Cultural safety: Nurses' accounts of negotiating the order of things

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Abstract

Cultural Safety is a significant nursing discourse in the nursing education curriculum in Aotearoa New Zealand. However, when nurses graduate and begin working in different practice settings it is only one of several competing discourses they negotiate in their daily practice.

Cultural Safety, which is based on privileging the knowledge of the person who is being cared for, becomes a point of conflict within an environment where discourses of traditional nursing care and medicine compete. In this paper we examine how power relations are played out in practice settings by registered nurses who at times struggle to implement cultural safety knowledge in their work practices.

> We tend to look at patients who won't do what we want them to do and think "What is wrong with them?" We look at cultural safety and say "It's not working in the way it ought to be working, so what's wrong with the environment?" It is about getting people to see the win for themselves and investing time effort, energy and thinking in this. Then it is making it "how we do things around here". At the moment we don't do either of these things well. (Participant)

Introduction

Cultural safety is a nursing and health discourse in Aotearoa New Zealand designed to guide health care delivery defined as 'safe' by the person receiving the care. Cultural safety grew out of challenges by Māori educators, nurses and Māori leaders to the Pākehā dominated health systems, who were concerned about access to health care for Māori. It eventually came to be about all users of the health services. Its presence in the nursing education curriculum sits uneasily alongside other educational discourses within nursing as it disrupts the natural order of the way nursing and health care knowledge is undertaken by situating a marginalised discourse within nursing education. More importantly though, by valuing the knowledge of the recipient of care, cultural safety discourses disrupt the historical hierarchical practices about whose knowledge counts in health care delivery and health care disciplines.

By privileging the knowledge of the recipient of care, education in cultural safety provides nurse graduates with knowledge of discursive practices that have the potential to disrupt the 'taken for granted' knowledge in health care settings. This paper discusses the experiences of nurses who have attempted to provide culturally safe care in environments where practice is shaped by traditional, nursing and biomedical discourses. The nurses' accounts position cultural safety in a wider context of health care to show how cultural safety's discourse within health care is tenuous.

What is cultural safety?

Cultural safety is designed to guide health care delivery defined as 'safe' by the person receiving the care. The term 'cultural safety' resonates with the wider discourse of nursing and health care and is consistent with the Nursing Council of New Zealand requirement for the nurse to demonstrate physical, ethical, legal and practice safety (Nursing Council of New Zea-

land, 2005/2009).

The origins of cultural safety grew out the challenges by Māori educators, nurses and Māori leaders to the Pākehā dominated health system during the period of the 1970s to the 1990s. As Irihapeti Ramsden, a driving force behind the introduction of cultural safety to nursing explained:

> [Cultural safety] was necessary to address issues of attitude and prejudice formation on the part of people in the health service because they held a great deal of power in the form of knowledge and other resources. This meant dealing with such social mechanisms as personal and institutional racism in the context of a violent colonial history and coming to terms with the inherent power relations, both historical and contemporary… Consciously or unconsciously such power reinforced by unsafe, prejudicial or demeaning attitudes and wielded inappropriately by health workers could cause people to distrust and avoid the health service. Nurses needed to understand this process and become very skilled at interpretation of the level of distrust experienced by indigenous people when interacting with a health service which has its roots in the colonial administration… Cultural Safety advocated and then implemented the replacement and demystification of the colonial history in terms of its development of attitudes and beliefs toward indigenous peoples. (Ramsden, 2002, p. 3)

Although it arose initially from Maori concerns about access to healthcare, it was also aimed at nurses and challenged them to focus on their professional attitudes and the power they had to influence healthcare[1]. A current reading of cultural safety is described as:

> [The]Effective nursing of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation; socio-economic status; ethnic origin or migrant experience; religious or spiritual belief; and disability… Unsafe cultural practices comprise any action which diminishes, demeans and disempowers the cultural identity and wellbeing of an individual (Nursing Council of New Zealand, 2005/2009, p. 4)

Culturally safe care requires the nurse to recognise that difference exists between her/him and the person for whom care is provided. It calls for an understanding of the influence personal, social, historical and contemporary life experiences have on the wellbeing of individuals and groups using health services. An understanding of how power shapes and influences the practices of healthcare, and the relationship between nurses and patients is central to the practice of cultural safety.

Irihapeti Ramsden (1990) identified four stages of learning about cultural safety. Firstly, attitude change; the focus of learning is on the personal history and the professional attitudes the nurse brings to the nursing encounter. The gaze is turned toward the provider of care rather than the recipient of care. Secondly and thirdly, an educational process provides a framework where the focus of analysis is on the critical examination and deconstruction of attitudes incongruent with effective and safe nursing practice. Finally, the nurse develops skills enabling them to translate knowledge and understanding gained from these processes into everyday practice.

Since its introduction into the New Zealand nursing education curriculum, the responsibility for delivery of culturally safe care in the practice setting has tended to fall on the shoulders of individual nurses, and has failed to take into account the existing discourses that shape the myriad of practices within the hospital setting that work to maintain power, order and discipline within different health care settings.

Research Method

Interviews with participants

In this paper we explore some of the experiences of nurses working in New Zealand health care settings between 2004 and 2007. These nurses were interviewed as part of a larger research project for a PhD. The participants were recruited through advertisements in a nursing journal and letters to District Health Boards who put advertisements on their notice boards. The six-

teen nurses interviewed were asked how they applied cultural safety in their everyday nursing practice. The interviewer asked the participants to describe their experiences of the day to day realities of using their knowledge of cultural safety in their workplaces. The interviews lasted between one hour and one and a half hours, and were taped and transcribed. Some of these accounts form the basis of this paper. All names used in this paper are pseudonyms to protect the identities of the participants.

Theoretical frameworks

We acknowledge that as Fergusson et al (1992, p. 299) write "As soon as we, as researchers become involved in telling *our* stories of *their* stories, we present *our* interpretations of *their* interpretations" [Emphasis in original]. In the next part of this paper we make explicit the framework we bring to our interpretations.

Central to our analysis are our understandings of Foucauldian notions of the relationship between power and knowledge. We draw on Foucault's (1980, p. 52) work which articulates that power "perpetually creates knowledge and conversely, knowledge constantly induces the effects of power". It is in everyday practices that power can be observed. As Foucault (2000, p. 87) explains

> ...the whole set of little powers, of little institutions situated at the lowest level.... gave rise to a series of knowledges – a knowledge of the individual, of normalization, a corrective knowledge.

We take up this idea that power is produced through knowledge and practice, historically and in the present, and in this paper explore the discursive practices of registered nurses as they strive to implement cultural safety in their workplaces, the hospitals. We explore the complex networks of power expressed through competing health care discourses that intersect with the application of cultural safety in everyday nursing practices.

Throughout this article we aim to make visible the power relations that were being created and re-created through the discursive practices of the hospitals. We interpret 'discourse' not simply as ideas or knowledge, but in the Foucauldian sense of practices and ways of shaping the world according to that knowledge (Crowley & Himmelweit, 1992, p. 237). It is by observing the "little powers" Foucault (2000) in everyday practice in the hospital setting that we observe the relationship between power and knowledge in these sometimes opposing discourses.

It is important to recognise that not all discourses are of equal power. Some are more dominant than others at particular times and places; they are always historically and locally specific (Richardson, 1994). In this paper we explore the participant's experiences of implementing cultural safety in an environment of competing discourses of traditional nursing, maintaining an environment of control, and the primacy of medical knowledge.

Gilbert (1995) suggests that nurses need to identify discursive practices through which they are formed because it is these practices and their associated norms and values, that nurses carry with them into their everyday roles. Applying this to understanding cultural safety in a hospital setting requires that the nurse be aware of power as a productive force and how cultural safety plays out in the setting within which she/he is working. The nurse needs to be confident in linking this understanding to wider political and socio-economic effects of power and be willing to bring this understanding to bear on one to one interactions with clients and colleagues and the technologies of care planning, clinical judgment and care delivery.

In this paper we discuss the nurse participants' accounts of how they negotiated cultural safety practices in their working environments where they encountered other powerful opposing discourses. It is through the taken for granted knowledges and everyday practices in the

hospital settings that the power of competing discourses were observable in these accounts. We started our analysis for this paper with the participants' stories and worked inductively to identify competing discourses. For this paper we have chosen to focus on discourses of traditional nursing care and biomedical imperatives to explore the way that the participants negotiated cultural safety in environments with competing discursive practices. We have also chosen to integrate published literature throughout the paper rather than in the 'traditional' way of separating it into a literature section at the beginning because we see it as another source of data, and do not wish to privilege it over the accounts of the participants.

Discipline and order

We begin this section with a brief review of the historical development of the role of the nurse and the development of traditional discourses of nursing practice. We then discuss how these traditional discourses shape practices of discipline and order described in the accounts of the participants.

The traditional, or as we have named it the 'Florence Nightingale' discourse of nursing, draws on Judaeo-Christian concepts of what constitutes the category of 'woman' and by definition a 'good nurse' as opposed to an 'unruly' or 'undisciplined woman'. Florence Nightingale was one of a number of powerful women in the mid to late eighteenth century working for health reform. Others included Elizabeth Fry and the St John's nursing service from Kings College Hospital, known as the model of the sisterhoods (Dingwall, Rafferty & Webster, 1991). The Crimean war and the hospital reform movement brought about by Florence Nightingale in 1861 (Williams, 1995) propelled Nightingale into the forefront of change in nursing education with the influence of her thinking being exported to colonial New Zealand in the late nineteenth and early twentieth centuries. The effect of this on New Zealand has been profound and we contend, continues to shape discursive practices of nursing today. This discourse constructs nurses as moral, good, disciplined, sober, honest, punctual, quiet, orderly, clean and neat (Dingwall, Rafferty & Webster,1991). Such a construct requires commitment to maintaining order through knowing one's place in the hierarchy of the institution (Nelson, 1995; Reverby, 1998).

Although beyond the scope of this paper, a brief description of the origins of social order is useful because the maintenance of the order and discipline derives from early English health and nursing reforms. Dingwall, Rafferty and Webster (1991) note that as nursing and medical education improved in conjunction with the industrialisation of England, so did concerns about social order with a greater need for social control of urbanised populations and the attendant problems of hygiene and sanitation. Dingwall, Rafferty and Webster equate social control with the "need to maintain a sufficient degree of order for society's members to plan and co-ordinate their daily lives so that the group can produce itself and survive through time" (p.25). With the increase in factory production, the need for sober work habits became critical to ensure continuity of output. Therefore workers had to be sober to be safe, well, and to turn up for work, thus the push for the moral reconstruction of society and the control of social behaviour. With increasing urbanisation, there was also a greater need for regulation of health through the growth of hospitals where sick people could be centralised, and for the development of hygiene laws to manage disease and control sickness.

Reverby (1998) argues that hospital morale was created through order, and that nurses were responsible for ensuring order through the control of diet, and hygiene such as ventilation, clean drains and sewerage, so that the healing process could take place. Self-discipline, self-sacrifice and maintaining order were key practices of this discourse and nurses under Florence Nightingale's tutelage were expected to act as agents of social and moral control and model discipline and order to those less able or equipped to do so.

The history of contemporary nursing practice is characterised by a 'profound conservatism' Walker and Holmes (2008, p. 108), and has tended to operate in the service of a patriarchy which has been complicit in encouraging this. Walker and Holmes suggest that as a result, nursing has perpetuated its own subjugation to medicine and the health bureaucracy and in so doing has failed to recognise possibilities for transformation. Nightingale's discourses of nursing not only constructed what a nurse is, but also established nursing within the medical hierarchy.

> Nightingale established principles of conduct in nursing not only in the conduct of behaviour but also in the conduct of relationships between nurses and other hospital workers (Williams in Davies, 1995, p.41).

Walker and Holmes (2008) draw on historical nursing texts written by Doctors Cuff and Pugh (1924) to illustrate the medical expectation of nurses in training toward caring for patients, and their relationships with doctors.

> The patient must always be [the nurse's] first care... her manner must be characterised by dignity and gentleness...familiarity must always be avoided; but the nurse should show her patients, as she can help in many little ways, a sympathetic willingness to help them, that her work is a pleasure, and that it is done ungrudgingly' (Cuff & Pugh, 1924, p. 24, cited in Walker & Holmes, 2008, p.5).

> To the medical attendant a nurse's first duty is obedience... and where altered conditions sometimes justify modification of the doctor's orders, her aim should be to proceed along lines likely to be approved by him rather than those, she herself might choose... she should always do her utmost to promote her patient's faith in his medical attendant (Cuff & Pugh, 1924, p. 24, cited in Walker & Holmes, 2008, p.5).

Walker and Holmes note that by the 1930s, "increasing bureaucratisation of the hospital and the health service sector ensured that this order of things would eventually cause the patient to be displaced from the apex of the hierarchy of importance" (p.112) and replaced by the medical personnel. In a medical text on ethics in nursing, cited in Walker and Holmes (2008, p. 112) Burbidge, (1935, p. 26) stated:

> [Ethics] have been defined as the science of moral principles and duties. They are an essential and integral part of nursing, and can be grouped under four main headings: 1. Duty to the doctor; 2. Duty to the patient; 3. Duty to those with whom she works; and 4. Duty to the profession.

Reverby (1989) claims that while the symbolic trappings of hierarchy, duty and discipline have gone, the 'Florence Nightingale' discourse of nursing remains. While we may think that higher education, more clinically focused roles, and the jettisoning of hierarchical titles, has moved nursing beyond these original practices, Reverby suggests that these discourses have been repackaged through different mechanisms of power. She argues that nursing is still closely bound to its origins as a moral, womanly and caring endeavour, and stepping outside those boundaries still threatens to bring downfall, reprimand or labelling.

This practice of 'keeping order' within a hospital setting is seen in many of the current nursing practices. One example of keeping order that can be seen as part of the traditional 'Florence Nightingale' discourse is the ordering of the day and the controlling of practices of hygiene in the ward. One nurse who worked in an aged care setting spoke about the need to get to know people and their likes and dislikes so that she could provide culturally safe care. The story she told gives an interesting example of discourses of cultural safety conflicting with the Florence Nightingale discourse of order and hygiene. Interestingly it also demonstrates that within a discourse, certain practices can be taken up and others resisted.

> We had a lady just recently who was reluctant to have a shower at all. And staff were saying "You know, she's terrible she won't have a shower" and for four days she had not had a shower. I said to her "I'm just wondering when it would be a suitable time for you to have a shower?" She looked at me and she said "Just before

I go to bed." All right. Fine. So I went back to the staff and I said "This lady would like to have a shower ***before*** she goes to bed". They said, "We can't do showers then; the afternoon staff are going to hate you for that." I came in the next day, and no she wasn't showered (Louise).

The field of aged care has traditionally been considered to be hard physical work carried out by a mainly unregulated workforce and thus until recently has been vulnerable to the development of practices which have relied on routine, ritual and repetition to complete the work of caring and maintain order. The need to maintain existing routines was considered by the staff to be more important than the imperatives of hygiene and the comfort of the patient. While Louise challenged her colleagues about the need for the woman to be showered, it was the suggested 'disruption' to the daily schedule that was opposed. As Foucault stated, it is in the everyday practices that the workings of power are visible.

Louise said that she was not surprised that the woman was still un-showered the next day, and had worked out an alternative strategy. She approached the woman and offered to shower her just before lunch when it was a quiet time in the bathrooms. The woman agreed. Louise went on to say:

> I thought about the time it would take trying to convince other people [staff] to get her showered in the afternoon, when the most important thing was to get her showered for her sake, but also for the people she was around, for everybody. So I did it, and of course it meant that I got a bit behind with stuff because I'm supposed to do a million and one things just before lunchtime, but I just thought "well it's got to be done". You see we get so tied up in our routines, but sometimes we just have to think outside the square a little bit. (Louise)

This account is as much about providing individualised care as it is about engaging in a relationship where the dignity of the person is held and maintained within the limitations of an established practice. While Louise reports being unable to reduce the potentially dehumanising effects of ritualised routines she was able to change the practice through changing her own routines. This story illustrates the struggle when trying to work in a culturally safe way while engaging in discursive practices that are difficult to shift. Louise managed to work in a culturally safe way with this patient, but she had to do it within an existing discourse that continued to privilege routines above cultural care and personal preference.

From this account, implementing culturally safe care required considerable energy to overcome and resist, what were to Louise unacceptable practices, and she wondered if it was worth it:

> I believe that nursing is about a partnership between the nurse and the patient. But things come in between that and prevent you from giving quality care and undermine it. If I wasn't able to provide quality care I would start questioning whether I should be in the job. And there have been a couple of times I've felt that perhaps I shouldn't be in this job. (Louise)

Debbie, another nurse also talked about how she negotiated cultural safety in an environment she identified as potentially unsafe for a patient.

> People are in the system that's all there is to it. I'm only there for eight hours and during that eight hours I do what I can, and if it's important, like people putting their food down on the commode chair I'd definitely say something. I'll say "Jack hasn't eaten today because they've been putting his food on the commode chair. I'm not sure I'd like that either." Then the nurse will go "Ooo Yuk". Yeah, then they'll see it from their [the patient's] point of view. (Debbie)

By talking about people being 'in the system', Debbie indicated an awareness of the powerful discursive practices in the hospital, but at the same time recognised that she did have agency to implement culturally safe practices herself, and to influence the practices of other staff members. She talked about the way she established relationships with the patients in her care, and during the first steps of assessing, appraising and using clinical judgement, specifically began to establish culturally safe practices. She explained that she did not make assumptions about what she could or could not do, but created the space for the person to express their needs with-

in the hospital setting. She said that she was vigilant regarding the practices of her colleagues, and where possible intervened to ensure that cultural boundaries were not violated. But she did this by consciously employing a particular strategy to get her message across.

One common site of struggle between the imperative of keeping order, and working in a culturally safe way is hospital visiting, particularly the way visitors of patients who are Māori or of Pacific origin are acknowledged and interact with staff. The ritual of visiting and the presence of visitors can become a site of tension and conflict. On one hand visitors generally, can be seen as threatening the order to hospital routines and at the same time recognised as providing a connectedness for a patient. Visitors can represent a sense of 'normality' in situations of 'abnormality'. A cultural safety interpretation of visiting dictates the primacy of the family to the process of healing and recovery. However, nurses may experience conflict while working at the intersection of healing, family nursing, medical and discourses of order. They do not want to be labelled as 'culturally insensitive', but at the same time more than a requisite number of visitors can be seen as disturbing the 'efficient' functioning of the unit.

> I find it really interesting when I look at people's work practices and how a lot of our work practices increase our work and extend and haemorrhage the time that things take and that can be in how we interact with people culturally. Rather than looking to support for example a Pacific Island family who want to have ten people present, we'll look for ways to put barriers in place and then argue with people about the barriers and so the whole interaction will become extended and take up more of our time than it would if we just looked for a solution whereby these people's needs could be most effectively met. So I think a lot of what we do increases the difficulty of doing what we set out to do, and extends the time that things take, rather than the opposite way round. (Jane)

In this situation the nurse has the power and governing authority to 'control' the behaviour of patients and their visitors by using rules of domination. Rules of domination are identifiable by stability, hierarchy and asymmetrical relationships of power where the subordinate person has little room to move or manoeuvre. In Jane's illustration above, the vulnerable patient is in an unfamiliar environment with the nurse enforcing rules aimed at producing a disciplined environment. The cultural need of the patient may be to have ten relatives, including children present at any one time, and to share food around the hospital bed, but this presents a major challenge to maintaining order and control.   This can result in conflict and tension for the nurse in upholding culturally safe practice and meeting the need for order.

Another participant shared a story about the need to balance cultural safety with the need for life saving nursing intervention. At times of acute illness there can be a perception that although the need for family to be near their family member is important, the life threatening nature of a situation can take precedence over this. This can sometimes create tension and conflict between the nurse, the person and the family. Elizabeth was caring for a person who was about to go for surgery. His situation was life threatening and her actions need to be swift and life-saving. At the same time she was aware that his family needed to be close to him during this critical time to give him strength, support him and offer prayer.

> I had to prepare him for theatre, he was exsanguinating[2] and they [family members] kept coming in, coming in and coming in and in…In the end I said "OK you let me do this bit, and then we'll get you all in together and he can address you and then we'll go to theatre", ...and everybody was really happy about that. I got my bit done. I think that as nurses, we have to value what we do, and it has to be done safely, but it can be done in a negotiated way. (Elizabeth)

The repetition of *'kept coming in, coming in and coming in and in'* conveys the degree of tension that Elizabeth was experiencing. She reports feeling pressure between her requirements as a nurse to administer a life-saving intervention, and to balance this with the need for family to be present. At this point she had choices in terms of how she would or could assert her power

in this situation. At times of pressure and tension there is a risk that the nurse will invoke her institutionally legitimated professional power to manage a difficult situation. Elizabeth could have removed the family by claiming the need to address life-threatening circumstances, but she chose to work with both sets of needs. As a result she proposed a solution where the needs of all might be met by negotiating a possible solution to the situation.

Elizabeth expanded on this story commenting further:

> Nursing is a relationship; it's not going to work if I say, "You're too fat or you have to give up smoking." It's not going to work, not going to work for anyone, [it] has to be a relationship thing and if I say to these people "Look I have to get him ready for theatre because as you can see his life is in danger, but also you need to speak to him before he goes to theatre, are you happy? Yes fine."

Biomedical imperatives

In this section we explore the participants' experiences of implementing cultural safety in environments where powerful biomedical discourses dominate practice. We discuss how the nurses describe their struggles to implement culturally safe care where discursive practices of medical assessment, diagnosis and treatment predominate. Biomedical imperatives clearly privileged the knowledge of the medical staff, and left little time for nurses to create relationships with those in their care.

> Medicine relies on 'scientific principle of objectivity' and the biomedical model which has an 'imperative of time' shaping medical and nursing, judgments. Value judgments are also made about a patient based gender, social class, ethnicity, age physical attraction and the type of illness' (Lupton, 2003, p.134).

Central to the discourse of cultural safety is the notion Ramsden (2001) asserted that cultural safety was a negotiated relationship between the nurse and the person for whom they provided care. A nurse who operated in a 'culturally safe' way recognised the power imbalance.

> I think with a lot of the strategies that we employ, we think that we're employing effective strategies. For example, if you come in to see me as a patient and you start telling me why you've come to see me, I think "Oh God this person is going to talk for ages" so I interrupt you to try and jump [get] you to talk about exactly, you know your chest pain. I don't care about anything else I want to hear about your chest pain. And when I interrupt you, you'll go back and you'll tell a lot of this story with more information and you'll slow it down and you'll lower your voice tone, and I'll think "What's wrong with this person?" Because that's what we do, anything that goes wrong we see it as the patient's fault, the family's fault, some kind of problem. We never think "God, what am I doing to contribute to this. (Jane)

In this account the patient is disrupting the expectation of the nurse that the nurse controls the interaction from the position of the 'health expert'. It is easy to see that if this interaction occurs between the health professional and a person for whom English is not a first language, or there is a need for a patient to tell their own story, then the person is at risk of being judged according to a set of stereotyping characteristics or be blamed for not making themselves understood. Jane identified a tension between the need to gain an appropriate medical assessment from a patient, and the additional time required if the patient is permitted to provide this information in a way that makes sense to the patient. For nurses committed to providing culturally safe care, such an environment can constrain or disrupt their practice in terms of time and unless they have the confidence to resist the discourse they will comply with its disciplinary effect.

Creating a culturally safe environment relies on the willingness of the nurse to establish a relationship with the patient where a patient's needs can be identified. Developing relationships takes time, and nurses often feel pressured for time. Jane reflected on how time pressures can shape nursing practices.

> We feel pressured and time-poor. We avoid engaging people in any way that we feel will increase the amount of time we have to spend with them, whereas if we actually engage them we would have to spend less time. They would feel comfortable in the interim that they were in a safe place where people were interested in them and cared about them. Mostly, they don't feel that because we avoid talking to them, because that pulls us in for time that we don't want to spend. Or we interrupt them. Usually that increases their anxiety and they call us back more often and try and find ways of engaging or extending engagements. So it all works against us the way that we work. And then we see them as the problem. (Jane)

This comment opens up a way of linking cultural safety directly with good healthcare outcomes. Jane's account identified that seeking to minimise time interacting with the patient because of other priorities, was actually counterproductive, not only in terms of effective care, but also in terms of effective use of time.

Another example of the conflict between the discourse of cultural safety and a dominant medical discourse is described by Patricia a nurse who works in a day surgical unit. Her experiences resonate with those of Jane, when she describes time as a major barrier to implementing culturally safe care. A short stay unit provides for rapid assessment, diagnosis and treatment of illness and disease. The unit is characterised by a high turnover of patients attending the unit for a specific procedure and at the same time arriving at the unit with complex health needs. It provides very little time for the nurse to establish a relationship of trust with her clients the patients. The following comments illustrate tensions experienced by Patricia in her commitment to provide culturally safe care and work within the time constraints within the setting.

> It is having too many people, coming to stay, when we're processing people like widgets on a conveyor belt and you know ….tomorrow I may be able to do more, whereas today we're just processing widgets. (Patricia)

In this short section of talk Patricia clearly expresses her frustration about days in which time constraints forced her to treat all her clients the same. Patricia's use of the industrial production term *widget* means that people are likened to objects passing before her like gadgets on a conveyer belt and she had little time to attend to them in any detailed way before they move onto the next part of the production process, this being medical assessment, diagnosis and treatment. On busy days Patricia struggled with providing a nursing service that went beyond serving the needs of the physician and the dominant biomedical discourse.

Lupton's (2003) identification of mechanical metaphors to conceptualise the way a person is viewed within the medical field resonates with Patricia's widget metaphor. A mechanical construction views the body as consisting of different parts which, like a machine, may stop working, fail or need replacing. Thus the focus of medical care is on technologies and practices designed to locate the non-functioning part in order to treat or repair only that part. Patricia's role created by this discourse was to provide nursing activities to support the medical assessment, diagnosis confirming the dysfunction of the patient who was a passive recipient of the care in this process.

Lupton (Ibid) argues that the mechanical view of the body does not take account of the spiritual nature of the person, nor healing relationships, intimate personal contact though relating, or the need to develop a deeper trust with the health care provider. For Patricia, it was primarily the time constraints that limited her ability to work in a culturally safe way that could allow her to establish trust and build relationships with her patients.

In contrast to describing her days working with 'widgets', Patricia did have some days where she was able to "do more". She described doing more with one patient in her care:

> An elderly woman came in for a minor operation as a day patient. She was one of the ones who stayed in one night till midnight. She still had her medication with her and she had asked the doctor what the different ones were for. He said "If you take them all at once it doesn't matter. Just take them in the morning; you don't need to worry about that". So she really didn't have a handle on those things. She'd worked out from looking

in a book that Prozac was for depression, so she'd just taken them the day she felt down. She hadn't been very well and she thought that with her diabetes if she just didn't have chocolate she'd be ok, so her blood sugar had been up and it was all over the place.

I did have time to do a lot for her, so I did get a Benefit Rights person to tell her what she was entitled to get so that she could get new teeth, because I know that people who have no teeth can have terrible self-image. The diabetes nurse came over from the outpatient clinic and spent time with her. So that was a day that I thought was quite good. (Patricia)

For Patricia, a good day was having the time to practice in a way she considered culturally safe care. She created a space which provided physical safety, but also she recognised gaps in care and acted to put resources in place to address the woman's health needs beyond those for which she was attending the clinic. She engaged with the patient and recognised that the woman needed a range of services beyond the narrow focus of a *'minor op'* in the short stay unit.

As a nurse, Patricia's account indicates that she used her knowledge and position within the field of health care to access resources for her client, and enlist the help of colleagues to provide specialised and appropriate care. Constrained by the dominant discourses of the short stay unit, but on this occasion empowered by time, she was able to focus on establishing a brief productive working relationship with her patient. Patricia was aware that this degree of care could only be provided on a "good day" when time was not subsumed by the biomedical and technological demands of the service.

Larsen (2003) asserts that the medical field is a socially prestigious and symbolic system because of its specialised concepts and classifications. Larsen claims medicine is a male oriented profession directed toward maintaining and raising the profession's social position and healing patients based on a background of medical examination and diagnosis. Nursing on the other hand draws on a multiplicity of discourses, some of which have parallels with medicine and some which do not. He argues that nursing is seen as subordinate to medicine because:

[For] practitioners, management and organisational specialists within nursing, the experience of being constrained in their efforts to gain autonomy reflects that fact that they indeed are constrained, and that this constraining process is taking place in an unnoticed way, e.g., in that which has not yet been articulated as 'something', in the natural and in the self-evident (Larsen, 2003, p.276).

Larsen's comment reflects a Nordic view, and in New Zealand this claim can be modified due to the critical consciousness developed through cultural safety training of nurse graduates. However, as the accounts of registered nurses in this paper illustrates, the implementation of cultural safety is a contested discourse within the New Zealand health care system and more dominant discourses constrain action.

Conclusion

This paper has drawn on accounts of culturally safe nursing from registered nurses working in New Zealand healthcare settings to illustrate how different discourses compete to maintain dominance through established practices and 'taken for granted' understandings. Every day practices of culturally safe nursing are embedded within the nursing relationship and have to compete for legitimacy in settings dominated not only by alternative discourses of nursing, but by medical discourses and practices. Cultural safety provides a discourse that enables a nurse to address the complexity of nursing practice which involves all aspects of physical, social, emotional, spiritual and political concerns of the patient.

In contemporary health care environments there is a view that the historically embedded discursive practices of hierarchy and privilege are no longer a factor in the way health professionals deliver health care. Traditional lines of authority and hierarchy may have been collapsed

into 'quasi' professional compatibility and equality, but we have argued that traditional discursive practices continue to maintain authority and power in healthcare settings. In this paper we have examined the intersection of traditional nursing, and biomedical discourses with those of cultural safety discourses. We believe that the accounts of nurses from a range of healthcare contexts show that cultural safety currently operates at the margins of other more powerful discourses, and that the ability of nurses to change the power relationships within hospital settings is tenuous. The degree to which culturally safe care can be delivered continues to be influenced by embedded historical discourses controlling the construction and maintenance of gender roles and the efficient functioning of hospital structures and practices through order and discipline.

Cultural safety knowledge is integral to everyday nursing practice. This means that if applied effectively, a person using health services can safely draw on their sense of identity, culture and life experience to help sustain their sense of well-being made vulnerable by negotiating complex health procedures, systems and relationships. With its origins in the experience of the recipient of care, cultural safety positions the patient at the apex of care and the nurse more in alignment with the needs of the person for whom she/he cares. This positioning disrupts traditional notions of discipline and order and creates a new 'order of things' in keeping with the health care needs of people in contemporary society. It is tensions between the 'new/old' orders that the nurse has to negotiate to meet the health care needs of the person for whom she/he cares. At the same time the nurse has to be skilled and confident to resist discursive practices keeping her/him bound by historical discourses determining gender roles and practices of health professionals.

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Notes
1 Cultural safety in all its diversity came to be acknowledged as a specialised area in nursing and is also referred to as Kawa Whakaruruhau (Ramsden 2002), a Māori term which can be translated as affording shelter or protection from harmful elements (Williams, 1990).
2 Exsanguinating means the draining of blood (Fowler & Fowler 1970). In this context the word is used to convey to the listener that the person was bleeding profusely or 'bleeding out' in nursing terms.

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