theoretical or practical approach to nursing education and no country or institution has yet found an adequate solution. Multicultural education likewise in nursing remains in limbo and its position in Australia is one in which it struggles to meet multiple requirements and needs: those of regulatory and registering authorities, those of the student and workforce and, most importantly, of the patients. The NRNE in 2002 identified the presence of a persistent theory–practice gap between the rhetoric of nursing education and the tensions of the practice setting: “for a practice discipline in which interpersonal encounters are an essential part of the therapeutic process, the articulation of reflection on culture and diversity seemed rather less prominent than it might have been” (NRNE, 2002, Section 8, p2). This position seems still to reflect the reality of cultural education and nursing in Australia today, a full six years later. There is little doubt that there is much progress that needs to be made in meeting the changes posed by the integration of cultural education into the curriculum. However, as Johnstone and Kanitsaki (2007a) point out, education cannot be held solely accountable and responsible for initiating and sustaining change or providing solutions for what is a multi-sectoral issue in the new world of cross-cultural nursing practice: “Whilst education might make individuals more aware, education alone does not necessarily translate

into practice and/or into the proactive responses that are necessary" (p184) on the part of individuals or organisations.

The contribution of key Australian scholars to the field of culture and nursing

Nursing in Australia does not as yet seem to have fully embraced the scholarship of cultural care. The number of nursing scholars dedicated to authorship in this domain is relatively small and, of those, very few have made any significant contribution internationally. From the mid 1980's, Australian authors began to appear in selected national publications, but on the whole the topic field represents the work of those few authors who have a sustained interest in culture. Those authors include: Cameron-Traub (1993, 1994); D'Cruz and Tham (1993); Jackson, Brady & Stein (1996) Daly & Jackson, 2003); Johnstone (2009); Kanitsaki (1983, 1988, 1989, 1992, 1993a & b, 1994, 2000, 2002, 2003, 2004); Kanitsaki and Johnstone (2004) Johnstone and Kanitsaki (2005, 2009); McMurray (2003, 2009); Omeri and Cameron-Traub (1995); Omeri (1996, 1997a, 1997b, , 2002, 2004a, 2004b, 2006, 2008) Omeri and Raymond (2008); White (2006).

Especially notable amongst Australian nursing publications listed above are the works of Kanitsaki and Omeri. These two authors are themselves immigrants and nurses, so their interest is perhaps not surprising, as they would probably have a vested concern in the health related experiences of themselves and their own community. Kanitsaki (2003) has voiced her concerns that action on the need for cultural care has been left "to a handful of immigrant nurses" (, pvi). These two authors will be considered individually because of the considerable profile they have developed in the field of cultural care scholarship.

Olga Kanitsaki...

The first publication in Australia with an explicit focus on culture and nursing was that of Olga Kanitsaki. Kanitsaki first wrote in 1983 of what she perceived, at that time, as the failure of the nursing profession in Australia to prepare its graduates for working with patients from diverse cultural and linguistic backgrounds. Kanitsaki described what she deemed a lack of interest on the part of nurses in Australia about the significant issues and barriers confronting minority patient groups, suggesting that "there has been little serious focus, if any, in the nursing curricula on the underlying concept of culture" (Kanitsaki, 1983, p 42). Kanitsaki's work over

time continues to point out to the nursing profession a need to become more aware of and responsive to the requirements of minority group populations and notes that "the unacceptable nursing attitudes and practices towards patients of culturally different backgrounds ... have been tolerated by the nursing profession — not least its failure to correct them, and by virtue of its silence, has tacitly validated them" (Kanitsaki, 1993b, p 124).

Kanitsaki worked for 30 years in nursing education, mainly in the state of Victoria, until her retirement from academia in 2005. Throughout those years she showed a single-minded determination to have transcultural nursing theory accepted and applied in Australia. Kanitsaki was a passionate advocate of Leininger's theory and promoted its adoption in the education of nurses as a solution to the problems facing nursing and the care of culturally and linguistically diverse patients here in Australia. Nurses in Australia "need to develop transcultural studies in nursing with the object of seeking educational changes"*(*Kanitsaki, 1983, p53). In her work Kanitsaki promoted transcultural nursing as the most suitable approach for the teaching of cultural care theory and its value for determining the practice and standards of culturally competent patient care. Although Kanitsaki (2003) acknowledges the "distinctiveness of Australian history" (pv) she nonetheless advocates the adoption of transcultural nursing without addition or alteration in the Australia context. Kanitsaki's many publications up until 2005 are largely dedicated to the description, teaching and application of transcultural nursing in Australian education and practice environments. She does acknowledge later in her career that "the impact of the introduction of these [transcultural] concepts] in nursing education and practice is however unknown" (2003, pvi) but nonetheless she had consistently remained a strong and uncritical advocate of this theory.

Although aware of the theory of cultural safety, developed and used in nearby New Zealand, Kanitsaki remained uncertain of its utility for Australia, noting that "The notion of cultural safety is poorly understood and does not have currency in the cultural context of Australia" (Johnstone & Kanitsaki, 2005, p182). However, she has acknowledged that cultural safety has been adopted by Australia's Indigenous peoples, Aboriginal health workers and nurses working in indigenous communities in Australia with some success (Goold, 2005; Papps, 2005; Wepa, 2005; Raymond, 2008). In 2005, Kanitsaki co-authored with Johnstone a report into the applicability of cultural safety in the Australian context. Whilst rightly criticising its lack of supporting research, she found no merit of any kind to support its use in Australia. Wilson (2008), a New Zealand nurse and supporter of cultural safety, has noted what she deems "a

covert agenda" underlying Kanitsaki's attempts to discredit cultural safety (p177). Leininger and Ramsden, the founders of transcultural nursing and cultural safety respectively, have for some years been at odds with each other and Kanitsaki's stance may merely represent her longstanding support of Leininger and reflect the polarisation which is a legacy of the cool relationship between these two theorists.

In 2005, Kanitsaki wrote the following in a manner that may have indicated a change in her outlook:

> *"The nursing profession in Australia has been called to action for many years now. The transcultural nursing movement, which began in the early 1970's, attempted to raise the consciousness of its members. At the centre of this movement were calls for changes to the health care system to make it more responsive to the needs of people from different cultures and who spoke different languages. This call required changes to take place in the minds, hearts and practices of nurses and other health care professionals. Just how effective this call has been, I will leave to individual nurses, nursing organisations and others to judge"* (p1).

Since 2005, Kanitsaki appears to have had a major change of focus and seems to have distanced herself from transcultural nursing. She began a co-authoring relationship with Johnstone (2009), a renowned nursing ethicist from Australia, and in her more recent publications has taken quite a different approach. Her new stance on cultural care is much more broadly based and demonstrates a deeper consideration of the 'big picture' issues associated with cross-cultural care, such as policy direction, quality issues around care, population ageing, institutional power and racism and ethics based deliberations on the need for change in Australian health care. The most recent 2009 publication of Johnstone and Kanitsaki explored racism and discrimination in hospital contexts and used a far broader range of underpinning literature than was the case in the past. Whilst still maintaining a focus on nursing, there is now a broader application to the health care disciplines, the field of health care provision and culture per se, bringing a fresh direction and contribution to the ongoing contemporary discussions and debates in Australia.

Akram Omeri....

Akram Omeri is another of Australia's most prolific nurse authors in the field of cultural care. Born in Iran, she immigrated to Australia in 1971. Like Kanitsaki, she believed that the solution for Australian nurses was the introduction and adoption of transcultural nursing theory when she proclaimed, “Transcultural nursing is the very foundation of the nursing profession” (Omeri, 2004a, p6). Omeri co-authored the first book on transcultural nursing in Australia with Cameron-Traub and has contributed many chapters and articles, with a special focus on transcultural nursing, to journals and textbooks in Australia and most recently a text for the UK market. Leininger (2008) considers Omeri “an outstanding role model, advocate and pioneer leader to open the doors to study and practice transcultural nursing” and felt “her leadership in Australia has been outstanding and appreciated” (Leininger, 2008, piv).

Omeri considers herself an authority on cultural care — as a transcultural scholar, researcher and an academic providing nursing education. She advocates the exclusive use of transcultural theory across Australia nationally because she “realised nurses and health care professionals were expected to provide health care without having had any formal study and preparation in transcultural nursing" (Omeri, 2008, p6). Omeri explains her motivation in designing what she describes as one of the first programs in transcultural nursing education in Australia in the 1990’s: *“*I wanted to make a difference in the nursing profession and was familiar with the pioneering work of Madeleine Leininger” (p6) ... “shortly after getting in touch with Leininger, I designed and began teaching courses in transcultural nursing” p4). Much of Omeri’s scholarship, like that of Kanitsaki earlier, was to encourage nurses to use the theory of transcultural nursing across a range of nursing practice domains and specifically for teaching programs. Omeri remains active as an academic primarily in the state of New South Wales and has recently been involved in developing a new Bachelor of Nursing course at a university school of nursing. Again, this is based in transcultural nursing theory, which she deemed to “be most suitable and fitting for the Australian context” (Raymond, 2008, p19).

In more recent years, Omeri‘s writing has been somewhat different in character and, to a certain extent, rather more defensive of, rather than campaigning on behalf of, transcultural nursing. She asserts that transcultural nursing, despite the best efforts of its advocates, is insufficiently acknowledged by the nursing profession in Australia. Omeri openly criticises the NRNE (2002) review for its failure to recognise the significance and potential of using a

transcultural nursing approach in Australia. Omeri (2004a) has pointed out a continued failure on the part of nurses in Australia to recognise and follow the leadership of transcultural nurses who have done much to promote and establish the theory here in the interests of patient benefit and nursing development (Omeri, 2004b). Omeri believes a negative attitude is being shown by Australian nurses towards transcultural nursing and this has led to this lack of support from the profession. In 2006, Omeri stated again, "Transcultural nursing is often misunderstood ... there is still a way to go yet before this field is recognised, learnt and understood" in Australia (Pandaram, 2006, p1).

In one of her Australian publications, which focused on her personal experiences, Omeri (2004a) appeared to be communicating a sense of disappointment and perhaps resentment. On one occasion she wrote about a course she introduced in 1991; she took particular issue with the replacement, by the nursing faculty, of the term 'transcultural' with 'multicultural'. She deemed this: "cultural ignorance, people said they had never heard of the term" (2004a, p6). Such a comment also speaks little of the adoption of transcultural nursing within Australia, as she had clearly hoped would be the case. Omeri believes that Australia's dismissal of transcultural nursing has been directed towards her personally, rather than being of a professional nature, suggesting rather defensively that "some of the negativity towards promoting transcultural nursing and my own successful work in the field, boils down to the 'tall poppy' syndrome and academic jealousy" (p6). Of her personal dedication and efforts to pursue and establish transcultural education in Australia, Omeri has asserted that "transcultural nursing has been and remains my passion, nothing or no-one can stop me from pursuing my aims" (p6).

Interestingly, Leininger has referred to Australian nurses and their uptake of transcultural nursing in a very unusual manner when she states that "Transcultural nursing has had a slow development in Australia":

> *"Australian nurses tend to act independently and speak frankly about outsiders. They seem to feel confident about what is 'best and right' about certain issues. Australian nurses are comfortable speaking out, confronting and challenging other nurse leaders and generally in a frank and direct manner. It is of special interest that Australian nurses tend to cut down figuratively, what they call the tall poppy or a nurse leader who moves too fast in leadership or becomes too pompous in moving into certain*

> *prestigious positions or roles. Australian nurses know how to cut off the stem of the tall and wild poppy to symbolically curtail the growth of a leader. This is a covert cultural practice ... to control nurses before other nurses are ready to move" (Leininger, 2002, p193).*

In 2004a, Omeri stated that there seemed to be a need for "critique [of] the transcultural perspective and the troubling issues of power, dominance and oppression that also impact on health and illness through neo-colonialism or neo-imperialism" (p36). Omeri has continued in her quest to see transcultural nursing established here in Australia and after a period of absence from publication has, from 2008, again been active in print. She was, in that year, the co-editor of a national journal devoted to transcultural nursing which detailed the advances of transcultural nursing into the twenty first century, although notably with few contributions from Australian authors. In this edition, similar to Kanitsaki, Omeri (2008) seems to show a change in direction of her efforts stating, "It seems that many of us, who have made transcultural nursing our life's work, especially exploring theory and research, now need to re-focus our leadership skills to direct our attention to ensuring that students and clinicians are nurtured in culture care principles ... the question is whether we are actually successful at disseminating that knowledge into clinical practice" (p2).

The impact of local cultural care scholars on nursing in Australia...

Kanitsaki and Omeri have dominated Australian publications on cultural care for some years and during this time made significant contributions to the field, albeit limited for the most part to transcultural nursing theory and education. How well does this represent the position held by other Australian nurses towards cultural care?

For the most part, other Australian nurses writing on cultural care have contributed in a somewhat ad-hoc manner, publishing isolated articles and authoring single chapters in nursing and midwifery textbooks. Examples of the breadth of different approaches taken over the last 10 years can be seen by looking at the range and scope of the topic area:

- Jackson, Brady and Stein (1999) on relationships between indigenous health workers and registered nurses;
- McKinley and Blackford (2001) on nurses' experiences of caring for CALD families when a child dies;

- Blackford and Street (2002) on cultural conflict: the impact of Western feminism on nurses caring for women of non-English-speaking backgrounds;
- Williams (2002) on working in a culturally safe environment;
- Blackford (2003) on cultural frameworks of nursing practice: exposing an exclusionary health care system;
- Cioffi (2006) on nurses caring for CALD patients in the acute setting;
- McMurray (2003 & 2009) on culturally safe evidence based practice in primary health care;
- Daly and Jackson (2003) on culture, health and social justice;
- Blackford (2005) on equity in care;
- Goold and Usher (2006) on meeting the needs of indigenous people and how nursing education is meeting the challenge;
- Sherwood and Edwards (2006) on decolonisation: a critical step for improving indigenous health;
- Jeon and Chenowyth (2007) on working with Culturally and Linguistically Diverse Background nurses .

This list of Australian nursing authors serves to demonstrate a certain lack of cohesion in the approaches being taken towards creating a domain of cultural knowledge in a local context. Whilst this could be helpful in facilitating nurses to explore a range of positions and a number of different contexts, all of which are potentially useful, it does little to advance understanding and capacity in a broader sense and contributes only modestly to the development of a distinct Australian discourse which might better match the needs of Australian nurses and be more acceptable for application to education and practice in this country.

Australian nurses have also contributed to the field by posing questions about the appropriateness of transcultural nursing in Australia. Despite the significant contribution made by Kanitsaki and Omeri, which skews the discussion in favour of transcultural nursing, there are Australian nurses who have expressed reservations about that approach. Bruni (1988) was the first Australian to undertake a critical analysis of transcultural nursing, where she claimed, "critical analysis suggests its application may well reinforce the very problem of paternalistic and ethnocentric care it seeks to replace" (p31). Gorman (1995, 2005) reiterated Bruni's findings and whilst he supported the need for the preparation of nurses to work with multicultural populations and appeared to understand the principles underpinning the theory

of transcultural nursing, he claimed "the teaching of transcultural nursing in Australia was ad hoc, and minimal, lacked structure and was prescriptive and descriptive with little opportunity for students to develop cultural sensitivity" (p29).

Daly and Jackson (1999) specifically discuss transcultural nursing as having received significant attention as nurses actively sought to meet the needs of the multicultural population. Unfortunately they also identify the critiques of transcultural nursing by Australian nurses as a strong challenge to its usefulness and appropriateness for Australia. Goold (2001) was also unsure that transcultural nursing has had any significant effect in Australia: "transcultural nursing has been known about for more than three decades, however the implementation of the principles has not yet become a reality in Australian nursing" (Goold, 2001, p94). Blackford, in 2005, stated that "approaches such as transcultural nursing or cultural safety have had limited impact on the quality of care in clinical practice in Australia" (Blackford, 2005, p30). It seems clear that despite the work of the transcultural nurses in Australia to advance this type of theory and research, to underpin cultural care practice in nursing, it has not proved to be successful.

Is cultural safety used in Australia?

New Zealand is relatively close to Australia and has met with a greater degree of success in determining a national approach to cultural care, one which has been well received in that nursing community and is also appropriate to the local context (Ramsden, 2002; Nursing Council of New Zealand, 2005). Goold refers to Ramsden's work on cultural safety and suggests that Australia might find this useful to re-inform its own work and conceptual development. Likewise Williams (2002), a nurse working in indigenous health, supports the construct and its utility for the Australian indigenous health care context. She wrote of the potential that this model appeared to hold for advancing indigenous health and supporting strategies to ensure the inclusion of cultural factors in health care service delivery. Apart from this interest within the indigenous community, cultural safety is less well known in Australia.

White (2006), having spent time in New Zealand and thus having gained familiarity with cultural safety, supports the use of this model. As does McMurray (2009) who writes in the areas of primary health care and community. Both these local scholars draw on Ramsden's work, but overall it has had little exposure in Australia. Johnstone and Kanitsaki (2005) rejected

it emphatically in their report, although as has already been suggested, this report is not without bias and should not be accepted uncritically (Wilson, 2008).

Cultural care and Indigenous Australians — an essential concern for Australian nurses

The Australian National Health and Medical Research Council (2006) asked that all nurses recognise the unique position in this country of Aboriginal and Torres Strait Islanders — the Indigenous Australians. Whilst this thesis is not looking specifically at issues of indigeneity, any discussion of culture in Australia must necessarily acknowledge the first inhabitants of this country. To examine the issues underlying the poor health status of Indigenous peoples and give these concerns the consideration they rightly need and deserve would be a separate thesis in itself, but one that is best placed in Indigenous hands. However, the ideas contained within and conclusions reached in this thesis are equally relevant to any vulnerable and marginalised population of people, such as the Indigenous population, who might currently be disadvantaged by Australia's health care system.

The health of the Indigenous people of Australia is one of the more pressing issues facing this country (McMurray, 2009). The Australian Productivity Commission's biennial review of 2009 found that the gap between indigenous and other Australians in terms of disadvantage was actually growing, not diminishing. Aboriginal Australians do not enjoy the same level of health and well-being as other Australians, at all ages and stages; their quality of life is not as good as that of non-indigenous Australians (Kelly, 2006). The health status of Indigenous Australians has been well-documented and widely recognised as the worst experienced by any population cohort in this country (Dodson, 1994). The life expectancy of an Indigenous Australian is approximately 15 to 20 years shorter than the rest of the population. Levels of chronic disease, mental illness, neonatal and child morbidity and mortality, and harmful poly-substance abuse and addiction are significantly higher than in the general population. Much of this negative epidemiology associated with indigeneity is related to economic and social disadvantage and most is directly correlated with the cultural and material harm perpetrated against Aboriginal and Torres Strait Islander peoples during British colonisation. The Indigenous nation has a different life experience as a result of Australia's colonial history. Goold (2001), an Indigenous nurse, describes this in the following manner: "what Europeans call settlement, they [we] call invasion" (p95). With the annexation of Australia to Britain in the 1800's, colonialism has imposed on the Indigenous community a values system, a language, a religion, a lifestyle, as

well as educational, legal, health and social institutions that were and still are vastly different from those originally in place amongst the many indigenous groups and communities at the time of settlement (Omeri & Ahern, 1999). The long term effects of colonisation have been characterised by a continued lack of access to education, economic power and the resources needed for the Indigenous nation to have the same quality of life as the rest of Australian society (Goold, 2001).

Colonisation has left an enduring legacy into the twenty-first century, which has been recognised in recent public policy as an urgent priority. Understanding the enduring legacy and effects of colonialism on Indigenous health is an imperative for all Australian nurses (Sherwood & Edwards, 2006). Goold and Usher (2006) write of the need for health professionals to be better prepared to work with Indigenous patients and communities, to be better educated about the factors related to health and also to understand colonial history and its enduring impact on Indigenous culture. These Indigenous nurse scholars advocate for the inclusion of the broader themes of culture and racism and the promotion of social justice and its relationship to health within the nursing curriculum in order to better prepare nurses to provide the type of holistic care needed by Indigenous patients. Goold and Usher (2006) discuss how in the main Australian nurses come from the white middle classes and have likely had little contact with Indigenous people. These scholars find that the process of nursing education is further evidence of the entrenchment of white values within nursing: “until there is an attitude change on the part of those teaching nursing and on the part of the students themselves”, this will remain unchanged (Goold, 2001, p99). Goold stresses that her comments are not intended to engender feelings of guilt or anger in non-Indigenous nurses — although her assertion may sound challenging to some — but rather it is about developing a concern for and a commitment to social justice: “it is really about a healing process and acceptance of each other” (p96).

There is significant evidence confirming that Aboriginal health continues to be a major challenge to government, its agencies, health professionals and nurses. Despite an increased level of expenditure and a commitment to improving Aboriginal health, data regarding Aboriginal health outcomes over the last 15 years demonstrates that progress is small. Outcomes have not been encouraging and there is only a minimal improvement in the health status of this specific demographic (Sherwood & Edwards, 2006). Sherwood and Edwards consider this lack of improvement to be directly related to the domination of the Western

worldview in health care research, policy and praxis, the pre-eminence of the biomedical model and personal and institutional racism, which is 'unwitting and systemic' and occurs when cultural assumptions become embodied in a society's established institutions and processes. Racism or negative discrimination occurs when a practice or policy appears to be fair because it treats everyone the same, but it actually disadvantages people from one racial or ethnic group (Levy, 2001). Today, in Australia, Indigenous persons appear to have access to the same health services as the rest of the community, however the impact of this history and these issues must be considered carefully when caring for Aboriginal peoples.

Cultural care preparation and indigenous health is now a curriculum requirement in all undergraduate education programs nationally and is increasingly being included in courses for specialist preparation and the ongoing education of those already in the workforce. Parker and McMillan (2007) found that even though there were multiple strategies for diversity and cultural teaching in Australia, there still appeared to be little real commitment to fundamentally changing the curriculum. Key professional bodies and regulatory authorities through the development of new standards for practice are supportive of the need for this type of improvement. But no matter how well nurses are prepared educationally for practice or driven with mandatory directives, this is vastly different from applying such knowledge in the clinical setting and as yet there is little evidence of significant impact from these strategies (NRNE, 2002; ANHRC, 2005).

To achieve equity for the Indigenous peoples, Sherwood and Edwards (2006) call for decolonising processes to be used in nursing education. That is, the promotion and use of processes which require individual nurses to explore their own assumptions and beliefs so they can be "more open to others ways of being and doing" (p188). Sherwood and Edwards (2006) believe it is critical that Indigenous knowledge and ways of knowing be incorporated into the national health agenda: "rarely is the topic of Indigenous knowledge discussed in relation to Indigenous health" (Smylie, Kaplan-Myrth, Steele, Tait & Hogg, 2003, p140). Suggested strategies include making better use of existing theories in undergraduate education programs and that Indigenous authors also support the use of the theories of transcultural nursing and cultural safety (Goold, 2001; Kelly, 2006; Goold & Usher, 2006; Sherwood & Edwards, 2006). They also advise that the 'linear' model of Western knowledge systems, which divides body parts and knowledge into categories, disease causations and remedial measures, is not well-matched to the more holistic model of the Aboriginal psyche. Health and culture, it is

suggested, are best viewed and evaluated in the context of their historical and Indigenous antecedents, with any examination, by necessity, including an analysis of the underlying structural inequalities that have had a major impact on wellbeing and which should be used as a fulcrum to determine the best way in which policies and services are determined (Smye & Brown, 2002).

Nurses need to make this a priority and support the Indigenous effort, recognise the need to develop a deeper understanding of Indigenous existence and build trust to genuinely address these health inequalities effectively. Collaborative ventures and increased concern for and consideration of how to work with the Indigenous nation can assist nurses in this process. As Kelly (2006) states, "it is not acceptable that health outcomes for Aboriginal people remain the same in the next ten to twenty years. My concern is that if significant changes are not made to the way we provide health care, this is a real possibility" (p325).

The current position — evolving discussion and debates on cultural care

The issues and scholarship around cultural diversity and its impact on nursing services in Australia are currently in a state of transition. There exist a number of points of view, questions, deliberations and often debates about how to guide and determine the best way forward. The Australian National Health and Medical Research Council (2005), when undertaking a process of national consultation across the health sector on cultural care, suggested, "many different perspectives within the landscape of cultural competence emerged, these are acknowledged rather than resolved" (p11). It seems that consensus may still be some way off and the implications of that are significant if progress is to be made in this area. The health of Australians is a national issue in which the government and wider society are heavily invested. Nurses must work into the future in search of answers to this challenging problem. Looking internally at the profession of nursing for a solution, however, yields rather more questions than it does answers.

The discipline of nursing in Australia needs to stand "back and reflect upon the way that we as a community of health professionals treat and interact with people who are marginalised and disempowered" within the health care system, of which nurses are an integral part (Jackson, Brady & Stein, 1999, p102). A people centered, rather than a task centered, approach has

been advocated as being pivotal for nursing. Nurses are expected to individualise care for each patient and consider the personal and particular circumstances in responding and caring for patients. Nurses themselves have articulated this aspect of their role as of primary importance and take pride in individualising the illness experience of the patient and being aware of the emotional dimension of illness and caring (Wilson & Neville, 2008). How can the nurse continue to 'know the patient as person' if they persist in ignoring the importance of culture and the way in which it defines and constructs the world of the patient?

Johnstone and Kanitsaki (2005 and 2009) found that most nurses in Australia had not really considered the relationship between minority ethnic groups and their health care or nursing outcomes. Nurses were also unfamiliar with and did not appropriate any of the cultural theory in nursing, despite over 40 years of multicultural policy and 30 years of its inclusion in nursing education and models of care (Goold, 2001). It is difficult to see how cultural care is considered, as yet, a priority by nurses in Australia, or perhaps even considered to be a significant aspect of nursing at all. It is not likely that many Anglocentric nurses will have experienced prejudice or racism on a personal level or when working in the health care system and, therefore, they may lack insight into the lives and experiences of those of who have - the users of nursing service. Even those committed stewards of transcultural nursing in Australia, Kanitsaki (2005, 2007, 2009) and Omeri (2003, 2004b), who first introduced and nurtured the concept, are not confident that it has been successfully adopted. Omeri (2003) states:

> "*There appears to be a degree of variability in defining cultural competence in Australia ... nursing is in the midst of a crisis as to how best to accommodate cultural care in its practice domains. Our policy guidelines are limited ... they are without defined premises relating to the knowledge and skills required to improve the care of people in culturally meaningful ways or to improve access to health services and to make nursing care culturally safe, meaningful and equitable"* (Omeri, 2003, p184).

A key imperative for nursing in Australia is to establish *how* nurses can come to understand the way in which the 'culture' of their patients has a substantial impact on the delivery of nursing care and health care outcomes in general. Cross-cultural care in the nursing sector is a significant issue in health care, but it is still the least researched and therefore the least understood by nurses. Without a proper foundation of theory and research, the only outcome can be 'best guess' solutions. This need is being reinforced in a number of ways, but none have

yet provoked any significant change here in Australia. Without strategy, tools and a framework for planning development, the nursing response to the need for cultural care in Australia is still generally at risk of being unrecognised, neglected and, at worst, will remain unsuitable.

The voice of the local health care consumer community, whether Indigenous, Australian by birth or immigrant, is notably absent from the dialogue, research and ideas exchange. Feedback from the multicultural population of Australia is currently almost invisible and without their presence in some form, the complex work of understanding cultural care will be only partially complete (Blackford, 2003). "Research, whether it is conducted with patients/clients or nurses, is most likely to help us articulate our particular Australian style and contribution to the discipline than the adoption of imported ideas or styles of practice" (Lawler, 1991, p211).

Chapter 6

THINKING CRITICALLY ABOUT CULTURAL CARE THEORY

... DISCUSSION AND SOME THOUGHTS FROM NURSES

"Issues of paternalism and racial, sexual and generational and class boundaries became more obvious and developed into ongoing challenges"

(Ramsden, 2002, p206).

The pioneering work of Leininger and Ramsden has attracted a great deal of attention for nurses seeking answers to the questions around culture and has already been much considered in this thesis. This chapter will present and discuss the alternative views, those lines of inquiry about culture and nursing that have been pursued by other nursing scholars. The work of these scholars will be outlined and explored for the significance they might hold for opening up and adding to the existing understandings of cultural care in nursing. These alternate views provide new insights, prompt discussion and on occasion have instigated a challenge to those more established theories of culture. The aim of this chapter is to create links between the themes currently being explored and to elaborate on this new thinking about culture which has the potential to drive theory development into the future.

The work of Leininger and Ramsden has for a long time constituted the 'accepted wisdom' in the field and many nurses have relied heavily upon those theories. Leininger and Ramsden's contribution as prominent authorities on culture, although still significant, has considerably diminished and now represents the early years of nursing's engagement with the notion of culture. Ramsden died in 2003 and so little of substance has since been added to her model. Leininger is retired and no longer adding to or re-developing her theory. The time of the 'grand', all encompassing theory seems to have passed. Although followers of the transcultural tradition continue to add to that already considerable body of ethno-nursing studies, the philosophy, methodology and methods remain little changed from Leininger's heyday. As well as those more orthodox and now predictable transcultural works, other nursing scholars have stepped up. They have taken the lead from Leininger and Ramsden by breaking new ground, adding to the body of knowledge and thus providing a reliable basis for new and innovative nursing practice and research. Different questions are now being asked and fresh directions

pursued. (Davis, 1997; Spence, 2003; Richardson, 2004; Giddings, 2005; Gibbs, 2005; DeSouza, 2006; Grant-Mackie, 2006; Clear, 2008; Wilson & Neville, 2008; Nairn, 2009; Racine, 2009; Reimer-Kirkham, et al , 2009).

There have been new themes introduced which represent topics not previously addressed in any real depth. As Blackford (2003) asserts, nurses are beginning to undertake acts "of looking back, of seeing with fresh eyes, of entering an old text from a new critical perspective ... until we understand the assumptions in which we are entrenched, we cannot know ourselves" (p236). The subjects of culture and ethnicity still continue to be examined and explored, although new challenges have been made to this way of defining people, as will be seen in this chapter (Drevdahl, 2001; Drevdahl, Phillips & Taylor, 2006; Lynam, Browne, Kirkham & Anderson, 2007; Kennedy, Fisher, Fontaine & Martin-Holland, 2008).

Adding to those important, if familiar, themes are new issues, which include racism and discrimination (Cortis, 2003; Dunn, 2004; Nairn, Hardy, Paramul & Williams, 2003; Lancellotti, 2008; Johnstone & Kanitsaki, 2009; Khalafzai, 2009) marginalisation (Blackford, 2003; Vasas, 2005) and ethnocentrism and 'whiteness' (Sutherland, 2002; Puzan, 2003; Allen, 2006; Martin-McDonald & McCarthy, 2007; Gustafson, 2007). More significantly, Indigenous scholars are putting their own perspectives forward and the opinions of ethnic minority groups are being voiced, some for the first time (Serrant-Green, 2001; Donnelly, 2002; Santos-Salas, 2005; Simon, 2006; Hassouneh, 2006, 2008).

This new theoretical work remains fragmented and lacks continuity across the discipline and is therefore still some way from being unified or able to provide complete answers. It does, however, offer new insights and has the potential to re-envision thinking. Examining issues such as ethnicity/racialisation, racism, discrimination, marginalisation and ethnocentrism is made more complex because these topics have the potential to be considered of personal and political as well as professional concern for nurses. Coming to appreciate different viewpoints on what personhood and the nature of the social world might imply can create tensions with personal beliefs or even lead to intellectual confusion. Nevertheless, in order for nurses to develop insight, become more perceptive and meet the new challenges of patients through cultural diversity, they will need to better understand the world and humanity and begin to see themselves, their patients and their colleagues in new ways.

However different interpretations must be considered as possible. Discussion in this chapter will also be accompanied by the comments of participant nurses interviewed for this study. Western philosophy and nursing theory has developed into a very particular means of reasoning and deliberation, often constituting a highly specialised intellectual activity. As Mason (2008) describes it, such scholastic activity is often "relevant only to a narrow audience of academics" (p6). Any professional body of knowledge or theory is intended for a broader audience of readers and needs to be understood within a larger interpretive context — that of the reader's world or the discipline of nursing at large. Theory must, for that reason, be presented in an accessible and useable manner if it is to benefit people other than the scholars and knowledge experts (Sandelowski, Docherty & Emden, 1997). That is, theory must resonate or be comprehensible to the potential users of the text, for example nursing teachers, researchers, policy makers, clinicians and students of nursing, who must be able to comprehend and understand it. For all that is written and published must, in turn, be reinterpreted by readers of that text. Cultural theory is of course conceptually ingenious, but is it instrumentally functional? That is, can it be used by nurses to develop and augment their understanding(s) of culture? Is it able to be assimilated into the "personal modes of knowing and valuing and/or doing" of the readers, who become the translators of the text (Sandelowski, Docherty & Emden, 1997, p365).

For that reason this study sought to identify and appreciate the different possible interpretations of theories of culture so as to show how the readers, as well as the scholars and authors of the text on culture, thought about and understood the theories of culture in nursing. These participants were familiar with cultural care theory and their observations have been included, because it is helpful to have the ideas of those on the 'inside' of nursing who can provide some clarification of what is 'really going on' outside the world of the scholars. Individual responses have been used verbatim and opinions 'expressed in their own words', as these excerpts represent particularised understandings of cultural theory.

Established cultural care theory ... has it provided the answer nursing needs?

Transcultural nursing…

Leininger (2006) considered that theory development on culture for nurses was, in principle, complete. Her theory of culture care: diversity and universality is, she deems, comprehensive

and well developed and it simply needs a greater uptake by the discipline of nursing and continued support from nurses for it to be the solution to cross-cultural care problems. She maintains, "this theory is relevant to nursing and makes sense; the theory and method have become well known as user friendly, rewarding and exciting" (pix).

The majority of transcultural nursing advocates certainly supposed that their theory had the potential to inform and change nursing practice across the globe. Papadopoulos and Omeri (2008) suggested "that it can be argued that transcultural theory and models are the most appropriate for the 21st century ... this will go some way towards elimination of the health equalities experienced by many marginalised communities and individuals" (p46).

Transcultural scholars widely regard Leininger's theory as suitable to meet the needs of nurses, stating, "the rigorous, theoretically solid and research based knowledge of transcultural nursing needs to be applied to clinical practice, education, research, administration and consultation nationally and trans-nationally" for the "best practices in transcultural nursing" (Andrews, 2008, p15). Andrews also believes that transcultural nursing can be used worldwide in nursing and is 'made to measure' to improve health outcomes for disadvantaged ethnic patients. This assertion has not, as already discussed in Chapter Three, proved to be the case. The underlying assumptions in transcultural nursing are increasingly being challenged and reconsidered (Sutherland, 2002; Gustafson, 2005; Santos-Salas, 2005; Culley, 2006, Hassouneh, 2008; Racine, 2008).

Comments from participants…. on transcultural nursing

Did these nurses share the sentiments of the transcultural nurse authors?

There was a strong sense of transcultural nursing not having been well accepted by the participants. Whilst Leininger was acknowledged for her pioneering work and bringing culture as an issue of relevance for patients to the attention of nursing, the participants did not rely upon this theory and even expressed some discomfort with the concept. It was felt to be limited, reductionist and needed to evolve and better reflect local concerns.

"In a sense Leininger's work created a path and opened up discussion but the more I work with this, the more critique I have" … "I do not like transcultural nursing, the theory just does not particularly attract me" … "it's just ideology, quite reductionist ... we need more than just the do's and the don'ts" (P1).

"Transcultural nursing never really resonated with me and I found it boring, it's awfully dry and boring, it's like the real people have been taken out somehow" … "it's not well thought out, it's a formula and it has no relationship to partnership" ... "It's too tight a box, its narrowing down on a theoretical perspective, it does not sit well or work with me, I feel uncomfortable even thinking about it" (P2).

"Her work has shortcomings and is outdated … I disagree with transcultural nursing and Leininger" … "this theory is just too vague, too airy-fairy, it just does not make sense, they keep wanting to know more" … I have read a lot of literature on it and I am very critical of an essentialist approach like this" (P3).

"*She's outdated in her thinking" … "the transcultural nurses are purists and they don't evolve their theory, they just stay in the same mode, some people totally agree with them because it suits them, but not me" (P4).*

"Transcultural nursing, I don't personally ascribe to it, because I think it ignores the effects of colonisation in this part of the world, the same is true in North America but there is not the same awareness of it" … "I would challenge the notion of a cultural smorgasbord used in transcultural nursing, that's okay at one level but you need to look deeper into the context" … "Anthropology is an outdated form of study as well" (P5).

Cultural safety …

Proponents of cultural safety similarly expressed a confidence that their approach would provide the new solution for nursing (Ramsden, 2002; Wepa, 2005, 2006; Wilson, 2008). As Clarke (2005) asserted, "Cultural safety holds the key for nurses and midwives to make major inroads into the task of improving health outcomes" (pvii). Culley (2006), from the United Kingdom, welcomed the construct of cultural safety to the field of inquiry. Johnstone and Kanitsaki (2007a) too have expressed some support for the use of cultural safety, suggesting it could be a springboard towards the achievement of cultural competence if used alongside transcultural nursing. Browne et al , (2009) in Canada also considered that "cultural safety will continue to hold value for nursing practice, research and education … it will be worthwhile to explore the ways of engaging cultural safety as a concept that can be used to bring the abstract theories of social justice into practice more fully "(p177).

However, the success of this model for general adoption into nursing is contestable at present. Cultural safety, whilst "holding promise and providing new perspectives is still open to considerable ambiguity in interpretation" (Browne, et al 2009, p167). It has provided an alternative to the transcultural approach but clearly continued work is required to enable better understanding and facilitate the application of cultural safety to practice if its potential is to be fully realised.

Comments from participants… on cultural safety

How did the participants react to this model?

Cultural safety received a more positive response from the participants than transcultural nursing, although feeling was expressed that developmental work was still needed. This model was felt to be more relevant to these nurses. Mention was made of its genesis in a local context and this may explain why these nurses seemed more engaged with this model.

Identification of leadership, relevancy, engagement with patients and a concern with broader socio-political issues were evident.

"I think that a lot of scholars in our part of the world are showing a lot of leadership, particularly Ramsden and the people in cultural safety, they have brought new perspectives" … "Ramsden's work and that New Zealand work seem so much more passionate and really living, it seemed more like it was really about real people" ... "the Aboriginal community and Canada as well, they have picked it up, but the Schools of Nursing in Australia we have not really picked it up" (P1).

"I really like cultural safety, I found it easy to understand but hard to use and develop, the concept of safety really resonated with me" (P2).

"Cultural safety, I know it comes from New Zealand originally and it came from the Māori people, I am preaching a lot about it for our patients to have cultural safety and I'd like to interchange it with patient safety" (P3).

"Cultural safety is about being grounded and they know about working with people, knowing yourself, acknowledging power, those key concepts you can use when you need to work with other cultural groups" … "not looking out saying 'isn't that interesting what they are doing in their culture', its bringing it back to the nurse–patient interaction, bringing it back to the nurse, I am the holder of power, I am part of the institution, how does it impact here and what you are doing with this person, can I make this possible" (P4).

"In cultural safety you look at lots of different kinds of cultural groups even within cultures. I think we have matured from the early rigidness, or I would like to think so, I think we have recognised the pain of the Māori experience of ill health and that was a catalyst" … "I think Ramsden was a purist, and I am mindful that with theory you have to be careful, it's an evolving concept and it will always need to be updated and to keep pace with nursing, changes in nursing are so rapid" (P5).

"Cultural safety is so similar to ethical safety, where it depends on the interaction at the time, at that moment" (P6).

Despite Leininger and Ramsden having both held expectations that cultural inquiry was well developed, authentic and ready to be applied with good effect to practice, nursing scholars — such as Smye and Brown (2002); Anderson et al, (2003); Gustafson, (2005); Culley, (2006) and Browne, et al , (2009) — are not as certain that the solution has been found in existing cultural theory and scholarship. Whilst Culley (2006) describes a sense of "naive optimism" (p146) that an answer has been found in cultural care's existing theory, it would seem that there is much work still to be carried out in fully developing the theoretical constructs of culture and nursing for it to be inclusive of the many positions that 'culture' might need to represent. Drummond (2008) urges nurses to "cast a wider net of philosophical inquiry" (p1) when considering issues of identity and difference in health and health care.

Re-considering the concept of 'culture'

The definition and understanding of culture is central to any discussion on cultural care in nursing. Even if the description of 'culture' is not outlined explicitly, assumptions are most certainly operational and can be assumed to be present in any scholarship. Meleis (1996) encouraged nurses to explore the meaning of culture by more deeply examining the concept itself. Reimer-Kirkham et al (2003), Browne and Varcoe (2006) and Browne et al (2009) all claim that despite critique and questions about what possible alternative interpretations of culture might exist, the frameworks in use in nursing today remain narrow.

Largely, conceptualisations of culture currently in use reiterate and reinforce the understanding of culture as something fixed or static and based in the beliefs and customs of 'other' groups, as discussed in this thesis. The continued use of this type of 'culturalist' definition, associated with cultural relativism, will have serious consequences for patients in terms of the type of knowledge and assumptions that nurses will employ to shape their understandings and, in doing so, use to inform their practice. Campesino (2008) recently commented that culture, as a concept, has as yet still to undergo any serious theoretical advancement, claiming it still to be used interchangeably with race and ethnicity and frequently employed in an overarching and ambiguous manner.

Bruni (1988), Culley (1996) and Pfeffer (1998) were amongst the first to express a concern that defining culture as fixed and based on shared customs and beliefs was in effect categorising individuals into fixed immutable categories. This reinforced the idea that culture means individuals have a set of characteristics that are permanent, unchanging and shared by all

group members within any particular category, for example as determined by country of birth. Pfeffer (1998) believed this type of essentialism inferred that "we each have a 'true' identity inherent in us and that we carry it ... from the cradle to the grave" (p1382). She explains how the use of common, broadly based 'cultural' descriptors can be entirely misleading. Using the example of the term 'Asian', it is easy to see how the implications of this descriptor can be vastly different in different contexts:

> *"the term Asian [is used to describe] people who have come to Britain from many different parts of the world, notably India, Pakistan, Bangladesh, Uganda, Kenya and Tanzania ... from peasant or urban middle class backgrounds ... and are also differentiated in their religion, language, caste, kinship obligations, diet, clothing, health beliefs and birth practices ... there is also growing recognition that the category 'white' which covers a diverse group of people ... is also nonspecific. Being Asian is also colour-coded; it excludes white people born in this area [from being Asian]" (Pfeffer, 1998, p1382).*

When the term Asian is used in some parts of the world, other than Britain, it means something completely different again. In the USA, Australia and the South Pacific, 'Asian' describes those people with an association to South East Asia and the Asia Pacific regions. Such broad descriptive terms, it can be seen, are of little use when they differ so significantly across geographies and contexts and refer to such totally different groups of people, yet all by the same broad descriptive title. It yet again becomes even more complex to consider what those persons being referred to as 'Asian' might actually call themselves. Yet the literature is replete with such supposedly ethno-specific terms of reference, which are in reality generalisations and as such have the potential to be misleading and non-specific. For example, the term 'Black' can mean African-American in one context and yet another completely different meaning in the case of 'Black fella's' in Australia. The designation of group membership merely by 'ethnic' group — when using the ethno-nursing research method —begs the question: how are they classifying group membership when such ambiguity of categorisation is possible?

Focusing on over-generalised and superficial manifestations of culture fails to address any dissimilarity and variant complexity that may be present within groups of people. Gooden, Porter, Gonzales and Mims (2001) suggested that nursing representations of culture had failed to come to terms with diversity and so ignored variations which might occur within any given

group, such as gender, sexual orientation, physical appearance and the different ideologies of influence, for example social class or political or religious viewpoints. Kumar (2000) also suggested that the term culture was presented in such as way that it led to this "superficial emphasis on common cultural knowledge" (p84). Kumar concluded that scholars needed to move beyond ethnicity or racially developed constructs of culture, recommending instead that nursing "un-covers or un-layers definitions to allow corrections in our current understandings" (p82).

Denzin and Lincoln (2000) also challenged the traditional framing of culture, claiming it to be monolithic in its assumption of context free and timeless representations about and among different groups of people. Such representations, they claim, fail to recognise the partiality and changing nature of any culture. Given the global mobility of people today and their settlement across the globe, categorisation of groups by 'ethnicity' certainly seems to be an issue that will require significant clarification for its usefulness into the future. Duffy (2001) also supported such contentions when she claimed that, despite best efforts to date, culturally-based problems between nurses and patients persist. They may even, she proposed, have been magnified with such approaches, as they have done little beyond alerting nurses to the superficial differences between themselves and others.

Chalmers and Allon (2003), Reimer-Kirkham et al (2003) and Stout and Downey (2006) all reinforced this in describing how the concept of culture being used in nursing has become an 'all-inclusive' term. Popular conceptualisation has embraced without discretion a very broad range of socially embedded constructs, for example, ethnicity, gender, religion or social class. These are all highly influential in defining individuals, yet there has only been a superficial exploration of the influence of other social determinants on individuals. Nursing has developed a propensity for defining culture as inherited personal belief and value systems, but without an adequate consideration of the impact of historical, social, economic and political systems on those individuals.

Nairn, Hardy, Parumal and Williams (2003) declare that the notion of culture has been framed as oscillating between "a rigid deterministic structure that shapes and forms our behaviour and which is a source of division and distrust, through to a malleable, ever-changing and flexible product of socio-historical circumstances" (p190). Lynam, Browne, Reimer-Kirkham and Anderson (2007) also argue against the approaches to culture taken in the past, which

placed an emphasis on cultural belief systems, values and the practices of immigrant groups coming into Western countries. They assert this approach may not serve us well into the future where we need to be more cognisant of culture as constructed and shaped by context.

The comments of all these authors collectively summarise the current position of nursing towards culture; there is as yet no definitive consensual understanding. Historically, research within nursing has paid little attention to the multiple and overlapping spheres of diversity and such work is only beginning to appear in most recent times. Reimer-Kirkham and Anderson (2002) described a need for nursing to continue developing the concept of culture, stating "we are in a position to move forwards in our nursing scholarship, building on the foundation laid for us by those who first pointed out the importance of incorporating cultural aspects into nursing care" (p8). This begs the question, why has this type of knowledge not been advanced and still, after some years, definitions of culture present with the same level of perplexity.

Comments from participants ... on the concept of culture

Participants expressed a mixed response to what might be meant by the definitions of culture currently being used. Ethnicity remained a strong theme and was evident as a primary framing construct in their comments.

Culture was portrayed by the participants as something not yet well understood and which nurses needed to learn more about. This also this resonates with the literature and critiques of the way in which culture is currently defined.

"As we all know ourselves, ethnicity is one part of us, but there is also our gender, our age, our life experiences, where we were brought up, you know" (P1).

"We kind of sanitise culture when it's taught to people" ... "some people are intolerant and do not see how it's really just their own perspective on the world" (P2).

"Culture is ethnicity: it's the ethnic group of somebody" (P4).

"It is a shame people get introduced to the idea of culture when they are adults, after they have embedded their own beliefs and biases, then their whole world is challenged" … "nursing education has a job to do that should have been started a lot earlier, that is part of the problem, learning as adults, so they do not get to the cultural care part until they have waded through their own biases" (P5).

"I still think that the majority see culture as an external factor, its external to them, so for the dominant group they think that they are normal and anything cultural is abnormal or its ethnicity" (P6).

"Culture is evolutionary because culture is dynamic not static, it changes or otherwise it's just a historical thing" (P6).

Understanding the impact of the ideological backdrop — liberalism, relativism and equality

Anderson (2003) remarked that nursing scholars seem to have been slow to appreciate or realise the effect of their own particular social location. All authors, although writing as individuals on specific and discrete themes within the topic field of culture, do so under the umbrella of much broader social and intellectual ideologies. Knowingly or unknowingly, all authors think and write from particular positions and within particular historically created and socially mediated contexts.

Cultural care philosophy and inquiry in nursing is currently said to espouse a Western, liberal, humanist standpoint in that it assumes all healthcare takes place in contexts that are situated within an egalitarian and equitable society (Gustafson, 2005; Racine, 2009). Baker (1997) credited Leininger with pioneering the introduction of the construct of cultural relativism into nursing, where it was first described as the means to achieve culturally congruent nursing care. Cultural relativism embodies the principle of a 'shared universalism'. That is, it embodies the fundamental premise that all people are or should be equal, without exception. This stance has, Browne et al (2009) consider, "created the conditions for conceptual muddling" (p173). If an understanding of different cultures is developed under the ideology of cultural relativism, this leads scholars to conceptualise culture as the values and beliefs belonging to other particular, usually ethnic, groups. This in turn fosters a "misplaced focus on the need for more cultural knowledge" (Browne, et al, 2009, p173).

McConaghy (2000) argued that the philosophy of cultural relativism has set up a binary, one of a "tolerating majority and the tolerated minority, a power-laden division" (p41). The use of a binary construct would, she alleges, lead to one group becoming dominant and the other in effect marginalised by comparison. Bannerji (2000) also cautions that using an ideology of cultural relativism has led to the creation of different categories, all determined by ethnicity, which in turn establish 'relations of ruling'. The problem with cultural relativism is that it reifies and reinforces only one particular way of thinking and understanding, that of the white, Western philosophical viewpoint, where whiteness is so embedded that it is invisible (Davies, 1997; Smith, 1997; Nairn, Hardy, Paramul & Williams, 2003). The risk is that the majority group, or in the instance of the Western world, those individuals "sharing whiteness and European ancestry, control that world through ... recognition and mis-recognition of the 'other'" (Bannerji, 2000, p200).

Reimer-Kirkham and Anderson (2002) consider that "despite critiques, the culturalist perspective with its underlying liberal ideologies of individualism and egalitarianism still carries considerable influence within healthcare and nursing circles" (p4). Under a multicultural frame, those 'others' who are 'different' from the mainstream population are extended the privilege of being considered equal to the dominant social group and thus merely reaffirming the Western tradition which ignores social inequities. Allen (2006) has described cultural relativism or multiculturalism as an agenda that silences issues of racialisation within nursing, by considering each culture the same as, or equal to, the other.

Spence (2003) described equality as a powerfully enabling prejudice in nursing, in that it constitutes an ideal, but one that has a yet to become reality. Applying the principle of equality implies balance and negates difference. The only judgement that can be made is that individuals, despite apparent differences, must all be perceived as equals. Cultural relativism requires that the Western moral principles of tolerance and respect for others be applied as a safeguard against racism, ethnocentrism and cultural imposition (McConaghy, 2000; Racine, 2009). For this reason cultural relativism has invariably been utilised predominantly in Western democracies (Puzan, 2003; Lancellotti, 2008).

Browne and Varcoe (2006) describe how the binary, which developed as a consequence of using cultural relativism and which underpins the egalitarian notion of multiculturalism, has inadvertently framed cultural groups, as one against the 'other'. This binary, in effect, places the dominant culture or, in nursing, the 'White West', in a neutral objective position and insists that other 'different' cultures must be accommodated in the spirit of social equality, but still in opposition to one another. Such categorisation, it is suggested, is a type of contemporary democratic racism, whereby two sets of values coexist, yet fundamentally conflict. Allen (2006) describes this succinctly as a process whereby "a bunch of 'other' peoples need to be taken into the mainstream ... but the mainstream is white ... the approach of many diversity recommendations is primarily one of 'add colour and stir'" (p66). In nursing this leads to approaches where, rather than fundamental sociopolitical structures being changed, culture and ethnicity are instead added; added to clinical experiences, to curricula, to case studies, to textbooks, to student bodies and to staff demographics. Rarely are those 'white-at-the-centre' approaches challenged.

Cultural relativism is still, claims Camphina-Bacote (2008), an essential moral commitment required by all nurses to care for their patients. That is, nurses must identify and suspend personal judgement about others' cultural beliefs, values or practices. There must be, Camphina-Bacote (2008, p142) argues, "a sincere and heartfelt motivation for the nurse to want to engage ... based on the humanistic value of caring and the spiritual aspect of loving one another ... unique individuals who all belong to the same race". This is an unmistakeable affirmation of an apparently value free commitment to cultural relativism.

Racine (2009) also questions the position of cultural relativism by claiming that the principle of equality falsely negates real differences between people, such as "privileged and underprivileged groups or minorities and non-minority groups" (p19). Racine (2009) suggests that with the wide range of beliefs and practices both within and among cultures, it seems almost inevitable that there should be some conflict between aiming to support and protect the many different ways that people might understand their world. The apparently suitable notion of equality, grounded in cultural relativism, has begun to come under some criticism in that it masks those historically located unequal power relations and does not acknowledge the impact of dominant cultural authority.

Comments from participants ... questioning the ideological context of culture in nursing

Participants showed an awareness of multiculturalism as an influential social ideology, but were questioning of it as a suitable social framework; they expressed some concern about quite 'how' it accommodated diversity, other than illuminating that people were different.

The participants were also uncertain about its function in determining equality. These comments indicate there is division and difference between people and that multiculturalism is still quite a new idea about social inclusion.

"I don't really necessarily think multiculturalism is a good ideology, it needs to be problematised" ... "one of the problems is that it makes the host culture invisible, I personally do not think it's a good ideology" (P1).

"I always say we are multiracial, not multicultural because if we were then all the cultures would have a say on how the institutions were run and language and all the rest of it. Australia thinks it is multicultural, I won't say this out loud but look at all the problems, Australia's really mono-cultural, they are just playing around with it" (P3).

"Multicultural ideologies and everything, it's so new, it's really only something that we've grappled with over the last twenty years, I have not got the answers yet" (P3).

"Multiculturalism means that you can find many different nationalities, so to me, it's like we all think we are all different ... we have to find ways to make it better for people" (P4).

"There is a problem with this multicultural thing because it says that people can come and practice their beliefs here and yet we have laws against stuff and in some cultures things like wife beating, genital mutilation and child abuse that we see as wrong are okay — because of our fear and this multicultural thing we fail to protect and some things are not okay" (P5).

"I think that multiculturalism in Australia is like everywhere else, it looks good in theory but in practice you can see that there are still pockets of people, I am talking about first generation here and then their children often identify as Australian and don't want to know their Greek or whatever background — it's a wide spectrum and think you cannot generalise like that" (P6).

'Teasing out' issues of race, racialisation and ethnicity from 'culture'

Where does ethnicity sit in 'culture'' ...

Binney (1995) questioned the accepted approach taken by nurses when they classify and summarise 'other' ethnic groups. An ethnicity approach, she claims, has an inherent assumption, one of Euro-centrism or concealed Anglo-Saxon superiority. Horsfall (1997) wrote that class, gender, religion, age and sexual orientation are all associated with ethnic groups, but these are not often referred to. Maintaining a focus on ethnic groups, who are seen as 'different', will ultimately reinforce negative qualities and might lead to perceptions of stereotyping and discrimination. Baker (1997) maintains that "nurses often belong to the dominant or mainstream cultural group and their client to a minority group, which enhances a tendency to be culturally blind, deaf and intolerant" (p9).

Pfeffer (1998) accused nurses of adopting a positivist approach to ethnicity in which "facts are observed and boxes ticked off" (p1382). Classifications of ethnicity employ mechanisms such as skin colour, religion, name or nationality, anything which allows a code or marker to be developed and people assigned to it in the interests of determining 'who they are' and how we must respond to them. The danger in continuing to use this approach, she maintains, is that it suggests that everyone designated as belonging to a particular group will be believed to experience and understand the world in much the same way.

McConaghy (2000) claimed that nurses are unknowingly assuming that the culture of others is "out there, to be read" (pxi), with interpretation invariably being made by a white nursing researcher. Duffy (2001) advocated an avoidance of such a 'traditional' anthropological approach, which she considers portrays the culture of 'others' as exotic and unusual. To

categorise in such a way leads to contrasts being made with the majority culture and potentially to stereotyping. Reimer-Kirkham and Anderson (2002) also passed judgment on nursing's current cultural theoretical approach, which they claim "focuses on the superficial manifestations of culture and fails to address the continuing hierarchies of power and legitimacy that still exist" (p9).

Gustafson (2005) also alluded to this when she challenged the categories of difference as determined by ethnicity that are currently "being held up as distinct, bounded and static biological facts or essentialised categories" (p4). Gustafson (2005) claims that in defining ethnicity as if it were a biological fact is misleading and organises social identity by "who we are, not what we do" (p4). This in turn, she claims, leads to nurses relying on "literature and textbooks [which] are heavily peppered with a cookbook approach to cultural diversity ... people are clumped together" (p7). This virtually ignores the differences among groups and homogenises human experience beneath the label of ethnic group. Gustafson also argues that, because nursing categorises the other by ethnicity, "whiteness has become a politically neutral identity position from which to interpret racial difference" (p9).

Drevdahl, Phillips and Taylor (2006) considered that, despite the best endeavours of many nursing philosophers and scholars over time, there still remains little agreement on how best to define race and whether ethnicity differs from race. Ethnicity, they assert, suggests birthplace, culture and traditions, whereas race equates with the sharing of biological ancestry. However, both definitions do little to clarify the differences between the terms. Such inconsistencies are significant because of their potential to shape nursing policy, research initiatives, resource allocation and service delivery.

Culley (2006) points out that we are all members of ethnic groups, but in spite of this, ethnicity is most commonly associated with non-whiteness. We rarely see white people constructed by ethnicity. Culley explains that there is "no single, universal concept of ethnicity" (p145). This aspect of ethnicity — the use of the term in relation to 'white' ethnic groups — is significantly under explored and little considered by nurses. Ethnicity is always referred to as the characteristic of someone else, and most defiantly not a characteristic that might be assigned to a 'white' nurse.

Reliance on ethnic categorisation and cultural checklists can reinforce, rather than ameliorate, stereotypes (Campesino, 2008). Lancellotti (2008) recognises this too when she states: "there is no doubt that cultural care theory has been misused through the superficial application of cultural holding knowledge" (p181). An example of this is the use of charts, developed for nursing textbooks, which provide stereotypes of food preferences or religious beliefs that are deemed then to be generalisable to entire 'ethnic' groups. Ethnicity has recently been described by Campesino (2008) as being often treated as an absolute, which it is not.

Racine (2008) claimed that the key limitation of this type of conceptualisation, so popular in relation to culture, is the enduring tendency to use such fixed representations of culture. This, she maintains, leaves little room to modify or expand the definitions and account for the fluidity of social representation in cultural identity, which also leads to a resistance to changing those ideas first established. Increasing attention needs to be paid in nursing to developing a deeper understanding of culture as embedded in and defined by individual experience, not in thinking about ethnicity in isolation, but in light of the complex socio-economic, historical and political milieu in which that human experience of ethnicity is immersed (Bannerji, 2000; Santos-Salas, 2005; Allen, 2006).

Recognising and acknowledging difference is foundational to the recognition of the distinctiveness of human beings and their subjectively different experiences as part of their identity. Instead there is a need to understand culture in a more critical sense. That is, as being created by people in relation to each other and, so, inevitably hierarchical, unbalanced and power laden. There have been suggestions that espousing cultural relativism to describe others actually sustains ethnocentrism (Mulholland 1995; Gustafson, 2005; Lancellotti, 2008; Racine, 2009).

Is the use of 'race' really obsolete? …

Race is another operational definition used, or more often not used, when trying to describe different cultures or ethnicities. Race has come to be associated with discrimination and intolerance. In the past, erroneous scientific notions around the biological determination of race have been accepted and used to create a supposed hierarchy of difference. However, Katz (1998) clarifies that "pure races, in the sense of genetically homogenous populations, do not exist in the human species today, nor is there any evidence that they have ever existed" (p35).

Reimer-Kirkham and Anderson (2002) deliberated on the characterisations of race. Race, in the current climate of social equity and justice, is considered an undesirable way of framing and thinking about different groups. By substituting the word 'culture' or 'ethnicity' for 'race', the discussion on issues of racialisation might seem to have become less contentious. There is often an avoidance of and concern about the use of the term race, largely because of the historically negative connotations associated with the word, when it was used to subjugate particular 'racial' groups. Has race really been removed from nurses' vocabulary through avoiding its use, or have we subsumed it inside ethnicity or culture? Reimer-Kirkham and Anderson (2002) do not believe it has disappeared but that "the concepts of culture and race continue to operate in tandem, most often with 'race' as a silent subtext to discourses of culture" (p5). Instead of referring to race or ethnicity directly, references to culture and cultural difference are increasingly used, but the authors believe this has merely driven the construct underground, rather than removing it.

Harrison and Falco (2005) describe the oversimplified characterisation of certain groups of people determined by ethnic group, which has the potential to lead to the development of generalising images which might negatively influence the nurse and so the delivery of healthcare. Difference is then typically defined as 'those people' who might differ in some way from the dominant group norm. Gustafson (2005) alleges that although culture could be acknowledged as a combination of a number of different attributes, ethnicity is most often given a certain primacy and is perhaps erroneously conceptualised as the most significant indication of difference: "the concept of culture stands in for and operates as a code word for race and ethnic difference" (p6).

Nairn, Hardy, Parumal and Williams (2003) discuss the conceptual difficulties of changing individuals' attitudes and the judgments made about others when teaching anti-racist theory. They describe the problematic nature of such an undertaking: "to talk of race, leads to discussions about culture and ethnicity and if one starts with ethnicity or culture, the issue of race and racism acts as a silent undercurrent" (p188). Papadopoulos, Tilki and Ayling (2008) echo this concern about racism, stating, "despite policy initiatives over the last 20 years, little progress has been made in addressing race inequality ... [this includes] unexplored assumptions, institutional behaviours, resistance from staff and confusion about what should be achieved" (Papadopoulos, Tilki & Ayling, 2008, p131).

Browne, et al, (2009) most recently advanced this debate in their discussion of 'racialisation', a contemporary term for the process of assigning labels to people according to their particular physical characteristics or by designating arbitrary ethnic or racial categories. Racialisation is different, although similar to racism and relates to the "discourses that are drawn upon to interpret the behaviour of people who are seen as being from a different 'so-called race' or ethnocultural group" (Browne et al, 2009, p168). Racialisation is a derivative of the theory of 'whiteness'. As such it defines racialisation as an "ideological discourse of power, that categorises non-white peoples according to their phenotype' (Racine 2009, p181).

There is little recognition, in nursing discourses on culture, around possible confusion in the categorisation of ethnicity or its potential use or misuse in applying it as a descriptor for patients. Ethnicity has been well accepted to explain both cultural needs and differences in health status and to predict behaviour among patients and much effort has traditionally been expended in education and practice towards developing knowledge about different ethnic groups for use in care giving. There is no easy answer to this debate but, most certainly, using ethnicity as a 'moniker' constitutes an issue that must be opened up, re-evaluated and consensus arrived upon. Browne, et al (2009) suggest that instead of looking towards mechanisms that label others centred on 'race-based' theorising, nurses instead need to focus more on developing a greater awareness of how individual and societal assumptions create stereotypes and how these stereotypes then fuel further misinterpretation.

Comments from participants ... teasing out issues of race, racialisation and ethnicity

Race and ethnicity was seen as problematic, a barrier and something to be dealt with by nurses but with little guidance as to defining diversity by ethnicity or any solution as to how to cope with 'difference' by ethnicity.

"Ramsden took it all away from ethnicity and said all interactions are bi-cultural" ... "but there is a natural or seemingly natural suspicion and unwillingness to share with students from different ethnic groups" ... "accept people for who they are and not for all the baggage when you see a person who looks a particular way, but how do you do this?" (P1).

"we get books that come out where they say, oh things about for example Korean people don't like eye contact and I guess we make generalisations of people and so we tend to in that way privilege ethnicity as being the most important set of who they are … but how do I make what they need possible?" (P2)

"I did focus groups with nurses about engagement with patients and ethnicity and language comes up as barrier number one" ... "ethnicity is a relatively new phenomena (sic), mixing people up like this and something we are now having to deal with, there are no established ways to manage this" (P3).

"A lot of nurses say to me, theory about ethnicity is too vague — just help me, this doesn't make sense and I have no answers either" (P4).

"If you are looking at ethnic groups, the principles are still the same — older than you, younger than you, different gender, different socio-economic background — that people are all different, no matter the terms of the difference but it's not only ethnicity" … "Articulating how to deal with difference in people and working out how to engage with ethnicity, it's very difficult for nurses" (P5).

Eurocentrism and 'seeing' the position deemed 'whiteness'

Until very recently, work on culture, identity and racism did not examine 'whiteness' as a focus and the position of 'whiteness' is notably absent in many discussions about culture. Most considerations on the apparent absence of the categorisation of 'white' as an ethnic group can be seen emerging from a small group of nursing authors (Puzan, 2003; Allen, 2006; Gustafson, 2007; Martin-McDonald & McCarthy, 2007; Lancellotti, 2008). Lancellotti (2008) speculates on the reason for this, as being because "being white is considered the norm" (p180) which goes some way in explaining the absence of any robust deliberations on this subject in the past.

Abrums and Leppa (2001) wrote that many white, middle class nurses claim "we don't have a culture, indicating that only other people have a culture" (p272). This warrants further investigation, given that the majority of nursing authors writing on the subject of culture, as well as their intended readership, are nurses working in Westernised countries that are white, or from a 'white', Westernised healthcare system. Drevdahl (2001) contended that the field of cultural education in nursing has a "Eurocentric bias ... that preserves inequalities that it purports to eliminate" (p285).

Much attention in nursing scholarship has been directed towards those who are "considered exotic, interesting and different" (Reimer-Kirkham & Anderson, 2002, p5). It has perhaps been easier to write about others, framed as ethnic groups, than it is about oneself. Those authors also indicate that much of nursing's theorising about culture has the 'white' nurse "positioned as normal" (p6). Puzan (2003) considers that whiteness engenders a particular form of racism through its concomitant position of power and privilege. The challenge for nursing, she considers, is to "engage in the exposition, critique and resistance needed to dismantle the structural and functional representations of unbearable whiteness" (p199).

Gustafson (2005) specifically names transcultural nursing texts as those which "legitimate whiteness as a politically neutral position from which to interpret race difference and construct theoretical and material responses to race differences in nurse–client relationships" (p9). Whiteness and white identity can be seen as implicit, in that it is a tacit backdrop to the different nature of 'colour' and 'ethnic' identity. As has already been suggested, much scholarship on culture in nursing emerges from the Western, white sector and is given authority in this way. Whiteness comes to determine what is counted as legitimate and authentic knowledge. Gustafson (2007) writes that "whiteness is both invisible to itself and at the same time a norm by which everything else is measured" (p309).

This does not mean that members of the dominant Anglo-Celtic group in society, including nurses, are intentionally discriminatory or perhaps even aware of the biases they hold. Gustafson (2005) explains how health care organisations and institutions are "filled with individuals who are deeply committed to their professional work, who are regarded as highly skilled practitioners, who believe they are liberal human beings — and yet they unknowingly, unwittingly contribute to racial inequality" (p383).

The description and categorisation of ethnic groups, as it occurs in cross-cultural nursing research, typically takes place within a dominant white perspective, is presented to white audiences and focuses on the description of a non-white or non-Western groups (Allen, 2006). The accuracy of such continued representations of ethnic groups becomes problematic. Ethno-specific research, such as it is used in transcultural nursing theory, relies on the premise that it is possible to communicate the essence of another individual through interpretation by those who do not share that culture, cogently and reliably, without losing the inherent and intimate meanings conveyed by group membership during that process. However, it is contestable that one can sufficiently 'bracket out' personal views, to comprehend new information with no element of interference from existing perceptions held on the part of the nurse receiving such information.

One reason for this might be the ubiquitous nature of white privilege and the inveterate Eurocentrism of academia, which is invisible to most dominant group members. Goold and Usher (2006) agree and confirm that the process of nursing education today remains one that entrenches white, middle class values within nursing. Underwood (2006) found when interviewing nursing students that most assumed that content related to culture and diversity

was 'nice to know', but not essential to nursing practice. Hassouneh (2006) found that nursing students preferred an ahistorical, depoliticised 'cook-book' approach to the study of culture. When discussion of systems of oppression such as Western colonisation were introduced, or when acts of political exploitation and racism were discussed, students began to express degrees of discomfort and felt 'unsafe'. In New Zealand, when cultural safety, with its overtly political agenda, focused on the processes of colonisation and concern with the social degradation of indigenous culture was first introduced, the backlash was considerable (Ramsden, 2002).

Gustafson (2007) informs us that the "most powerful message communicated in culturalist literature was the need for tolerance and sensitivity when caring for the racialised other" (p156). Whilst this may appear to be a caring and commonsense approach, she identifies that this position is invariably one adopted only by those who operate from a position of power and who are therefore in a position to exercise tolerance and sensitivity. Gustafson describes how the knowledge, stories and experiences of marginalised and racialised groups are collected to identify how racially defined needs are not met within the current healthcare system. Rather, she suggests it might be more useful to investigate how white nurses were complicit in creating a system that marginalises others. Gustafson alleges that knowledge claims typically arise from one subjective location (usually white) and thus can only ever render partial truth. She contends that white discourse continuously produces and perpetuates racialised identities, within which the white discourse constitutes the 'unspoken centre' of authentic cultural knowledge and is given primary authority in nursing. This line of discussion focusing on the 'whiteness' of cultural knowing is still new and emerging in the discipline, but brings much promise and will hopefully be added to over time.

Comments from participants ... Eurocentrism and the position deemed 'whiteness'

The participants did not actually name either Eurocentrism or whiteness specifically. However, their comments suggest an awareness of difference designated by membership of the dominant social group.

Most comments here tend to identify Eurocentrism as a problem, as it closes possibilities of thinking about other people. The comments also indicate little understanding of how to change this.

"One of the things I think about some of the discourses around culture and nursing and the issue of multicultural groups and that sort of thing is that, we, it, nursing is positioned as, you know, a very white middle class activity" (P1).

"when you give people some hard information, like aboriginals die twenty years younger than anyone else, you would think nurses would say 'that is terrible', but it just seems to go over the top of their head, most of them have never been in a position where they were in a marginalised group, it means nothing to them " (P3).

"Westerners say, this is our way and we are the norm and these others deviate from the norm, so they need special attention" (P4).

"It's just so dangerous, if people have uni-dimensional lenses on and just look at it from their perspective. That is just not okay, you cannot be a safe competent practitioner that way, but what is the way?" (P5).

"Nursing, it's mono-cultural and its female dominated and all those sorts of things, you know they dominate" ... "so can you bring in diversity, not really, not very easily" ... "it's unfortunate that people come as adults to learn about dominant cultural thought" ... "they do not think they are cultural if they come from the dominant culture, they have not really experienced being at a disadvantage" (P6).

Marginalisation, discrimination and racism

Lister (1999) made the following observation: "ethnicity as such may or may not be an issue ... what will be an issue is how meanings are shared and negotiated within the context of power relations" (p317). Today, accepted convention in nursing remains one where there is an avoidance of naming or exploring these structural systems of power that are operational in healthcare. Most scholars writing texts on culture in nursing, including Leininger and Ramsden, advocate for the avoidance of cultural bias and stereotyping, but are less expressive on how exactly nurses might achieve this. These two seminal theories on culture both allude to a need for the exploration of power and a deeper analysis of the healthcare system which reinforces inequalities surrounding care provision, yet neither have undertaken such analysis.

Chalmers and Allon (2002) suggest that much of the marginalisation and stigmatisation of certain groups of patients, by nurses, is not only related to an individual patient's particular cultural or ethnic group membership. They claim it occurs as part of the structured relationship built between any non-dominant social group and a dominant group health care system. Anderson et al (2003) claim that nursing literature is rather silent on matters of inequality, the marginalisation of nursing practices, prejudice and racism: "there is a common representation, that healthcare systems are removed from the messy terrain of ideologies and inequities" (p769). Abrums and Leppa (2001), and Kirkham et al (2003), both postulate that nurses might try to deny or avoid suggestions of racism or cross-cultural tension and refute the possibility of being discriminatory. However, these authors consider that the nursing profession is then

intellectually paralysed through the deliberate avoidance of such issues altogether, attempting to avoid prejudice by using a philosophy that contends "discrimination is constructed as 'out there', not in 'here'" (p770).

Harrison and Falco (2005) wrote that just as increasing nurses' knowledge about culture is an important part of correcting inequality and disparity in healthcare, it is also important to acknowledge that inevitably this "conjures up harsh and abrasive words like discrimination, prejudice, bias, racism and bigotry, these words are used interchangeably and are usually hard to swallow when directed at us individually or as members of a group. We tend to deny such allegations and distance ourselves" (Harrison & Falco, 2005, p252). In transcultural nursing, Gustafson (2005) tells us, racism is rarely mentioned and Culley (2006) believes that in the nursing profession, by and large, "racism is euphemised, denied or negated" (p145).

Browne and Varcoe (2006) advise that members of a dominant culture, i.e. white nurses educated in the Western style, can hold negative, racialised views of other ethnic or social groups while at the same time espousing the more acceptable democratic, liberal principles of equality, tolerance, fairness and justice associated with the West and membership of the 'caring' profession of nursing. Racialisation and representation are powerful mechanisms through which domination and subordination are enacted: "all levels of racism may be linked in terms of their exclusionary or inclusionary undertakings" (Reimer-Kirkham & Anderson, 2002, p7). Anti-discrimination legislation that aims to enforce the principles of equity and diversity is now apparent in most multicultural societies, with the goal of safeguarding the position of cultural relativism. Such legislation has been used to ensure, at least to the level of official scrutiny, that everyone is 'treated the same', but its effect is less certain.

Lancellotti (2008) writes of a pervasive normalcy, which might be seen to support the development of a 'white' bias and of a tolerance–intolerance binary in nursing. Citing the way in which the nursing care of patients is taught to nursing students, Lancellotti claims the 'normal' patient is invariably portrayed as a "white Anglo-Saxon Protestant with accompanying guides on caring for those who are different" (p180). Prejudice is present in nursing, in the same way it is present in wider society, but "racism, as an ingrained institutional force is largely unacknowledged" (Lancellotti, 2008, p180). Structural systems of power in healthcare include the operation of racism, ethnocentrism, sexism, classism and paternalism that are manifested in policies, every day practices and interpersonal interactions (Campesino, 2008;

Johnstone & Kanitsaki, 2009). Racine (2008) postulates that globalised cultural intolerance is the most visible consequence of multiculturalism. Such intolerance is most especially evident when émigrés are noticeably different and fail to attune easily to the mainstream way of life.

Ultimately, marginalisation and racism must be better understood. For the future this must be an important part of the work of nursing scholars in the field of cultural studies. As Cortis (2003) states, "there is a need for nurses to understand and study the concept of racism ... challenging racism needs to be 'elegant', that is, tactful, timely ... and with a commitment to social justice ... racism will not disappear simply because nursing refuses to recognise it" (p62).

Comments from participants ... on marginalisation, discrimination and racism

Participants did comment on the existence of racism or stereotyping.

Interestingly, much of their comment was not concerning nurses' attitudes or comments about or to patients, but referred to what they deemed 'racist' behaviour coming from patients and within and amongst nurses from different ethnic groups, something little mentioned in the literature to date.

"Our junior nurses are appalling, it's trying to break down the barrier, they are absolutely resistant and negative, so rude and racist, you tell them a patient's story of discrimination and they almost argue that that would not happen" (P1).

"Recently I noticed that some students will report nursing as racist, and I make them go back to it and ask, look around you — who are the nurses? They are not all white middle class women, they are from India, Asia, all sorts of backgrounds and it's too simple to say that nursing, as a whole group, is racist" (P2).

"I don't try and tell them rules about behaviour, just to try and let go of some of the prejudices and just have an open mind and that's all I can do" ... "One of the things that worries me about transcultural nursing particularly, is the way it's conceptualised, in some ways it fosters stereotypes of people" ... "some people are quite outspoken, I would not say racist but intolerant and not seeming to see" (P2).

"There is a lot of racism from patients to nurses, a lot of patients are older and from a not well educated background shall we say" ... "we are all different and the nurses on the ward are also extremely diverse, some local, some from overseas and yet all racist to each other" ... "I have a good picture of what's going on in the wards; it's horrendous" (P3).

"It's all made up of diverse influences and to say its racism is a very dangerous way to look at it because it has the potential to be patronising and put people into boxes and actually be racist just defining it" (P3).

"Our Indian nurses tell me that it's the male patients who give her a hard time and it's not appropriate she touch them or treat them" ... "A Muslim nurse or someone who covers her head, they are just sort of really *racist — sometimes it makes her leave the room, there's a lot of racism" (P5).*

The new methodologies of inquiry and why they might be useful into the future

The growing influence of alternate methodologies — such as post-modernist, post-colonial and feminist — in the discipline of nursing offer a paradigmatic alternative to the traditional approaches used in scholarly inquiry (Racine, 2009). Blackford & Street (2002) exemplify the new types of exploration when they used a liberal, feminist methodology in the Australian context. Using this methodology, they identified and researched inequalities of access to nursing service for non-English speaking women who are receiving health care from white, European nurses. They found that nurses' personal worldview and preconceptions about the role of women as understood in their own Anglo world (and thus grounded in gender and feminism) became a source of oppression for their patients and counterproductive to providing quality nursing care in the eyes of Muslim women patients. This new style of work has served to illustrate the need for greater exploration of the issues that many current approaches have failed to deal with. Such alternate methodologies provide a new means of exploring the influence and impact of constructed understandings of culture. Blackford and Street (2002) suggest that a more critical approach would provide the opportunity for "voices that have been silenced to construct nursing knowledge for praxis and practice with a vision of social justice for all people (p19)".

Spence (2001, 2005) investigated the value of exploring cross-cultural nursing practice using hermeneutics as a philosophical tool to guide exploration. Philosophical hermeneutics takes a view that understanding is both a process and a mode of being. Spence asserted that, as nursing is an interpersonal practice, with dimensions relating to the emotional, cognitive, cultural, historical and political contexts of individuals, using hermeneutics facilitates and supports the deepening of interpretation. Spence asserts that notions of prejudice, paradox and possibility arose from the works, which are common findings from other cultural studies.

Discourse analysis, is another research methodology that has been appropriated by nurses to guide their explorations about culture. This approach is underpinned by a number of philosophical precepts but principally explores the construction and inter-connectedness of power, knowledge and constructed understandings to uncover the partial truths in our comprehension (Huntington & Gilmour, 2001; Giddings & Wood, 2002). Browne and Smye (2002) also recommend discourse analysis for use by nurses looking at culture and suggest this concept may provide a useful tool for nurses to use in analysing the dominant ideology that

underpins health care policy and nursing services. They drew on discourse analysis in their study of healthcare for indigenous women in Canada when they determined that focusing on the 'culture' of the women ignored issues related to poverty, education and social disadvantage. Browne and Smye encourage nurses to better understand how culture, history and socio-political relations intersect together to shape health problems and suggest that using new methodologies to analyse healthcare discourse will assist nurses to gain new insights into socially structured inequities.

Postcolonial theory, with its interpretations of race, racialisation and culture, offers nursing yet another set of powerful analytical tools with which to explore the concept of culture. Reimer-Kirkham and Anderson (2002) explain how postcolonial or neo-colonial theory refers to those theoretical and empirical studies that explore issues stemming from colonial relations, indigenous suppression, the social impact of colonisation and its aftermath. Colonisation is, in this paradigm, believed to have subjugated the indigenous voice in many parts of the world. Its central themes are race, ethnicity, nationhood, subjectivity, subjugation, self-determination and power. This type of approach works best with constructions of identity that have a relation to particular colonial historical and indigenous contexts.

Reimer-Kirkham and Anderson (2002) discuss the use of a postcolonial perspective and research methodology for nursing: "Postcolonial theory, with its interpretations of race, racialisation and culture, offers nursing scholarship a set of powerful analytical tools unlike those offered by any other nursing and social theory" (p1). Ramsden herself employed a post-colonial position to develop her model for cultural safety, which has had much resonance with the experiences of indigenous peoples in New Zealand, Australia and in Canada. These authors criticise the current cultural relativist approach described earlier in this chapter and question its focus on culture as a relatively static set of beliefs, values, norms and practices attached to a discrete group. Focusing on those superficial manifestations of culture and the accompanying ideologies of a false egalitarianism subjugates these socially created aspects and will ultimately silence the human voices within the discourse if not addressed.

Anderson and McCann (2002) describe the development of post-colonial scholarship as providing "a new window for understanding conceptions of race, notions of the racialised 'Other' ... fluid identities and hybrid cultures" (p8). This new methodology has much utility to enable exploration and gain a deeper understanding of the notion of culture, in that ideas are

framed from the perspective of the 'colonised' and not the 'coloniser' or dominant Anglo-Celtic perspective. Although there will be important differences across the different continents in which such methods will be used, Anderson and McCann argue that "the post-colonial perspective offers a valuable analytic perspective in the development of knowledge for nursing practice" (p10).

Collectively, those authors using the new methodologies argue strongly for nursing to draw on critical theories in addressing the challenging social issues. Anderson and McCann describe this: "We must lift analysis beyond the micro level to an examination of the complex socio-economic, historical and political nexus in which human experience is embedded" (Anderson & McCann, 2002, p2). This resonates with the work of Ramsden, as it justifies a legitimate interest for nurses in issues of macro level importance, such as social structures inherent in health care. Critical methodologies offer nurses another instrument to utilise in undertaking deeper explorations of culture. Anderson and McCann (2002) suggest that using critical methodologies offer a direction for research and theory development in nursing which sublimates white eurocentrism and has the potential to "address unequal power relations and increase the responsiveness of health care services to the varied social locations of its clients" (p25).

Racine (2003) suggested culture might not be seen by some nurses as a legitimate domain of inquiry for the discipline of nursing, but encourages nurses to dispute this view and find ways to further investigate health inequalities in the interests of social injustice. Racine also advocates the adoption of critical methodologies in nursing to "correct the failure of Western science to properly address the complexities of health problems" (p95). Such approaches question the status quo that prevents the integration of marginalised knowledge into nursing theories and might offer a means to counter the dominating effects of Western thinking. Racine claims "nursing research is still perceived as neutral and apolitical, which explains why sensitive issues ... need to evolve" (p91). Racine also suggests that nursing needs to adjust its theoretical lens and "include subaltern knowledge and gain insight that cannot be obtained from the 'centred' or dominant location" (p92).

Critical cultural theory is the bringing together of postcolonial, feminist and critical methodologies to explore the internal logic of cultural care theory in nursing and "interrogate the underlying assumptions, goals and strategies of this [current] approach to race and other

human and social differences" (Gustafson, 2005, p2). Gustafson asserts that, "a critical cultural critique is unlike most critiques that accept the underlying assumptions and are concerned with fine-tuning" (p3). A critical cultural perspective has an overtly political agenda that "supports sweeping social change ... it constitutes a challenge to the liberal individualistic discourse that is central to the construction and reproduction of nursing knowledge and institutional practices ... that will unsettle power inequalities and effect meaningful changes in our local and translocal social networks" (p14).

Boutain (2008) writes of the indigenous paradigm and asks that nurses begin to see this as viable and credible knowledge: "the indigenous paradigm is concerned with a participant's ways of knowing that are culturally and socially bound" (p243). Indigenous knowledge, in the past, has been subjugated to that of the Western knowledge creation and believed to be epistemologically inferior.

Sherwood and Edwards (2006), Indigenous nursing academics in Australia, state: "Although our academic standing is equitable with non-Indigenous health professionals, our voice when speaking of our lived experience is often contested and dismissed … we face the fact that Euro-Western theories remain safeguarded and upheld as superior sources of knowledge and analysis in text … they resist any loss of power and authority, erecting more barriers and moving the goal posts further along in an effort to exclude and isolate" (p181). For any of this to change, non-Indigenous nurses must become more receptive and respectful towards new and perhaps different ways of knowing and being.

Writers such as Huntington and Gilmour (2001), Donnelly (2002), Anderson and McCann (2002), Serrant-Green (2001), Reimer-Kirkham and Anderson, (2002), Giddings (2005), Gustafson (2005), Culley (2006) and Racine (2008, 2009), all encourage constructive debate, provoke the identification of non-traditional viewpoints, prompt nursing researchers to explore issues of identity and difference and support an increase in the depth of understanding about the frames of reference used in considering culture and cultural care. It seems as if much of the critique to date has been little acknowledged and even less acted upon in reconfiguring the approaches taken in nursing. New knowledge development in the field of culture in nursing is somewhat static and at best problematic. There is increasing criticism and a challenge both from within and beyond nursing for nurses to do better, to further explore their position and develop a greater sense and understanding of the representation of the

unknown cultural *'other'*, as recognised in the crisis of representation in anthropology in the 1980's.

These new methodologies offer a chance to break away from "the dangerous and destructive patterns that were established when the concept of race was elevated into an essential concept and endowed with a unique power to determine history and explain its selective unfolding" (Gilroy, 2000, p14). Nursing scholarship needs to reflect on what merits inclusion in its explorations of the significance of culture and healthcare. The contemporary methodologies that are now available and which are increasingly being used in the discipline of nursing may offer an alternative way to expand the body of knowledge about culture (Racine, 2003). These is also the promise that new such tools have the capacity to transform knowledge that may have been largely overlooked within traditional nursing's scholarship and practice: "Nursing cultural research is at a crossroads of its development ... the future depends upon our abilities to define new theories and methods to explore and understand cultural differences (Racine, 2003, p99).

Conclusion

It is clear that some progress has been made in developing the theoretical foundation and knowledge base that nurses might use to deepen their understanding of cross-cultural care, through the different arguments and explanations put forward by nursing scholars. Whilst much effort has, in the past, been put into exploring the more esoteric or abstract elements and conceptualisations of culture as a philosophy, less attention has been focused on the context in which nursing care takes place and in identifying the broader characteristics of the social world or the environment in which nursing is practiced. Many of the ideas from scholars already discussed, in this and previous chapters, claim that the next step in exploring culture and nursing care is to come to understand why nursing as a discipline has made little progress towards change. Health is a socially mediated process and if nurses are to participate in changing the health outcome profile and improving the care experiences of minority group patients, a greater understanding of the way in which the social environment influences health might help nurses develop greater insight and place them in a better position to effect change.

Nursing theory, despite its rhetoric, is not always reflected in the practice of nurses. Typically vulnerable and marginalised patients, such as those from minority ethnic groups, are still often

disenfranchised when they use health care and nursing services (Wilson & Neville, 2008). Nursing practice is in essence a microcosm, entwined with and reflective of other healthcare professions and inclusive of the wider social structures and systems of governance under which it takes place (Giddings, 2005). Ethnic and cultural diversity challenge the often taken for granted assumptions about the nature of health, illness and health care practices (Papadopoulos, Tilki & Taylor, 1998; Spence, 2001). One of the problems in having such a strong focus on ethnicity, rather than its associated factors, is that this can lead to the inference that ethnicity itself causes poor health (Lynam, 2005).

Griffiths and Daly (2008) also describe how clinical decision making and practices continue to "reflect convention and tradition" (p99). Racine (2009) tells us that such "theoretical orthodoxy represents a serious shortcoming" (p20). While this does not necessarily mean that cultural content cannot be dealt with differently, it does indicate that the more controversial conceptualisations around culture, such as race and whiteness, will likely continue to be little considered, deemed irrelevant or be avoided altogether. Continuing to develop and use a theoretical perspective that places attention and focus exclusively on individual nurses is probably unhelpful because nurses function as representatives of the domain of health care. They observe, classify, evaluate and judge, comply with and apply the established protocols of care and behaviour in many situations (Blondeau, 2008).

Some closing comments from the nurse participants …

These comments do not align with the themes in the nursing literature. However, they do indicate issues of concern to practitioners that may warrant deeper analysis.

"You know the structures are not in place, hospitals are not learning organisations" ... "there are all sorts of issues in this, that affect our ability to take collective or individual action and one is the level of autonomy that nurses have and in nursing we really lack a space to come together to talk about this stuff' (P3).

"It's almost now, like, where does nursing stop? Because a lot of these issues are kind of social issues, primary health care issues and we prepare our students for the hospital environment only" (P1).

"We have this theory that is meant to help us, that's meant to be a framework to help us to do this and then teachers try to understand that and convey it to students and even the transculturalists say it, we don't know why people are not playing this out" (P1).

"We don't get a choice of which patient we care for and they don't get a choice of which nurse they get. We are thrown together because they need something from us and we need to do something for them in some way and I guess if you can do that in a respectful way and realise that you don't know everything and every nuance of culture and you are never going to, I think that holds you in good stead" (P1).

"I talked to a lot of people in education that write material for nurses to deal with cross-cultural and bi-

cultural interactions and they are all telling me the same story and that's just not being able to engage with patients very well — it's very difficult to go in and be open to patients and be receptive, it's a hard thing to do and I am starting to think we should do more communication training with nurses" … "cultural care is too boring, it's too theoretical, too text-bookie, use critical thinking, just teach them to deal with people, just don't talk to them badly, just don't say to them 'like I don't care'" (P3).

"It's a slow process — I find that task orientation is at the forefront of nursing, because it is so visible and it's seen and people see that as practice. Caring is less of that and we have come a long way and people now see culture as part of caring" (P5).

"I think we need to have strong leadership, because it's difficult for people to comprehend and people lack confidence. It's not like science and the medical model — science does not need strong leaders, the knowledge is already there and it's been debated and argued but culture is developing new knowledge or knowledge that has been hidden and needs to be revealed" … "the stories need to be told and they are there waiting to be captured and I think to be published" (P5).

"Partnership needs to be with and not for, especially in primary health care, acute care needs more emphasis on people and not the tasks and culture is just part of people" … "Just try and have openness to each other, this is a person and they need respectful care, even with people who cannot speak the same language, you can still pick up a sense of respect" (P6).

Chapter 7

CONCLUSION: A FINAL DISCUSSION AND WHERE TO FROM HERE?

"The only difficulty I see with intellectual development is that it gets frozen in academia and academics read about it and debate it, but it doesn't actually get out to the people"
(Ramsden, 2002, p126).

The key question underlying this thesis at its commencement was...

When nurses have had access to cultural care theory and its related literature for some 30 years, why has this not, as yet, had a significant impact on nursing?

This thesis constitutes an examination of the significant theories of culture and cultural care that nurses are using today in order to answer this question. This chapter will outline the conclusions drawn and recommendations being made for moving into the future. The different theoretical nursing approaches to understanding culture and its related concepts have been considered in this study and, whilst each has had a distinctive contribution to make, there were also limitations and inconsistencies associated with them. Despite the availability of such theory, it is still an ongoing challenge for nurses to discover and understand how they might best provide appropriate care for patients whilst taking into account cultural diversity and difference. The findings of this thesis should hold some interest for nurses in all Western countries and offer important insights for considerations on culture into the future, but awareness must be maintained that all nurses work in different contexts and with different populations.

Nurses claim to offer holistic care to meet the needs of patients as unique individuals, but to realistically achieve this they will need to advance their knowledge about culture and its influence on health and illness. If they do not, those positioned at the margins of society by virtue of their culture, be it defined by ethnicity or otherwise, will remain at risk of harm from inadequate levels of nursing care and will continue to have negative health outcomes. These

socially vulnerable groups will continue to be rendered invisible and silent unless nurses review their own position and come to better identify and understand culture and, in time, learn to act in the best interests of their patients.

Making a positive difference to the safety and quality of a patient's experiences of nursing care and engendering positive health outcomes is what really counts. This will take a considered effort to 'step outside the comfort zone' and will involve setting and meeting personal and professional challenges. It requires imagination and innovation if we are to reconfigure our practice to remove the cultural barriers to good nursing service. As stated at its onset, this thesis is intended as a starting point, not a conclusion. It is hoped that the findings of this thesis will encourage nurses to begin to understand what culture might really mean for nursing in a new century.

The first step — looking backwards into the future

For many years the foundation of nurses' knowledge about cultural care was underpinned by Leininger's theory of cultural care and its associated practice, transcultural nursing. This model dominated the discipline internationally from the time of its emergence in the 1970's and still has considerable professional power. The continued usefulness of this theory for a contemporary globalised world is questionable. A major problem in using the transcultural model for nursing is in its continued framing of essential concepts within a traditional anthropological representation, one that is largely redundant. There is little place today for constructs of what culture means when this leads us to use narrow definitions of racialised or ethnicity based identity. Broader descriptions are required which take into account issues such as gender, religion, social class or sexuality, all of which are as responsible, if not more so, for shaping social identity as ethnicity. The continued practice of isolating supposed ethnic group or 'cultural' customs and traditions and the development of cultural checklists to determine care giving practices requires re-examination. Such continued practices are irrelevant in a globalised world and reinforce stereotyping as they lead to social labelling, marginalisation and racism.

To use such theory in shaping interaction in the social world of nursing offers little more than a shallow 'accommodation of the other' within the dominant structure of the Western paradigm, rather than leading to any reorientation of the social environment. Applying this

theory to practice places the nurse in a position of authority, positioned as one who knows what this patient needs and situates the patient in an inferior position, the passive recipient of the nurse's knowledge of their culture. There is no patient-to-nurse interaction to identify the patient's individual needs, beliefs or requirements. Instead, the ethno-specific 'checklists' of the peculiarities of different ethnic groups is operational. It reinforces a dominant social binary, where all is judged by the standards of the 'norm'. Transcultural nursing has problematised the ethnic 'other' and puts forward solutions consistent with the Western biomedical 'diagnosis and treatment' paradigm operational in healthcare. Recommendations that the nurse assist the patient to adapt to new patterns of behaviour, if their own beliefs suggest potential harm, only serves to reinforce the need for patients defined by their ethnicity to conform to the norm of the nurse and their world.

Transcultural nursing today sits in a timeless vacuum and is blinded to the concerns of the modern world, so it is little wonder that its implementation into nursing practice has not occurred to any significant extent. The basic tenets of Leininger's theory have remained static since its development. Ethno-specific research studies are being conducted in sizable volumes but the basic theoretical concepts and research methodology has remained unchallenged and unchanged since the 1960's. Leininger and the transcultural nurse experts of today are enthusiastic in defence of their theory but less so in terms of driving its development and adopting or even considering new ideas. New understandings of anthropology, which are much changed since the crisis of representation, have seemingly by-passed the transcultural theorists. Key issues related to the socio-political context of health care, the impact of Western institutional culture, racism, discrimination and whiteness as a model of social dominance are not addressed. These concerns of the modern world have been neither acknowledged nor integrated into the body of work and most certainly require consideration as relevant and worthy of inclusion.

Currently, transcultural nursing theory is largely ethnocentric, positivistic, reductionist, behaviouristic and mechanistic. It makes routine nurses' interactions with potentially complex, high-risk clients. This theory constitutes a doctrine at risk of inferring cultural imposition, one which brackets out the diverse reality of culture. Transcultural nursing theory has failed to take into account the socially constructed nature of culture and in doing so avoids addressing the historically driven social practices in health care, which have led to exclusionary and oppressive practices. Transcultural nursing theory is deeply flawed and perpetuates the social

norm, rather than challenging it. Whilst this theory has in the past significantly contributed to bringing cultural care in nursing to the attention of nurses, it is time for this to be part of our historical legacy, not a blueprint for the future.

Ramsden's model of cultural safety, which appeared in the 1990's, is a relatively new concept that emerged from the small country of Aotearoa/New Zealand. Although it has been taken up quite enthusiastically by a small group of scholars in Canada, and has some mention in international literature more recently, it is still little used outside of its country of origin. Whilst offering a useful reconsideration of the indigenous position in a postcolonial context, it also mounts some challenge to the power of the Western nursing and health care model. It too has limitations which have impeded its uptake. Like transcultural nursing theory, cultural safety has employed anthropology in defining culture and it frames Māori only in terms of a generic ethnicity. This unfortunately limits any variation of the experience of being Māori in modern Aotearoa/New Zealand where all citizens have both Māori and Pakeha (non-indigenous) ancestry and live within a Western democratic society rather than in separate and more traditional ways of life. This aspect of the model has received considerable national criticism over the years and especially during the period when it was mandated into nursing curricula.

Cultural safety has suffered from problems associated with its vague theorisation. The first explanatory text was only published in 2005. Inconsistencies are also apparent. For example, the term cultural 'safety' is used but the concept is actually defined more by a lack of safety and the presence of cultural risk and harm being perpetrated on the part of the nurse, than any definition of what constitutes 'safe' cultural practice and how this is provided. Achievement of cultural safety is judged by the patient but there is to date no mechanism offered for achieving this. For these reasons there have been problems with its educational operalisation and in application to practice as it uses a highly reflexive and challenging personal approach to pedagogy.

Whilst this model holds much promise in terms of critical social theory, it is regrettably best understood only in its country of origin and it can be quite confusing to comprehend unless one has a significant appreciation of the social environment in Aotearoa/New Zealand. Much of the foundational premise in cultural safety is highly context bound and relates to issues specific to that country: its Indigenous Treaty, its legislation and its health care traditions. The unique bicultural relationship between Māori and Pakeha has also restricted the function of

this theory in populations that might be more socially pluralised and demographically different from that of New Zealand. One of the concerns with this model is that it comes only from a 'colonised' point of view and this is not the only perspective that could be held. Its proponents have yet to undertake the recommended deep critical analysis of existing social and political structures that affect episodes of care, or comprehensively examine the collective construction of healthcare services as an institution exercising social power.

Whilst the philosophical and theoretical basis of cultural safety has been developing for nearly two decades, there are still few practical applications of the model and, in the main, cultural safety is still framed largely within the idea of an attitudinal shift on the part of the nurse. Cultural safety is a pedagogical tool that endeavours to identify and transform attitudes. What cultural safety does offer to nurses, that transcultural nursing does not, however, is a comprehensive and well articulated focus on the power in the nursing role, considerations of institutional power imbalances and concerns around cultural relativism, racialisation and social justice. But if these themes are not further developed and cultural safety made more relevant, both within and beyond New Zealand, it will likely slip into academic obscurity. This risk is increased now Ramsden is no longer championing its development or adding to its literature.

Collectively, both transcultural nursing and cultural safety share theoretical weaknesses that reduce their plausibility and authority and this minimises the credibility, function and application of these theories. Both focus on individual nurses rather than recognising wider social structures and health care institutions as complicit in determining the problems experienced by vulnerable groups. Neither theory recognises that there is a possibility of considerable variation in individual experience and so they conceptualise using generalisations and in doing so homogenise the experiences of ethnic groups. Equally both fail to acknowledge vulnerability and negative health experiences within the dominant culture social groups, in terms of considering ageism, homophobia, sexism or discrimination by categories of, for example, religion, disability or socio-economic or educational standard.

Today, at the beginning of the twenty-first century, these 'grand' unified theories are being submitted to a significant critique and there is no longer a theoretical basis for cultural care that can be deemed rigorous enough to rely upon consistently. However, this lack of overarching theory might be seen as an opportunity rather than a danger, as this provides an opening for the scholars of nursing to re-envision and renew conceptualisations of culture and

cross-cultural care. The knowledge field is in a state of transition — theoretical examination and re-examination is a constant and ongoing process, with few conclusions having been reached as yet. For some time into the future this area of nursing inquiry is likely to be in 'a state of change' and nurses will be required to tolerate that uncertainty as a necessary part of change and as being essential to moving forward.

This thesis challenges long established assumptions of individuals and 'comfortable' beliefs, which could be construed as simple fault-finding. Discussions of racialisation, racism, whiteness, privilege and discrimination are not, for many, easy topics to discuss. The priority at this point must be to build up a well developed scholarship which will enable articulation of culture in a way which reconceptualises theory, so it can reinform research and education; this in turn will then flow into and influence practice.

To progress and develop the nursing knowledge base on culture, new theoretical development must be prioritised. It is crucial that nurses cultivate and maintain a sustained interest in this field. Comparatively little attention is paid at the moment to the importance of cross-cultural care as part of the essential foundation to skilled nursing care. To bring this to attention does give nurses an added burden, with so many resource and workforce issues already demanding their attention. Nonetheless, they also have a professional responsibility and a moral obligation to progress the best interests of their patients and such a commission provides the impetus and drive for them to 'do what they do' better.

Scholarship and the need to find a new sense of what 'culture' might mean

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Nursing discourse has for many years focused predominantly on constructing culture through a lens of ethnicity, which is a culturalist approach and the inheritance from the work of Leininger and anthropology. A similar definition can also be seen in Ramsden's work, although she offers a different approach, coming from a postcolonial perspective. Now there is a need to understand culture in a different way and move beyond interpretations that portray culture in such a fixed and static manner. Current representation has resulted in an understanding of culture that can be likened to a series of discrete 'boxes' that contain people differentiated only by their membership to certain ethnic groups. Migration and the development of a 'global village', achieved through modern communication networks, has meant that 'culture' or 'social meaning' for individuals and for communities has changed. By necessity, culture as a notion

needs to re-defined and re-negotiated, taking into account our new and different social conditions and requires the construction of migratory national identities.

'Culture' no longer exists as an entity aloof from or independent of the 'local' situation in which it was developed. In the contemporary world, what constitutes either 'their' or 'our' culture might change for individuals during a lifetime as they relocate or are exposed to an international rather than a local community of knowledge, thought and behaviour. It would be rare today to find a cultural group where everyone holds the same view and this effect is compounded now that people have mixed and intermingled, creating new social groups across the globe. Although it is still important to appreciate the influence of an individual's birth, inheritance or social traditions, we are now learning that peoples' beliefs and values can and will change over time. This thesis demonstrates that, for this reason, the definitions of culture relied upon in the past now have a diminished capacity to bring real meaning to a contemporary understanding of culture that will benefit and inform healthcare and nursing. The conclusion reached is that a different conceptual approach is required.

Definitions of culture to date have been focused primarily on the social inheritance of individuals, as passed down from their own ethnic group or from groups of 'similar' people. Characterisations of culture must grow and adapt to encompass the relationships within and between groups. Inside any given cultural group or community of people there will be variations. Different people will hold different views and there will be diversity in attitude, life-ways, behaviours and expression. The appreciation of variation 'within', as well as across, cultural groups would benefit from being better theoretically developed.

All people are individuals and represent diversity across a range of socially constructed variables, for example, age, gender, ethnicity, sexual orientation, religion, social class, socio-economic status and functional ability as well as by ethnicity. Investigating such issues in greater depth is essential and theory development must be broadened to encompass the other determinants associated with diversity. Inequalities between and across different social locations is evident. A deeper critique must be developed of the way in which these lead to a loss of social power and result in marginalisation and discrimination. The new scholarship related to topics such as prejudice, whiteness, social intolerance and the according of privilege hold much potential to re-inform the ideological understandings of nurses.

The term culture is in danger of becoming an 'inclusive, all encompassing' descriptor, which it most certainly is not. Considerable challenge will be encountered in uncovering new ideas, but this must nonetheless be confronted. To examine culture in any depth means that the meaning of 'culture' must firstly be established in order to consider how this meaning might be constructed in various ways from different individual viewpoints and social positions. Contemporary social diversity means that there is a risk of making potentially misleading assumptions and generalisations and of drawing incorrect conclusions about difference and commonality if reliance continues on those previously accepted, but now contestable, notions of race and ethnicity.

What is of concern, however, is the relatively small number of scholars who have taken on the challenge of fresh and innovative inquiry in this domain. Publications to date have been isolated and piecemeal, with little interest or support coming from practicing nurses. Change will require the coming together of the discipline, where communities of scholars are supported and encouraged to take part in and own such work on behalf of nurses. Exploring culture will not be easy and will involve debate within the discipline. It is evident that there will be many difficulties in exploring the notions of race, ethnicity/racialisation and whiteness — the related constructs that are all part of this discourse. It is critical to become cognisant of former inconsistencies and unsubstantiated conclusions made and reached about culture and ethnicity and the implications this has for scholarship, education and practice. This is especially significant for scholars and researchers who produce knowledge and information that is considered valid and taken up as such by others in the discipline. Scholars and researchers must reconsider research design, findings and any analysis and begin to interrogate as well as study the categories they construct and use in their investigations.

Defining culture has in the past been limited to the activity of Western scholars and was a pursuit undertaken in isolation from the very groups of 'ethnic' people they sought to define and understand. Representatives from patient groups, vulnerable and minority social groups, indigenous and native peoples, the community and healthcare organisations need to be part of any discussion. Unless the full range of people involved in the care relationship are engaged in the formation of an alternative discourse, the risk is, yet again, that of imposing abstract theoretical ideas onto the discipline of nursing.

It is essential that the discipline now focuses on reinvigorating the concept of culture to one that is more representative of the 'way we live now', rather than based in custom and tradition associated with birthright and long-established social inheritance. Identity is better portrayed in terms of the ways in which a person is, or wishes to be, known by themselves or others and culture as the outcome and product of interaction. Or, to put it another way, to see people as active in the creation of culture rather than passive in receiving it. Such considerations that take a more modern and alternative perspective would better serve nursing in reframing what must be a vital first step in redeveloping a workable foundation from which to instigate new growth.

Coming to better understand the current ideological paradigm

Cultural relativism, with its close association to multiculturalism, has previously been discussed as the pre-eminent ideological approach taken towards culture by nurses. Certainly it underlies the work of Leininger and Ramsden and many other nursing scholars. Originally developed out of anthropology, this stance implies that each culture is bound by its own particular and fixed principles and is immutably embedded in individuals. Relativism implies that there is an imperative for equality to exist between groups and relies heavily on the exercise of understanding, tolerance and mutual respect between different cultures during interaction. Relativism obliges people to be constrained and segregated by their difference and, although 'respectful' of each other, such differences invariably define the relationship. And therein lies the problem: difference becomes problematised, which in effect preserves the very inequalities it claims to address.

Nurses are currently encouraged to hold their own cultural biases in check when dealing with 'other' cultures, thereby reinforcing that difference is something to be isolated, concerned about and potentially a problem. Exhorting the exercise of 'tolerance' is a common approach, usually shown from the majority towards the minority and it frequently masquerades as equality. Is it unrealistic and impossible to 'bracket' out certain behaviours and practices that might be acceptable to one group and abhorrent to another, as has been taught? It would certainly be challenging to work as a nurse inside an equality framework when individual taboos or even statutes of law were transgressed. If, for example, an Anglo nurse in Australia were to accept certain practices such as female genital mutilation as appropriate, just because it was espoused as acceptable and tolerated by a patient from a different ethnic group, the

attitude of such 'tolerance' is tokenistic. It reinforces the message that there is something 'different' or 'wrong', but that nurses must mask disapproval and for reasons of fairness or 'equality' tolerate cultural diversity. The tolerance implied in this current approach offers nurses no opportunity to challenge difference and fails to open up important 'space' for dialogue, even if finding answers is difficult and such conversations potentially controversial.

Purportedly relativism, as used in Australia, juxtaposes minority ethnic groups against the normalised and legitimate dominant Anglo-Australian culture; care provided to different ethnic groups is considered to be dissimilar to that usually provided. In this manner, 'different' groups of people are invariably not really equal. Unequal valuing and lack of respect is clearly evident across different cultures but it is currently not treated as a real issue. The relativist position is invariably one adopted only by those who operate from a position of power and who are therefore in a position to exercise tolerance and sensitivity. Denial of an inequitable health care system, where others are only just 'tolerated', is clearly part of the 'majority rules' normalisation strategy operational within such hegemonic systems and structures.

To disagree with an equality strategy can be criticised as constituting a racist stance, but avoiding provocative talk about social difference is just another part of avoidance and serves only to reinforce the identity formation of the dominant group. Such counsel needs to be heard by scholars and relativism re-considered in light of its hierarchical effect on social relations, with new debate opened up on the legitimacy of difference. This thesis contends that instead of 'fine-tuning' or expanding upon the existing concept of relativism — which compels nurses to use an equity approach, which is clearly problematic — reconsideration should be given to identifying the problems that are inherent in this ideology.

The politics of 'difference', as opposed to the tenets of cultural relativism, might serve nurses well in respect to this, where the values of 'identity' and 'recognition' may be more useful than those alluding to a non-existent equality, most especially when equality is clearly not operational in either nursing service or health care organisations. Adopting a position which recognises difference allows for the appreciation of human diversity and acknowledges subjective dissimilarity. In this way, when some groups such as the indigenous peoples have different needs because of their distinctive uniqueness, this can be recognised and accepted. It will remain impossible to understand the experience of non-Western people in health and illness if it is studied outside of the historical and social context in which it was created. This

might raise some concern in a multicultural society such as Australia because it means giving recognition and status to concerns that are clearly not universally shared.

Engaging more realistically with the 'socio-political' of the healthcare system

Although the underlying causes of a widening gap evident in the health status of populations worldwide are complex and multivariate, most health disparities are created and sustained by the institutionalisation of discriminatory healthcare policies and practices. Nurses have a professional and ethical responsibility to recognise and act upon the needs of their patients, but despite the best efforts of nurses to address individuals' health needs, these are often undermined when they have no resources, strategies or institutional mandate to address the social conditions that underlie their concerns (Lynam, 2005). It is unquestionable that nursing needs to develop the ability to provide care that is inclusive of culture and cognisant of social diversity. It is important that communities can expect safe and skilled nursing care as a right and the complexity of dealing with culture, difference and discrimination must be confronted and resolved in nursing. Theory has already been written that is designed to assist nurses in such an undertaking. However, it seems that the uptake and application of those models available is inconsistent and what is even more challenging is how to actualise nursing care using such theory. Spence (2001) stated: "The voices of practicing nurses ... are all but absent from the literature" (p624).

The existing understanding of how to work as a nurse in a cross-cultural sense is currently framed in terms of the nurse-to-patient relationship and relates to one-to-one interactions. Nursing has a tradition of association with the direct 'care' of patients and much of nurses' work involves individual, personalised encounters with patients. Providers of healthcare and patients have traditionally defined their relationship as one where they are separated by a cultural gap due to the different understandings held by each other — one as part of an institutional system and the other as a socialised member of the social 'sick' role. Culture and its relevance to the practice of nurses can no longer be limited to the dynamics of the nurse–patient relationship. The literature is replete with references to the desirability and potential means of measuring an individual nurse's progress towards becoming culturally competent, culturally sensitive or culturally safe. Again this reinforces the nurse–patient relationship as private and does not acknowledge the power of the institution in its influence upon or control of the scope of a nurse's practice or decision making capacity.

It is also increasingly important that nurses begin to understand how they construct their own world, that of the 'culture' that frames the healthcare system. Australian healthcare is created from within a structure and that structure is culturally determined: it is predominantly from an Anglocentric and Westernised viewpoint. Nursing practice takes place within such a community, that is nurses and patients both interface with a socio-political structure that is the healthcare system and the hospital is a complex place of language, history and environment. Nursing scholarship has in the past focused on nurses as individuals who need to undertake change. Whilst this is true, it is also overly simplistic. It is contended that the wider world of the healthcare system, which controls and constrains and within which nursing takes place, would be a valuable new site for consideration.

Current theory has established, in the tenets of the discipline, that the solution to improving cross-cultural care is for individual nurses to take personal responsibility by becoming more 'culturally competent, sensitive or safe' in respect of cross-cultural care. However, this too is overly simplistic and merely deflects attention away from highly influential and powerful wider systemic and structural issues. There seems to be an avoidance of those analyses which relate to the more complicated issues of social structure that are aligned to 'culture'. For example, those involving nurses' and patients' real power in the system, the privileging of individualism, the 'depoliticising' of healthcare as a social organisation, the lack of awareness of local context and structural constraints to change, all of which might challenge nursing's current theoretical position. Such issues remain relatively unexplored in any significant depth, for all the nursing rhetoric about the need for deeper exploration into social factors of influence. Cultural care in nursing must move from a narrow, individualistic position and consider the socio-political structure. For this is where nursing takes place, in the broader setting of health care as a public and social institution. Nurses have significant input into healthcare delivery and sustain the current order and system. Culture shapes not only individual understandings of health and its associated practices; it also has a profound influence on the way that formal systems of care are structured, organised and sustained.

The role of the nurse is certainly charged with the power to either facilitate or contradict the actions and decisions of the patient, but only as far as the nurse's behaviour complies with the expectations of how a nurse is 'permitted to act'. The institution will exercise control if the Western, biomedical paradigm is operational in health care. It is unlikely that a patient would

be offered traditional Chinese medicine should they even request it. It is almost naive for nursing scholars to continue to pursue and perpetuate such an artificial impression of what might really be the case, or achievable either for themselves or patients in terms of the need to comply with hospital policy and social mandates.

Currently, theory constitutes one of the structures that reinforces rather than challenges the existing social order. The socio-political context in which nurses work is one where the traditional and habitual 'way of doing things' will predominate and lead to health care service being organised in a way that continues to frame and regulate nursing practice in patterns which constrain nurses' independence, autonomy, and creative potential. This thesis has highlighted that these might be some of the reasons why little progress has been made towards change and that this is likely to be the case into the future if nurses fail to act now.

'Trapped in the academy' — a need to move from paper to practice

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The existence of a body of knowledge on cultural care, in itself, has not ensured that such information has or will be read, understood or used, let alone that it becomes a means of changing attitudes and transforming nursing and healthcare, as the authors of such texts might have hoped. Theory about culture, at this time, remains primarily epistemological. That is, it has a concern with the nature of knowing, not the experience of that knowing. Theory is meant to provide roots to ground and guide the practitioners of a discipline, but unless theory is enabled through education and infiltrates practice, it will be of little use. Many nurses working in clinical environments express the sentiment that they do not see nursing theories and models as useful to their day to day practice. The best theory in the world will not be successful unless there is a resonance with the clinical work of nurses — the real world of practice must be the starting point for any nursing endeavour.

Traditionally, nursing education programs have been guided by the principles of the 'norm', that is the white, majority segment of society and been aimed at helping students to function effectively within that group. Such an educational approach, with its reproduction of the 'norm' and its racialised relationships among and between students and academics, has proven to be of little help in preparing students to work in our 'multi-racial' world. It is important that these issues are pursued and further investigated. Critical to developing new educational approaches is revisioning what is actually being taught in nursing, questioning

whether that is working and establishing anew what might need to be taught. This requires that nurses reconsider the usefulness of the theories that were previously assumed to be suitable for underlying such teaching. A new perspective of culture is needed to invigorate the relationship between theory, education and practice.

Scholarly and theoretical clarification also seem to be problematic. Scholarship to date seems to be largely informed by exchanges with and between scholars themselves and be largely of an intellectual and abstract nature. Those people best placed to understand practice and make changes are the nurses themselves. In Australia, as in other Western countries, there is little evidence of nurses' involvement, other than as recipients of theoretical knowledge.

Establishing the local context and developing new insights

Particularly for Australia...

Since the 1980's, the nursing theory of Leininger has been used in education and research in Australia, although it has never been adopted wholeheartedly. In recent times some limited reference has been made to the work of Ramsden. The discipline of nursing in this country has built little local theory upon which to base the provision of care to its own population. Such theory as it has been utilised has been often 'imported' from other contexts. For this thesis much of the literature informing cultural care had to be sourced from outside Australia and scrutinised, to a greater or lesser extent, for its fittingness and extrapolation into the Australian situation.

At one time in nursing, the work of internationally acclaimed scholars and academics would have been regarded as an authoritative and informative way to guide research and practice. To date, however, the grand 'theories' of cultural care have had only minimal impact on nursing practice in Australia. Domestic scholarship has failed to produce a convincing or trustworthy solution and the apparent lack of authentic research in any significant volume has not helped Australian nurses to identify a solution to their problems in providing a high quality and appropriate discourse for meeting multicultural nursing care skills development.

Australia, like New Zealand and Canada, is a post-colonial nation and was formerly annexed to Britain. However, unlike those countries, Australian nurses have not looked to their recent

colonial past for illumination or explanations and to date no significant interest has been shown in using the work of authors in this field, already described in previous chapters, which may offer new insights for consideration. Whilst this thesis has not been focused entirely on the interests of indigenous persons, it is apparent that nurses have failed to pay attention to the situation of vulnerable Aboriginal people in their own country. More careful consideration needs to be given to Australia's Indigenous peoples, whose morbidity and mortality rates attest to the deleterious impact of socio-economic, political and historical factors over the last 200 years. The postcolonial legacy needs to be either acknowledged or perpetuated; there is no neutral position. The patient is notably absent from the voices that contribute to knowledge on cross-cultural care and most especially the indigenous discourse. Whilst being pivotal to its construction, they do not have a place in either the design or assessment of the outcome of care.

Internationally...

Cross-cultural care needs to become a priority in the education, research and practice of nurses, but this is proving difficult to achieve, as has been found everywhere across the world. There has been some call to change but an apparent unwillingness on the part of nurses to 'engage with' culture, which has proved to be an obstacle. Providing clear direction is vital. Education and nursing practice 'is only as good' as the research that informs it. Adaptation to the demographic shift in Western nations is essential. But rather than seeing cross-cultural care as a problem and relying on the largely monocultural approach that has informed current theory and practice, revisioning in light of local circumstances and each countries' distinctive need and social context is critical.

The patient perspective is missing in cross-cultural research. Theory and research is needed that is more inclusive of all people, not, as in the past, just studied as the 'ethnic' subject, but included as active partners. Patients will not necessarily emphasise the same concerns as 'experts' or nurses do. The contribution of the patient and the wider non-professional or minority ethnic communities to nursing discourse is inadequate. Nurses must develop relationships and consult the cultural 'Other'. Not, though, in the way that ethno-nursing has collected data about other ethnic groups in the past, through interview and observation alone. More, rather, in the sense that nurses begin to see other knowledge paradigms as a viable and

credible way to understand others and become aware of and engaged with the concerns of others as articulated by the 'other'.

Scholarship is needed that is inclusive of knowledge from different social locations, most especially from those that have been rendered invisible through their place within the socio-historical landscape. Nurses who work so closely and intimately with patients should better understand partnership. The 'real' views and social position of the 'ethnic other' need to be captured and embedded in theory, which unfortunately currently articulates and operationalises a white, Western 'monologue' on cross-cultural care. Marginalised knowledge, experience and worldview will remain hidden, as it is now, if the holders of that knowledge stay silent.

Diversity is also becomingly increasingly evident in local terms, in respect of the changing demographics within the health care workforce. The demographic of the nursing profession in Australia does not currently reflect or represent the cultural diversity of the population and this only serves to reinforce the status quo (Parker & McMillan, 2007). The NRNE (2002) suggested nursing needs to move from a largely monocultural group to one that better reflects current Australian society. With a growing number of overseas qualified registered nurses and international students being recruited into the health service, and a growth in the cultural diversity of the local population, it is likely that into the future, diversity in the nursing workforce will increase. This, however, might increase rather than decrease problems and it could reasonably be expected to introduce a new subset of problems (Jeon & Chenoweth, 2007). Jeon and Chenoweth's work reveals that newly employed registered nurses from non-dominant cultural groups may expect to encounter the same set of problems that minority patients do. Such issues as challenges in communicating with English speakers, difficulties in being perceived as competent team members, loss of confidence and an inability to exercise their own cultural approaches to care have led to social isolation and caused dissatisfaction with their nursing work. Given that nurses from minority groups are likely to "lack a voice in determining the evolution of contemporary nursing practice" (Jeon & Chenoweth, 2007, p19) they will probably face the same problems encountered by minority group patients. Increasing, cultural diversity within the nursing workforce might only serve to intensify concerns unless Australian nurses generally develop a better understanding of working across cultures and the capacity to function effectively as a profession as well as when working with patients.

Nurses will need to begin considering this issue of diversity amongst their nursing colleagues and also within the health professions with whom they interact. The Western nations, including Australia, have become a destination of choice for migrant nurses and current workforce shortages have only escalated this trend in recent years. Within provider organisations, nurse managers and practitioners are trying to deal with the new challenges that this will generate in an already rapidly changing health care context. This will have implications for organisational culture, the dynamic of care giving and on an interpersonal level. There is an urgent need to understand how this impacts on service delivery, the experiences of this immigrant group and also to examine ways in which to respond effectively. Few nursing scholars have either acknowledged or examined the potential impact of this new demographic.

What is extremely important to remember is that scholars, educators and those who promote the development of cross-cultural skills have had the opportunity to give these matters a great deal of thought and often have the benefit of immersion in this topic field. It will take considerable time and effort to capture the interest of nursing as a whole and to begin that process recognising the limitations of current theory is crucial. Nursing as a discipline cannot move forward unless there is acknowledgement that a problem exists in current theory building around culture.

Last words

Despite Western nurses in practice now having to work closely with culturally diverse populations of patients every day, they have not yet developed sufficient understanding of the complexities inherent in cross-cultural encounters. Improvements in the quality of care offered, enrichment of patients' experiences or positive correlations with health care outcomes have not occurred to any significant extent, most certainly in the case of non-Western immigrants or similarly vulnerable groups.

As has already been described, there are important new directions being opened up which need to be pursued in greater depth by scholars and researchers to investigate more vigorously the issues related to cultural diversity and advance the work of the founders. It remains unlikely that nursing scholarship on the topic of culture and nursing care will be advanced unless nurses better appreciate that the consideration of cultural issues in nursing

care is crucial. Whilst it is impossible for any single individual to effect change on the scale that is required, the need has been clearly identified and what is required, first and foremost, is for individual nurses to answer the 'call to action' on behalf of their patients and decide to take part.

Finding solutions will require sound theory that resonates with nurses and needs time, patience, processes, resources and trust to ensure any forward movement takes place. Without nurses to lead and direct conceptual development or provide guidance and clarification through ongoing intellectual interrogation of the complex knowledge field that is culture, it will be very challenging to continue to advance cultural care in ways that puts this on the nursing agenda and enhances health outcomes for patients. Nurses need to become a part of the process towards changing the lives and health of minority groups and socially vulnerable patients. To neglect this would constitute a concerning oversight on the part of nurses if they are to remain effective into the future.

Forty years after cultural care theory was introduced to the discipline of nursing, the discourse is entering an important phase in its continuing development. Nursing as a discipline has choices. It can maintain the current position and carry on with 'business as usual', believing that cultural care theory is adequate and make use of the existing models of cross-cultural care to underpin education, research and practice. To achieve this, all that is required is to ignore any evidence to the contrary, such as the lack of adoption of theory by practicing nurses; the clear failure to have better health care outcomes; the evidence provided through patient narratives of negative experiences with nurses; or the poor collective statistics of indigenous and minority group patients. Alternatively, there could be a collective admission that we have 'some way to go' in clarifying cultural care theory, in supporting scholars and researchers in this area and acknowledging that there is a need for ongoing development and solution seeking.

At the commencement of this study and the writing of this thesis was a key question: *when nurses have had access to cultural care theory and its related literature for some 30 years, why has this not, as yet, had a significant impact on nursing?* This question has been answered but in doing so it has demonstrated a need for nursing to take on new work, which requires a commitment and concerted effort on the part of the profession of nursing as a whole. As individuals, some nurses have made a significant contribution to the topic of culture, but as a

community nursing has important 'distance still to cover'. Australia has made little progress, the USA and Britain are in a static position and Aotearoa/New Zealand anticipates problems into the future. Canadian nurses seem the only ones seeking new solutions and positioning themselves to move forward. Nurses using a cooperative sense of enterprise need to undertake a self critique of their standpoint on culture and use this as a fulcrum to move forward. Drawing the attention of nurses to these concerns will compel them to re-investigate this phenomenon, better understand what established knowledge has to offer, assist them to make decisions about the quality of that knowledge and then come to a conclusion on how to move forward in a meaningful and purposive way. On the basis of the conclusions in this thesis, nurses must take action, for if they fail to do so, the current situation will persist and patients, not nurses, will remain at risk.

APPENDIX I – UTS ETHICS COMMITTEE APPROVAL LETTER

14 May 2007

Professor Kim Walker
Practice Development & Research Coordinator
St Vincent's Private Hospital
SYDNEY

Dear Kim,

UTS HREC REF NO 2007-069 – WALKER, Professor Kim, STEIN- PARBURY, Professor Jane (for SEATON, Ms Lesley PhD student) - "Cultural care in nursing – a discourse analysis"

At its meeting held on 08/05/2007, the UTS Human Research Ethics Committee considered the above application, and I am pleased to inform you that ethics clearance has been granted, subject to correction of consent form to consistent use of the first person.

Your clearance number is UTS HREC REF NO.2007-69A

Please note that the ethical conduct of research is an on-going process. The *National Statement on Ethical Conduct in Research Involving Humans* requires us to obtain a report about the progress of the research, and in particular about any changes to the research which may have ethical implications. This report form must be completed at least annually, and at the end of the project (if it takes more than a year). The Ethics Secretariat will contact you when it is time to complete your first report.

I also refer you to the AVCC guidelines relating to the storage of data, which require that data be kept for a minimum of 5 years after publication of research. However, in NSW, longer retention requirements are required for research on human subjects with potential long-term effects, research with long-term environmental effects, or research considered of national or international significance, importance, or controversy. If the data from this research project falls into one of these categories, contact University Records for advice on long-term retention.

If you have any queries about your ethics clearance, or require any amendments to your research in the future, please do not hesitate to contact the Ethics Secretariat at the Research and Innovation Office, on 02 9514 9615.

Yours sincerely,

Professor Jane Stein-Parbury
Chairperson,
UTS Human Research Ethics Committee

APPENDIX II – PARTICIPANT INFORMATION SHEET

UNIVERSITY OF TECHNOLOGY SYDNEY

INFORMATION SHEET

CULTURAL CARE IN NURSING: A discourse analysis

(HREC approval number 2007-069)

WHO IS DOING THE RESEARCH?

My name is Lesley Seaton and I am a PhD student at UTS. (My supervisors are Dr Kim Walker and Dr Jane Stein-Parbury)

WHAT IS THIS RESEARCH ABOUT?

This research is to find out more about cultural care in nursing – its literature, its teaching and its application to nursing practice.

IF I SAY YES, WHAT WILL IT INVOLVE?

I will ask you to take part in an interview OR take part of a focus group discussion of one hour's duration.

ARE THERE ANY RISKS?

There are very few, if any risks, because the research has been carefully designed. However, it is possible that you might feel some embarrassment, worry or concern about any information that you may disclose or share. You are encouraged to be open and frank, as any information which may identify you during the course of this interview will be rendered anonymous during the process of transcribing the interview into printed text. The original tape recording will be kept in a secure place and destroyed without your identity ever being made known to others.

WHY HAVE I BEEN ASKED?

You are able to give me the information I need to find out about because of your experiences in or with this field of knowledge and teaching.

DO I HAVE TO SAY YES?

You don't have to say yes.

WHAT WILL HAPPEN IF I SAY NO?

Nothing, I will thank you for your time so far and won't contact you about this research again.

IF I SAY YES, CAN I CHANGE MY MIND LATER?

You can change your mind at any time and you don't have to say why. I will thank you for your time so far and won't contact you about this research again.

WHAT IF I HAVE CONCERNS OR A COMPLAINT?

If you have concerns about the research that you think I or my supervisors can help you with, please feel free to contact me on (02) 9514 5717 or lesley.seaton@uts.edu.au

If you would like to talk to someone who is not connected with the research, you may contact the Research Ethics Officer on 02 9514 9615, and quote this number (*UTS HREC Approval Number 2007-069)*

APPENDICES III – CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

UNIVERSITY OF TECHNOLOGY SYDNEY

UNIVERSITY OF TECHNOLOGY, SYDNEY

Consent Form

I, _____ (*participant's name)*

agree to participate in the research project **Cultural care in nursing: a discourse analysis** (HREC reference number 2007-069) being conducted by Lesley Seaton, Kuring-Gai Campus, PO Box 222, Lindfield, NSW 2070, Australia, Telephone: 9514 5717 of the University of Technology, Sydney for her degree, a PhD, within the Faculty of Nursing.

I understand that the purpose of this study is to provide greater understanding about cultural care in nursing though an exploration of its literature and its teaching and appreciate more about how it is understood by and used in the practice of nurses when working with patients.

I understand that my participation in this research will involve my taking part in an interview, of one hour's duration which will be audio taped. I realise that it is not intended that any embarrassment, worry or concern is felt by myself about any information that I may disclose or share. I have been encouraged to be open and frank, as any information which may identify me during the course of this interview will be rendered anonymous during the process of transcribing the interview into printed text. The original tape recording will be kept in a secure place and destroyed without any individual's identity ever being made known to others. I understand that I may be re-approached on one further occasion by the researcher in the case that clarification of any information is needed or more information is required.

I am aware that I can contact Lesley Seaton or her supervisor(s) Dr Kim Walker Telephone: (02) 8382 7442 or Dr Jane Stein-Parbury Telephone: (02) 9514 5260 if I have any concerns about the research. I also understand that I am free to withdraw my participation from this research project at any time I wish, without consequences, and without giving a reason.

I agree that Lesley Seaton has answered all my questions fully and clearly.

I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

_____ ____/____/____

Signature (participant)

_____ ____/____/____

Signature (researcher or delegate)

NOTE:

This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: 02 9514 9615, Research.Ethics@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

APPENDIX IV – INTERVIEW QUESTIONS AND PROMPTS

INTERVIEW QUESTIONS AND PROMPTS

An important consideration in the interview questions to be used was that any opportunities to express individual experiences and perspectives is maximised and that the researcher remains open to unanticipated information from which important new discoveries may arise. For this reason a semi-structured style of interview has been chosen. Only five guiding questions will be used in each interview to ensure that a consistent approach is utilised with all participants.

1. When I use the term 'cultural care in nursing' – what does this mean to you?
2. What significance do you feel cultural care has for nursing as a profession?
3. What do you think are the most important aspects of cultural care in nursing?
4. How, if at all, do you think exposure to cultural care theory has made a difference to the practice of nursing?
5. Do you have any suggestions about what aspects of cultural care in nursing might require improvement?

Between these questions I will speak only in relation to the nature of responses from participants. Some further questions may be required to seek clarification, some may be needed to draw out detail or examine complexities in the participant's answers. General prompts may be required such as "can you give me an example of that "or "could you tell me more about that" to develop certain remarks or follow-up on statements made.

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